ETHNOSPECIFIC HEALTH AND CARE: A CRITICAL ETHNOGRAPHIC STUDY OF A GREEK NURSING HOME

Submitted by

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ABSTRACT

This study examines how a Greek ethnospecific nursing home functions - situated within a health care system that operates within an English-language, and Anglo/Australian derived culture. The nursing home was examined within a critical science paradigm guided, however, by Bourdieu's reflexive sociology. Critical ethnography as a research method was combined with Greek forms of speech in order to accommodate Greek women's forms of social interaction and oral culture and to avoid imposing an alien research process on participants. Group discussions, formal and informal interviews, participant observation in a variety of forms and document examination were the approaches used to collect data in the field. A key and controversial finding of this inquiry is that the delivery of ethnospecific aged care is heavily constrained and ultimately undermined - by the policies and practices of the Australian and dominant culture that was transposed in the nursing home, via the distribution of capital that privilege dominant groups in Australia. Because of this residents and carers remained structurally excluded from participation and decision making processes and located at the bottom of the institutional hierarchy. This inevitably helped, particularly in regards to Greek women carers, and domestic staff, including Greek speaking registered nurses, not only to maintain but increase their negative ethnic experiences, historical oppression and exploitation. Nevertheless, ethnospecific care was provided to the residents at the cultural expressive level reflecting larger society's tolerance of a conservative multiculturalism. Significant Greek cultural care, was mediated through the Greek carers, domestic staff and residents dispositions

(habitus) that contextualised their interactions, relationships and practices, enabling their past (and because of this themselves) to live in the present in a meaningfull and dynamic way. For this reason, ethnospecific services, even when constrained by external socio-cultural and political hegemony, has more to offer the Greek aged than do mainstream aged care services.

STATEMENT OF AUTHORSHIP

This is to certify that

(i) the thesis comprises only my original work,
(ii) due acknowledgment has been made in the text to all other material used,
(iii) the thesis is less than 100, 000 words in length exclusive of tables, bibliographies, appendices and footnotes.

A. Kosmatopoulos 17/11/99

[Signature of candidate] [Date]

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TABLES

ABBREVIATIONS

GSRN	Greek-speaking Division One registered nurse
BD	Board of directors
CEO	Chief Executive Officer
CN	Charge nurse
DON (MII)	Director of Nursing Manager two
ESBIDA	English-speaking British Irish descent Australian
ESB	English-speaking
GMCS (MI)	General Manager Care Services: Manager one
NESB	Non-English-speaking background
PCs	Personal carers
RN	Registered nurse
SEN	State enrol nurse (Division Two)
SBW	Switchboard Woman (operator)

PREFACE

Please write the truth about the nursing home

- **Staff and residents**

You need to write the objective reality, the facts

- **Senior Nurse Manager**

On the day of my departure at the end of a two year period in the field, residents and staff emphatically reminded me 'to write the truth' about what I saw and experienced in the nursing home. They were talking, however, about *their* experiences and reality believing these represented the 'truth'. At the time, I recollected that senior nurse managers also reminded me to write about 'the objective reality of the home'. They were also talking about *their* experiences and practices which they also saw as 'objective truth'. Both responses reminded me of the pervasiveness of taken-for-granted assumptions about the existence of 'truth', 'objectivity', and of there supposedly being only one (universal) social 'reality'. They also reminded me of the need to question such assumptions.

To begin with, notions of 'truth', 'objectivity' and 'reality' are historically and socially constructed and hence partial, or incomplete, situated and local (as opposed to universal) concepts (Haraway 1991). Their existence rely on human beings - their practices, interactions and experiences that, in turn, are interpreted, produced and given meaning by them. Consequently, the experience and interpretation of social 'reality', 'truth', and 'objectivity' depends on individuals' socio-cultural, historical and scientific trajectory rooted in their social position and situation - the place where social reality is structured, experienced, perceived, interpreted and represented.

'Truth', 'reality' and 'objectivity' are embedded in and cannot be

distinguished from the socio-cultural, historical or political contexts that produced them. As such, they can never be any more than situated, local and partial/incomplete social constructs (Haraway 1991). Nevertheless, these constructs are often abstracted (notably by the powerful elite) from their contexts (situatedness) and treated as being *universal* in nature. What is portrayed by powerful elites to be a universal truth, reality or objectivity, however, is little more than 'legitimated capital' produced and sustained through networks of power relationships which serve the interests of those dominant elite in a given society at a given time (Bourdieu 1990; see also Foucault 1977; Harding 1991, 1987).

The significance of this study lies in its aims to: explore how a Greek nursing home works in the socio-cultural political context of Australia; identify and examine critically a range of issues that may arise in a health care context where dominant and subordinate groups of different cultural, ethnic and linguistic backgrounds work together; clarify who 'operates the tools of reality/realities production' (Van Maanen 1988:128) in such a context; and finally, to describe and critically examine the nursing home structure and the production of relative power relationships and their effects on people and practices in the Greek nursing home under study.

CHAPTER ONE

INTRODUCTION

Research problem

Research has shown that despite their needs for care, dependent Greek-born elderly (and dependent ethnic[1] elderly generally) are not gaining equal access to mainstream[2] aged care services

1 Ethnic: As a descriptive term it refers to-those who were born in countries where the first language spoken is not English, and who now live in Australia ... and it does not imply definitions of ethnic identity' (AIMA 1986:1).

As a categorising and identity concept, has been variously described. According to Bottomley (1992:60) ...'ethnicities are imposed, as well as assumed and inherited. A 'consciousness of kind' also includes a consciousness of the Other. Ethnicity can be a resource for mobilisation, but it can also be a stigma and a liability'. Ethnicity in this study clearly holds both meanings for Greek migrants as indicated in Chapter Two.

Banks (1996) explains: Ethnic is a complex and multidimensional concept. It is socially constructed, and serves a number of purposes or functions. It relates to individual and group identity; self, felt and ascribed identity; as well as to identity external to individual or group ascriptions, that the individual or group may reject or disagree with but is stuck with because the ascription has been made in relation to them by a dominant political power within a nation. In this senses the term 'ethnic' in Australia refers to 'an individual or group that is subordinate politically and culturally to the dominant political and cultural forces of a majority ' Banks (1996:27) There is no monolithic and homogenous identity or ethnicity but rather a number of identities are manifest depending upon the situation'. Political ethnicity is a strategy for corporate action (34) 'Political ethnicity is goal-directed ethnicity, formed by internal organisation and stimulated by external pressures, and held not for its own sake but to defend an economic or political interest' (Banks 35) Banks (1996:44) explains that 'Williams notes that ethnic groups in a society do not exist as isomorphic, each structurally similar. Instead there are overlapping sets, groupings which encompass other groupings. The relationship between these groupings is defined, not by their relative power or status in comparison to one another, but by their position within the state: "[[t]he concept of ethnicity, whether defined in terms of nested segments or horizontal interest groups, is most useful when used as a label for a dimension of the identity formation process in a single political unit, most specifically the nation-state" (Williams 1989:421). Williams agrees with the instrumentalist that there is competition between groups, but this is less over resources and more over defining whose voice will accord with the tenor of the state. The competition between groups is competition over defining the rules of the game of nation-building. Unsuccessful groups, those that are marginalised and disadvantaged, are those that are perceived not to have made any contribution to the building of the nation. Of course, there is no objective criterion of what counts as a useful contribution in these cases (just as for Richness there is no objective criterion of what counts as a resource to be competed over). Rather, it is the politically dominant groups that set the agenda, while subordinate groups compete among themselves to show that they have lived up to that agenda. As a consequence, 'ethnic' is a label that is given to the groups that fail to make the grade and which are "denied a place in nationalist rhetoric by the ruling elite, who refuse to acknowledge their own ethnicity'" (William's 1989:426)'.

2 Mainstream here refers to the existence of a main current of socio-cultural hegemony and normality that is embedded in middle class Australia as the result of a tradition derived, from British/Australian values, beliefs, ideologies and institutional processes which withstand pressures from other cultural traditions to transformation. This is supported and reproduced by the hegemonic forces that are exerted by elite social groups and core Australian institutions, that structurally have changed very little over the years. Core institutions have deeply embedded a British-based core tradition in their educational and legal system, professional bodies, politics and government (Stokes, 1997; Jamrozik, et al 1995:115; Hage, 1998). This is even apparent in the development of what might be considered by many, as progressive government policies such as the multicultural policies. For example Towards a National Agenda for a Multicultural Australia policy 1988 makes clear that: the Australia's structures and mechanisms are derived

compared with others constituting the aging Australian-born population (AIMA 1986; *Ethnic Working Party Report* 1987; The *Ethnic Older Persons Strategy* 1995; *Office of Multicultural Affairs* 1995; Tsingas 1998). Those who do gain access are not gaining access to quality care, that is, care that maximises a 'minimally decent' quality of life in old age (Kanitsaki 1992, 1996; *Ethnic Working Party Report* 1987; AIMA 1986; Cahill 1983; Hearst 1981; Galbally 1978).

Greek-born elderly Australians have been particularly affected by lack of access and equity to quality aged care. In an attempt to overcome this problem, over the past 15 years a number of ethnospecific[3] Greek residential aged care facilities have been

from a particular tradition, that of Britain (161) and that the policy of multiculturalism builds upon the basic values which underpin Australian society but extends and enhances the rights and freedoms which form part of our heritage and tradition ((5). Similarly in the National Agenda for a Multicultural Australia 1989, is stated that: all Australians are required to accept the basic structures and principles of Australian society - the Constitution and the rule of law, tolerance and equality, Parliamentary democracy, freedom of speech and religion, English as the national language and equality of the sexes' (National Agenda for a Multicultural Australia 1989). Australian institutions in turn ensure the reproduction of British /Australian hegemony via the dominance of English language and institutional processes, and in particular via the education system, in interaction with individuals whether they are Australian from an English speaking British Irish decent or from non English speaking backgrounds, as they influence the constitution of individuals dispositions (habitus). Such influences have the effect of assimilating individuals from different cultural and linguistic backgrounds (even though in different degrees) to traditional core British/Australian values, beliefs and ideologies which are reproduced in the interactive process between structure habitus and culture. It is also to be noted that such a state of affairs is protected from external diverse cultural pressures by excluding or limiting the employment of people from non-English speaking backgrounds in these institutions particularly at the higher levels of their hierarchy (Stratton, 1998; Jamrozik et al. 1995).

3 Ethnospecific: AIMA (1985:43) identified as ethno-specific services those which meet at least two of the three following criteria:

(I) the service providing organisation identifies with the ethnic group or has established its facilities with the specific objective of serving a particular ethnic clientele;

(ii) the clientele are predominantly of a specific ethnic background or include a number of groups of non-English speaking background

(iii) the facilities are distinguishable by particular characteristics suited to their ethnic clientele, for example language ability of staff, meal preparation, religious facilities and cultural activities.

1985, the Institute identified 62 different facilities which could be defined as ethno-specific. 24 in Victoria, 24 (designated) in NSW, 6 in WA 4 in SA and 4 in Queensland. These facilities had been established and were being operated by 42 different management groups. Of the 62 ethnospecific services identified there were 13 nursing homes, 24 hostels, in 24 complexes of independent living units and one special accommodation (AIMA 1985:43. A total of 2, 600 residents were accommodated in these above facilities - in there were a total of 807(designated) nursing home beds, 1,084 hostel beds and 709 independent living units. Most of the facilities were located in urban areas. The birthplaces of the residents in the above facilities were: Russia (15%), Italy (13%), Poland (10%), Germany (10%), Australia (9%), UK and Eire (8%) and Hungary (7%) Between 1985 and 1995, while multiculturalism was being promoted particularly to strengthen the social justice policy of the Australian Labor party, an additional of 36 ethnospecific nursing homes and 24 hostels were established around Australia. By way of historical comparison, in the 35 years between 1950-1985, 62 ethnospecific nursing homes, hostels and independent living units were established in Australia. An additional 62 nursing homes and hostels were established

established in Australia. Funded with money raised by the Australian-Greek community and supplemented by government grants, these facilities have provided culturally and linguistically relevant care for the Greek aged and have rescued them from being isolated and culturally dislocated in mainstream institutions (Kanitsaki 1983, 1992, 1996; AIMA 1986; *Ethnic Aged Working Party Report* 1987; Cahill 1983; Hearst 1981; Moraitis 1979; Galbally 1978).

Greek immigrants to Australia are ageing rapidly, and increasing numbers are in need of residential aged care. Demand for placements in these facilities has outstripped supply. Despite the growth of and demand for Greek ethnospecific residential aged care, little is known about *the way* it works and *how well* these services work within the mainstream Australian cultural context. Presently there is a lack of research on the subject. This thesis aims to redress this deficit by providing a critical study of a Greek ethnospecific nursing home.

This thesis constitutes a critical ethnographic study of a Greek ethnospecific nursing homes located in the Australian State of Victoria. I started this project with a broad orientation. The purpose was to make visible the relationship between culture, structure and agents' taken-for-granted or 'normal' actions, and to show how these mediated the Greek nursing home processes and practices and how they affected the people involved. The broad interest that guided my research therefore was:

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within the 10 year time span between 1985 and 1995. This latter number included 2 Greek nursing homes and 2 hostels in Victoria. Since 1995 another 2 Greek ethnospecific nursing homes and 1 Greek hostels has been established in Victoria.

The most common objectives that led to the establishment of ethno-specific facilities, are as follows:

(i) to provide care and support which recognised particular language, cultural and religious needs
(ii) to ensure that old people who sought to do so could live in an ethnic community setting
(iii). to provide accommodation, especially for those aged who were living in social isolation (AIMA 1985:44).

In Australia almost all facilities were set up with financial assistance from the Commonwealth government.

How does a Greek ethnospecific nursing home function within the context of mainstream Australian socio-political, cultural, professional and 'normality' discourses that set standards against which all aged care settings are measured?

My study has a political and ethical aim in that it involves research which assumes that oppressive and exploitative social practices have been 'normalised' in industrial and multicultural societies, and often are 'misrecognised' because of dominant hegemonic[4] forces (Thomas 1993). Hegemonic forces are themselves produced and sustained by the social reproduction of dominant and powerful groups (classes) in society. Such groups, through the working of social and cultural institutions, have the ability to maintain the legitimacy of social classificatory distinctions and stratifications which they have already produced to serve their interests. Such cultural representations are portrayed as authentic and legitimate, while concealing the interests of powerful groups as well as general social and institutional injustices (Swartz 1997; Young 1990; Bourdieu & Passeron 1990).

These dominant and powerful social groups are unconcerned about or 'misrecognise' that 'the exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces effects of power' (Foucault 1972: 52). This is done by a variety of social and scientific means that assume the 'objectivity' and

4 Hegemonic: Is used in the sense that (Street, 1992:78) defines this concept. '...[D]escribes the complex ideological control exercised by the dominant beliefs, attitudes, and codified patterns of social action within interlocking political, cultural, and social formations. In this sense Gramsci argues that hegemony denotes the boundaries of common sense and common concerns for most people and as such can explain the failure of structured oppositional movements to change the balance of power within the hegemonic relationship of dominant and subordinate cultures. Analytically, hegemony denotes an instrument of domination and legitimation in culture that represents the structured inequalities in means and capacities, which are taken-for-granted [dominant normality] and constitute social reality for most people. As such, hegemony can be described as a totalizing concept that saturates social understandings to the extend that political, cultural, and social constructions or reality become invisible to most people [or according to Bourdieu 1990, are 'misrecognised']. This invisibility or 'misrecognision' enables hegemonic relationships to be continually recreated and reconstituted through power and knowledge relationships, which legitimate the dominant group. It is however to be noted that 'hegemony of power and knowledge that legitimates the domination of a cultural group is never completely under the control of that group (Giroux 1981)'. Or according to Bourdieu the habitus of a person as it is confronted and challenged with different situations, social circumstances and conditions, which are in tension, personal agency is exercised and critical moments are recognised which hold the potential for change.

'truth' of such social classifications and distinctions and present them as superior to other ways of knowing and being. Their use as standardised and universalised evaluative measures of a 'good' society and 'life' in social institutions and practices sustain the status quo and the interests of the powerful. People who do not measure up to dominant standards and ways of life can be marginalised and disadvantaged in a number of ways. People with disadvantaging classifications, as in this study, are at risks, that is, people who are primarily female (women), ethnic, non-English speaking, uneducated, aged and disabled (Omeri & Cameron-Traub 1996; Jambrozik et al. 1995; Lopez & Fazzalori 1995; Parsons, Blackford & Street 1994; Stanfield II & Dennis 1993; Pettman 1992; Bottomley 1992; Cope, *et al* 1991; Alcorso 1989; AIMA 1986; Galbally 1978).

Research on Greek ethnospecific nursing homes in Australia is limited. There are several reports published and aged care research findings which have incorporated Greek-aged among a number of other ethnic groups. (see, for example, Hearst 1981; AIMA 1986); a series of works published by Westbrook and Legge/Legge and Westbrook between 1989 and 1992). For example, the AIMA (1986) survey investigated the number and characteristics of ethnospecific residential facilities in Melbourne and Sydney. Wilkinson and Taylor (1986) surveyed resident satisfaction with ethnospecific facilities (including nursing homes). With respect to the latter, and of interest to this study, Greek respondents (along with German respondents) recorded the highest satisfaction rates (AIMA 1986:218). Wilkinson and Taylor (1986) found that the facilities provided care that was sensitive to residents needs; significantly, this was achieved mainly by the employment of staff who spoke the language of the residents. This was important as it was found that 40% of the residents in all facilities spoke English with difficulty or not at all. The facilities also had constructed a physical environment that was reminiscent of the residents' cultural backgrounds. Westbrook and Legge (1992) surveyed 47 NESB residents and their carers in mainstream nursing homes, and 46 residents and their carers in ethnospecific nursing homes, in Sydney. Their findings indicated that residents and their carers in ethnospecific nursing

homes were more satisfied than those in mainstream nursing homes, in particular with the food and companionship they were able to have. They also had better relationships with staff. Both groups and their family carers had similar patterns of reaction to placements.

An extensive search of the literature has, however, failed to locate any research investigating the function of a Greek ethnospecific nursing home in the cultural context of Australia. An extensive search of the literature has also failed to locate any research that critically examines relationships and interactions between residents (and their families) and staff of a Greek ethnospecific nursing home, and how the relationships of culture, structure, and individual dispositions (habitus) mediate nursing home processes, power relationships and care practices. An important aim of this thesis is to redress this lack of research.

This project is situated and contextualised; it is also partial and local in nature. A critical examination of how a Greek ethnospecific nursing home functions might reveal how to overcome difficulties and problems that the Greek aged and community were and are likely to face in mainstream residential care institutions. This is particularly important as the enthnospecific nursing home is set within a mainstream society, whose everyday practices and processes are taken to be 'normal' and universal and, as such, are used as the standard against which to measure the normality and legitimacy of any group's practices within Australian society. The Greek ethnospecific nursing home also relies on mainstream institutions to produce its professional staff, insofar as it draws its personnel from the general population. (Professionals with overseas qualifications still have to undergo a long and uncertain process before they can be accepted - if they are accepted - for registration and to practise in Australia). In addition, the Greek nursing home, like all others, is regulated by Commonwealth Government legislation and policies which have emerged from mainstream Australian culture, ideologies and scientific and professional discourses.

A critical examination of the Greek ethnospecific nursing home's living culture and structure in action called for questions to be asked in relation to how Greek cultural diversity can be accommodated and/or dominated and controlled when power relationships are constantly mediated by diverse socio-political interests. Similarly, questions needed to be asked in relation to how the culture of various health professionals, as well as health professional education and health care practices, influence care delivery in the Greek ethnospecific nursing home.

Guiding research aims

The key underpinning aims of this research are to:

- explore how the Greek nursing home works;
- critically examine and reveal pertinent issues that may arise from working in health care contexts where dominant and subordinate ethnic, linguistic and cultural groups work together;
- explore the delivery of ethnospecific health and care practises in a Greek nursing home;
- explore and identify health and care practices which could be viewed as culturally congruent and incongruent with the Greek residents and staff;
- *problematise* 'normal' everyday practices of a Greek nursing home with the purpose of critically examining such practices with groups and/or individual participants;
- make visible ethnospecific issues and insights which may motivate the Greek community, the Federal and State governments and the nursing profession alike to promote beneficial changes;
- explore, describe and analyse how a Greek nursing home works relationally, as seen from the eyes of disadvantaged groups,

within a disadvantaged aged care field in relation to general health and ethnospecific care field.

- make clear who 'operates the tools of reality/realities production' (Van Maanen 1988:128) in a Greek nursing home;

- describe and critically examine the structure and the production of relative power relationships and their effects on people and practices in a Greek nursing home.

The significance of this project: Explaining Greek aged migrants' subordinate social position in Australia

Australia's post-Second World War immigration program targeted and gave priority to 'acceptable' young and healthy applicants in order to help build and populate the nation (Adelman *et al.* 1994 Vols. 1 & 2; *A Fair Go For All* 1996). In order to build an industrial sector, deemed necessary at that time, young, strong, healthy and preferably docile bodies were required to work in jobs that anyone who had educational qualifications and spoke English would not readily accept. The importation of young people and young families was also calculated to reduce the average age of a fast-aging Australian population which, without a steady increase in birth-rate would slowly contract to a low level.

A large number of post-Second World War non-English speaking Southern European immigrants, including Greeks (see Chapter Two) were purposely selected to be the factory fodder of Australian industry. The majority of migrants who did have educational and professional credentials (a form of 'capital' according to Bourdieu [1990]) also ended up working in industry and doing other menial work. The cultural and social capital they possessed, prior to their coming to Australia, was denied any value by the host society's dominant institutions and professions (*A Fair Go For All* 1996; Adelman *et al* 1994; Jupp 1991; Kapardis & Tamis 1988).

Non-English speaking migrants and, indeed many Greeks, were not only culturally and linguistically different but also had emigrated from rural and technologically undeveloped areas to an urbanised and developing country. The dislocation for some of these migrants was profound. British-Australians defined mainstream society's 'normality' and therefore dominated migrant cultures in Australia in such a way that ethnic groups' differences (in comparison to the mainstream) rendered them as 'other,' lacking, inferior, marked and marginal. Using mainstream 'common sense[5]' and 'normality' as the universal measure, non-English speaking (NES) ethnic groups were classified as subordinate to the British-Australian population. They were also located in the social hierarchy of Australian society according to their ethnic/race and cultural 'distance' each was perceived to have in relation to mainstream society. While ethnic groups as such might not have escaped such social locations many ethnic individuals did succeed in escaping their given social locations and excelled in mainstream society.

Of the many immigrants who arrived in Australia between the 1950s and the late 1960s, a large proportion were Greeks from rural areas (estimated by Moraitis to be as high as 90%). They arrived in Australia with a vision of creating a better life for themselves and their children, of escaping their country (which had been left devastated by the Second World War and subsequent civil war) and, in many cases, poverty. They did not, however, expect, nor were they prepared to come to a country with assimilationist policies that would make them feel that they

5 According to Gramsci (1971:322) (Footnote) 'Broadly speaking "common sense" means the incoherent set of generally held assumptions and beliefs common to any given society, while "good sense" means practical empirical common sense in the English sense of the term'. Gramsci 1971:419 Explains common sense in the following way: 'common sense is the "philosophy of non-philosophers", or in other words the conception of the world which is uncritically absorbed by the various social and cultural environments in which the moral individuality of the average man [sic] is developed. Common sense is not a single unique conception, identical in time and space. It is the "folklore" of philosophy and, like folklore, it takes countless different forms. Its most fundamental characteristic is that it is a conception which, even in the brain of one individual, is fragmentary, incoherent and inconsequential, in conformity with the social and cultural position of those masses whose philosophy it is'(p. 419). One cannot assume, that common sense is common (universal) even within a given group before it is critically examined and differentiated and brought back to the group by socialisation. Of course then it becomes, according to Gramsci (1971) 'good sense', or a form of philosophy. For a person, in order to avoid the mechanical imposition of a conception of the world upon oneself by an external environment (whichever it may be at the time) one needs to work out consciously and critically one's own conception of the world and according to their own thinking 'choose one's sphere of activity' (p. 323).

had to deny their history and experiences, to culturally 'cleanse' themselves and change their identity before they could participate fully and as equals in mainstream society policies (Stokes 1997; *A Fair Go For All* 1996; Jupp 1991).

The social structure of Australia and the assimilation policies of the time, and their affects in the years to follow, created a situation for migrants where, unless they had the ability to assimilate or integrate, their interests and needs would remain invisible and excluded from the mainstream social fields of power, including all the fields of health care and related services. (For example, their exclusion and dislocation is reflected in the results that Moraitis [1979:403] reported of a survey undertaken by the Australian Greek Welfare Society in 1974 which showed that 70% of males and 90% of females surveyed had no contact with Australian society, while 54% of males and 80% of females had no contact with other Greeks.)

Many Greek migrants, confronted with unfamiliar social systems and institutional practices and living for many years under Government assimilation policies and community expectations to assimilate, experienced incapacitating and dehumanising treatment that left them traumatised and scared as they struggled to survive and to provide better life chances for their children (Piperoglou 1988; Treloar, Petritsi-Jones & Kerr 1977; Moraitis 1972, 1979, 1981; Retchford 1972; Ellard 1970; Cox 1972). The host society, while expecting them to assimilate, provided little help in this regard. For example, while 90% of non-English speaking background migrants did not speak English, only 24% were offered support to learn English (*A Fair Go For All* 1996; Moss 1993). Moss (1993) explains:

> Many of the post-War settlement services and the official Good Neighbour movement which co-ordinated them, were directed towards the British, as had been the case since Caroline Chisholm's pioneering work in the 1840s (Moss 1993:12-13).

Non-English speaking migrants, including Greeks, on the other hand received little if any help. Further, the Australian Government even 'reassured' Australians that migrants were

meant to remain in their unskilled occupational locations (Jamrozik *et al.* 1995). This, the government claimed was so that (British) Australians could have the better jobs and be free (of the unwanted interferences of menial work) to pursue their life's goals and aspirations.

For many Greeks who wished to integrate, the process proved extremely difficult because of the mainstream institutional barriers, and the lack of Commonwealth, State and Local government help in addition to be labeled as undesirables (*A Fair Go For All*, 1996; Moss 1993; Galbally 1978; Henderson 1975).

This thesis is about Greeks migrants who, while they have accommodated many mainstream practices, have also retained some Greek cultural practices vital to their quality of life and survival. The majority have aged in Australia (or, as Greek aged express it, 'We have eaten our youth in a foreign land' [Εφαγαμε τα νιατα μας στην ξενιτια]). After 20 to 50 years in Australia many Greek migrants now aged people, find themselves still at the margins[6] of mainstream society, and still experience a number of difficulties in accessing relevant mainstream health care services (Tsingas 1998; Moss 1993). It seems that both non-English speaking migrants and Australian mainstream institutions, including the aged sector, have changed very little to accommodate each other. This is so despite Australia's social institutions being developed for the purpose of providing for the

6 Marginalisation Young (1990: 53-54) explains that "Marginalization is perhaps the most dangerous form of oppression. A whose category of people is expelled from useful participation in social life and consequently potentially subjected to severe material deprivation and even extermination". Liberalism has traditionally asserted the right of al rational autonomous agents to equal citizenship. Early bourgeois liberalism explicitly excluded from citizenship all those whose reason was questionable or not fully developed, and all those not independent (Pateman, 1988, chap.3;cf. Bowles and Gintis, 1986, chap.2). Poor people, women, the mad and the feeble minded, and children were explicitly excluded from citizenship, and many of these were housed in institutions modeled on the modern prison: poorhouses, insane asylums, schools. Today the exclusion of dependent persons from equal citizenship rights is only barely beneath the surface. Because they depend on bureaucratic institutions for support of services, the old, the poor, and the mentally or physically disabled are subject to patronizing, punitive, demeaning, and arbitrary treatment by the policies and people associated with welfare bureaucracies. Ethnic people who have no English language fluency and are located at the lowest level of the social structure suffer a similar fate. Their cultural difference often are labeled as irrational and illogical and because of this, are often indirectly connected to being incompetent or lesser to 'normal' people. Their dependence on alien and excluding social systems to satisfy their needs places them in a marginal social position that further disadvantages them by being unable to participate in the social processes which create the conditions they live in.

needs of *all* members of society whose taxes have supported - them and continue to support - them.

When they were young, many of Australia's Greek migrants lived under the pressure of assimilationist/integrationist government policies, that excluded them from mainstream society. Today these same migrants in their twilight years live in a more open multicultural and tolerant society. For many of these Greek aged migrants, however, it is now too late to improve their life chances. This is despite the introduction of the Labor government's social justice and multicultural policies (*Advisory Council on Multicultural Affairs* 1988) in the mid-to-late 1980s, which started to pose a serious challenge to the invisible mainstream institutional expectations that migrants should assimilate or otherwise 'fit in' with mainstream services.

These policies, contributed to distributive justice by the diversification of the aged health care system that facilitated ethnic aged service provision. They saw the development of a number of different models of care service delivery and the removal of some of the barriers (particularly relating to funding and the number of beds per aged population) to the development of ethnospecific residential care services. With the diversification of the aged health care, the Greek community has had the opportunity to establish a number of residential care facilities in Australia for its aged.

The Greek nursing home as an ethnospecific home and its subordinate position in the mainstream aged care sector

Having been ascribed an 'ethnospecific' status by the dominant society as opposed to mainstream health care institutions, the Greek ethnospecific nursing home under investigation, symbolically holds the marginal social position ascribed generally to 'ethnics', a position that ultimately devalues its presence and role in the field of aged care sector. This status also indicates its shaky political foundations, because any government with policies unfavourable to ethnic organisations could threaten its existence. Recent racist attitudes expressed at Australia's national

political level by Pauline Hanson's One Nation[7] Party, and endorsed by 1,000,000 votes at the 1998 Federal election, is a disturbing prospect for anyone who is perceived to be ethnically 'other'. Ethnic differentiations are not simply names without meanings attached; they symbolically encapsulate ascribed meanings of 'ethnicity' that carry with them images of their presence and their social trajectory in Australia, subordinate to dominant mainstream society and its concept of 'normality'.

Selecting critical ethnography: a political and moral approach to research

In light of the considerations outlined above, it has been essential that the research approach, method and processes used in this thesis took into account issues related to the legitimacy of dominant mainstream interests as opposed to the subordination of Greek interests (defined as 'other'). For example, the research site (a Greek ethnospecific nursing home) itself is considered to be a non-mainstream institution, and I ask why this is so. Another example is the fear by mainstream proponents that the establishment of ethnospecific nursing homes would encourage ghetto formations (Barnett 1988), as indeed ethnic organisations were perceived to be during the assimilation period (Hage, Stratton, 1998; Moss 1993; Galbally 1978). The persistence of such beliefs implies, on the one hand, that migrants are full participants in mainstream society; on the other hand, however, such beliefs express fear of differences and mistrust of the 'other' that has the potential to further marginalise ethnic groups. The existence of such characterisation and expressions of concern might well indicate that mainstream society still operates on

7 One Nation: A far right political party that emerged during the 1990s with Pauline Hanson as its leader. Hanson and her party were opposed to multiculturalism and immigration, and were widely known and presented by the media to be a racist party. In the Queensland State elections, One Nation gained seven seats in the single chamber State parliament. At the time many migrants including myself, felt the terror that racist attitudes can bring against humanity. This was heightened due to the fact that a Federal election was near. Federal politicians, however, fearful that the One Nation party had a very good chance of gaining the balance of power in the House of Representatives or the Senate, organised their vote preferences in such a way as to virtually ensure that no seats were gained by One Nation in the Federal parliament. One Nation, however received 1,000, 000 votes in the 1999 Federal elections.

taken-for-granted assimilationist attitudes, perhaps without recognising it.

Critical ethnography accepts the role of values in research and openly explicates its own values, which focus on a commitment, through dialogue and critical reflection, to examine 'normal' everyday practices and to unmask their underpinning assumptions to reveal the interests and needs they serve. A critical approach to research, in the first instance, requires the rejection of taken-for-granted 'normality', while at the same time recognising its symbolic power and the violence that it can enact whilever it remains 'misrecognised'. Such 'misrecognition', according to Bourdieu (1990), permits everyday practices that are taken-for-granted to mask dominant groups' interests and help to form and sustain relevant power relationships that serve dominant groups' and class interests and needs.

Critical research approaches are essential at all times, but particularly when research is undertaken with social groups where people hold a relatively subordinate and often invisible position in society such as, (as in this study) non-English speaking 'ethnic' aged, disabled, and mainly women. Research should promote such groups' voices to be legitimately heard, even though they might be weak and timid and even if what they say makes us uncomfortable. In addition, research undertaken with such groups ought to aim to provide insights into how oppressive cultural practices operate on a daily basis under the guise of mainstream, professional and scientific 'normality'.

For this ethnic nursing home study, it was essential to adopt a research approach that was informed by a social theory that does not, in its fundamental assumptions, accept that social facts can be separated from values, beliefs and interests, nor one that can claim to be value-neutral. It was important to also recognise, from the start, that knowledge production is a social and political process and, as such, knowledge cannot be divorced from power (Foucault 1972). To ignore this would be to ignore the dominating and often oppressive effects of legitimated knowledge.

Critical ethnography was considered to be an appropriate method to adopt for this research project. My approach to critical ethnography, however, is informed by Bourdieu's social theory of symbolic power[8] (Swartz 1997). The selection of Bourdieu's theoretical concepts of *capital, habitus* and *field* (discussed in Chapter Four) facilitated explanation of how practices and processes in the Greek nursing home were mediated by the relations of culture (capital and, consequently, power), structure and agents' dispositional (habitus) actions, and how these processes and practices affected the lives of the people who worked and lived in the nursing home.

Bourdieu's theoretical social constructs are useful for this ethnic study since they attempt to explain how stratified social systems of hierarchy and domination persist and are reproduced from generation to generation. For change to take place oppressed people in society need to recognise how power relationships work to mask the dominant groups self interest; they also need to resist dominant groups and their hegemony.

Bourdieu's notion of culture as power (Swartz 1997) calls for reflexivity and critical examination of cultural resources (capital), processes and institutions - 'normality'- that hold individuals and groups in competitive and self-reproducing hierarchies of domination and often oppression. His theory promotes the problematisation, critically reflective examination and evaluation of the given, 'misrecognised' everyday, taken-for-granted social processes and practices (or dominant 'normality'). This includes dominant social, scientific, and professional discourses, among other things. The aim is to make visible the underpinning assumptions of everyday social process and practices which

8 Symbolic power: Swartz, (1997:6) explains that ' Bourdieu proposes a sociology of symbolic power that addresses the important topic of relations between culture, social structure, and action. Whether he is studying Algerian peasants, university professors and students, writers, and artists, or the church, a central underlying preoccupation emerges: the question of how stratified social systems of hierarchy and domination persist and reproduce intergenerationally without powerful resistance and without the conscious recognition of their members. However, Swartz (1997:6), in a footnote, explains that 'this is a variant on Durkheim's fundamental concern for what produces social solidarity, though for Bourdieu the social order is a stratified order with hierarchical and inegalitarian arrangements among individuals and groups ...' Swartz (1997:6 footnote) adds that '[f]or Bourdieu, no expression of sociability or its symbolic representations can be detached from its constitutive power relations.'

encapsulate the interests of dominant groups of people (classes) given as 'normal' and universal (Swartz 1997; Bourdieu & Passeron 1990).

Swartz (1997) explains Bourdieu's fundamental premises, on which he builds his critical reflexive sociology, as follows:

> The social unconscious consists of those unacknowledged interests that actors follow as they participate in an unegalitarian social order. Since, according to Bourdieu, it is the misrecognition of those embedded interests that is the necessary conditions for the exercise of power, he believes that their public exposure will destroy their legitimacy and open up the possibility for altering existing social arrangements. By exposing those underlying interests that bind individuals and groups into unequal power relations, sociology becomes an instrument of struggle capable of offering a measure of freedom from the constraints of domination (Swartz 1997:10)

I considered here that ethnographic descriptions alone would 'reaffirm and reify the given social reality' (Young 1990: 5) while I wished to challenge, problematise and critically examine such reality.

Selection of the research site and its significance in critical ethnography

Informed and motivated by my own personal experience as a Greek-born, non-English speaking immigrant of 1961, I decided to undertake research and state its political and ethical aims. I selected a setting which by its mere label ('Greek Nursing Home)' denoted its 'ethnic' position in relation to mainstream health care institutions and its marginal status in society. My site selection itself was in purpose political, as the site is the product of the Australian socio-cultural, economic and political environment - and of the Australia-Greek community's resistance and/or accommodation to such environment.

The structure and function of the home were expected to reflect, in the main, Greek cultural norms and values which supported the provision of ethnospecific health care services. All residents

were from Greek-speaking background, born in Greece and other countries, and the majority spoke little or no English (see Chapter Eight). The established structure of the nursing home reflected mainstream institutional hierarchical arrangements: the home is run by registered nurses who are of Australian British Irish descent, (AEID) who do not speak Greek, and who were educated within the Australian/British-centric health education system. There were two Greek-speaking registered nurses (RNs), both educated in Australia. Of these, one was born in Greece, and the other in Australia. There were two other RNs employed in the home who were also of non-English speaking background, neither of whom however spoke Greek; of these one was educated overseas, and the other in Australia.

The majority of personal carers (PC) and all 'domestic' staff, including cleaners, kitchen staff, gardeners and maintenance staff were Greek-born and speaking. Many care providers (personal carers) had received up to six weeks training in personal care. In addition, other professionals, Australian and Greek-speaking (doctors, social workers, physiotherapist and other therapists) provided their services occasionally.

This setting comprised a complex multicultural, multiethnic and mainly female context that arguably stood as a microcosm of the larger society and particularly of health care settings. Group differences and social distinctions and classifications that sustain social inequalities and hierarchies of domination can be examined and unmasked within such an environment - that is, social distinctions and classifications within the nursing home of both Greek and Australian socio-cultural fields alike. Further, one also might discern in such a multiethnic context the contradictions, misunderstandings and power relationships as expressed in everyday action, as well as cultural juxtapositions which would make visible sociocultural interruptions that might provide an opening for thinking of alternative ways and/or different ways of being and acting. Such a complex environment provided a rich context within which critical questions (for example, concerning domination and oppression, and hence injustice) could be raised and investigated.

Young (1990:8-9), explains that '[o]ppression[9] and domination should be the primary terms for conceptualising injustice'. But in order to do so, asserts Young (1990), justice should extend to include the political fields of society, including institutional organisation and functioning, as they are potentially subject to collective decision making. This, she explains, is necessary because the paradigm of distributive justice (commonly used to promote and evaluate a just society) tends to focus on material goods and social position. This focus, she argues, obscures other issues which should be taken into account such as institutional organisations and their taken-for-granted everyday practices which often oppress by inhibiting the development of the values that contribute to the 'good life', namely, '(1) developing and exercising one's capacities and expressing one's experience... and (2) participating in determining one's action and the conditions on one's action' (Young 1990: 37). She explains that, for this reason, justice should be extended to cover institutional and organisational, decision-making procedures, the social division of labour, and culture (Young 1990: 8-9).

Critical ethnography creates a critical research environment and calls for critical debate and thinking that 'challenges the "truth" in ways that subvert taken-for-granted ways of thinking' and practice (Thomas 1993:18). In this study institutional processes and care of

9 Oppression: According to Young (1990) oppression usually includes domination, so far as it constraints oppressed people to follow rules that are set by others. Not every one subject to domination is also oppressed. Hierarchical decision making structures subject most people in our society to domination in some important aspect of their lives. Many of those people nevertheless, enjoy significant institutionalised support for the development and exercise of their capacities and their ability to express themselves and be heard. Oppression consists in systematic institutional processes which prevent some people from learning and using satisfying and expansive skills in socially recognised settings, or institutionlised social processes which inhibit people's ability to play and communicate with others or to express their feelings and perspective on social life in contexts where others can listen. While the social conditions of oppression often include material deprivation or maldistribution they also involve issues beyond distribution. (Young 1990:37-38) She devides oppression to five categories, or as having five faces, that is, exploitation, marginalisation, powerlessness, cultural imperialism, and violence. Each form of oppression according to Young (1990) involves issues of justice beyond distribution. In the more general sense, all oppressed people suffer some inhibition of their ability to develop and exercise their capacities and express their needs, thoughts, and feelings (Young, 1990:40). Clearly in the Greek nursing home the structural distribution of capital legitimated what capital is valued, which consequently lead to domination but also oppression of Greek carers and residents as they were structurally and linguistically segregated and therefore their relative power diminished, unable to participate in the institutional processes that affect their lives, and unable to make their voices be heard at a level that could benefit their interests in relation to other structurally nore privileged agents.

a Greek ethnospecific nursing home are critically examined in a way that subverts their taken-for-grantedness. It is premised here that experiences and meaning produced within the nursing home's particular cultural and socio-economic setting were shaped and transformed by its social structure and power relationships.

I made attempts to adjust my research approach in a way that I could avoid the historical practices of social science that often imposed the dominant culture's scientific frames of thought and research methods upon subordinate groups and cultures, that permitted researchers to construct and represent the 'other', usually in a way that disadvantaged them. Groups of people usually disadvantaged by such scientific 'representations' are usually women, black and indigenous people, ethnic people (mainly women) and, particularly, those who speak a language other than English (Smith 1999; Denzin & Lincoln 1994; Stanfield II & Dennis 1993; Young 1990; Rosaldo 1989; Clifford & Marcus 1986; Marcus & Fischer 1986).

Situating myself in the research process

It is essential at the start to make visible the ethnohistorical and professional lens through which my angles of vision scanned and captured my fieldwork. I was born and grew up in a small village on the Greek island of Crete. In 1961 I emigrated to Australia to begin a new life. On arrival I stood like so many others, without a completed secondary school education, speaking no English, knowing absolutely nothing about Australia or its systems, and lacking any relevant technical skills. As a Greek 'ethnic' female, 'unskilled', rural, non-English speaking migrant of the 1960s I experienced overwhelming constraints in my struggle to escape my initial social location as a factory worker and subsequently hospital cleaner. My ethnohistory and my diverse experiences in the process of overcoming linguistic, socio-economic, cultural and educational barriers to become a registered nurse, midwife and academic enriched me greatly. In my journey I had gained multiple, partial (incomplete) differently situated experiences and knowledges. In the process, the social conditions I experienced

helped me to develop and sustain an enlightened vernacular (McLaughlin 1996) or localised critical world view.

Throughout the years I practiced nursing, I regularly witnessed health workers (nurses, doctors, and general hospital personnel) who either ignored or were not able to recognize the fact that non-English speaking migrant patients might be unfamiliar with the system, care and treatment given in the hospital context, and who insisted on conformity to ethnocentrically-defined behaviours and responses. Those who were most different from the 'norm' of the compliant, English-speaking Australian patient and those who did not conform to health professionals' expectations were especially vulnerable to hostile and dismissive treatment.

I could feel their suffering and the despair that a 'culture of silence' (Freire 1972:57-58) imposed on them when they sought help from health care institutions. According to Freire (1972):

> a 'culture of silence' 'is the result of the structural relations between the dominated and the dominators. ...[u]nderstanding the 'culture of silence' presupposes an analysis of dependence as a relational phenomenon which gives rise to different forms of being, of thinking, of expression, those of the 'culture of silence' and those of the culture which 'has a voice' (Freire 1972:58).

This suffering and despair that I witnessed often did not relate directly to a patient's diseases or states of illness, but to their care and treatment as human beings. Suffering and despair were brought about by experiencing the dominant health care systems' and the health professionals' ethnocentricity and cultural imperialism[10] (Young 1990). Ethnocentric and culturally

10 Cultural imperialism: This is seen by Young (1990) to be an aspect of oppression. It involves the universalisation of a dominant group's experience and culture, and its establishment as the norm. Some groups have exclusive or primary access to what Nancy Fraser (1987b) calls the means of interpretation and communication in a society. As a consequence, the dominant cultural products of the society, that is, those most widely disseminated, express the experiences, values, goals and achievements of these groups. Often, without noticing that they do so, the dominant groups project their own experiences as representative of humanity as such. Cultural products (or resources capital, as Bourdieu calls them) also express the dominant group's perspective on an interpretation of events and elements in the society, including other groups in the society, insofar as they attain cultural status at all. An encounter with other groups, however, can challenge the dominant group's

imperialistic attitudes in health and health care practices by necessity oppress, silence, objectify, devalue and misrepresent.

As a nurse educated in Australia and as an immigrant, I was critical of the social structures that upheld systems of authority which placed immigrant patients at the lowest level; I identified with the experiences of such patients and, at times, shared the feelings of frustration and anger that discriminatory treatment generated. I recognised that I was dealing with a culture of exclusion within the social field I inhabited: the medical nursing/hospital institution.

It is my contention that the intersubjective relationships (and the nature) that I formed with informants in the nursing home would have been influenced by my multiple and partial experiences and historical trajectory. This does not mean, however, that my vision was socially irrelevant or distorted. Rather, it means that my vision was grounded in the social conditions within which I worked and experienced life as a member of society in multiple social fields and situations. So that, while my vision remained vulnerable to the different impacts that my experiences had on me, my different positions from an ethnic factory worker to assistant nursing director academic and so on and at different times provided me with useful social and human insights that made me empathetic with and sensitive to the cry of suffering or distress, albeit, also, always 'socially situated' (Young 1990). As I have experienced domination and oppression within both Greek and Australian society, I could not deny nor could I justify its existence. This left me with several alternatives: to remain in a state of detached oppression and domination, to reinforce such social situations, or to struggle against them. I decided to follow the latter. My vision was varied, situated in and partial (incomplete) to each and multiple and

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claim to universality. The dominant group reinforces its position by bringing the other groups under the measure of its dominant norms. Acceptance of such practices render the Greek community differences, from the mainstream, Greek women from Greek men, and in relation to mainstream society women and men, workers from professionals, and so on, become reconstructed largely as deviant and inferior. Since only the dominant group's cultural expressions receive wide dissemination, their cultural expressions become the normal, or the universal, and thereby the unremarkable. Given the normality of its own cultural expressions and identity, the dominant group constructs the differences which other groups may exhibit as lack and negation. These groups become marked as 'Other'.

social realities in the nursing home (Haraway, 1991). I was also engaged as a cultural 'insider' of Greek, Australian and nursing cultures. As such, it was inevitable that everyday taken-for-granted nursing home processes and practices would stand in my vision in juxtaposition with each other, challenging my multiple partial understandings, and situatedness and forcing me to ask questions about possibilities rather than accepting and being content with what is.

A synopsis of the thesis chapters

This thesis comprises nine chapters. Chapter One introduces the research problem and its significance and indicates why it was vital that the research approach required a critical rather than simply a conventional descriptive ethnography. The political and ethical aims of the research are also made clear. The stance which is assumed accepts that we are embedded in a historical socio-cultural human world that is never value-neutral, and openly accepts that knowledge is socially constructed and that particular knowledge cannot be claimed as universal 'truth' without bringing about domination.

Chapter Two contextualises first generation Greek migrants in the Australian historical socio-political environment that framed their lives. The critical aspect of this chapter is that it attempts to illustrate the *historically cumulative* affects of disadvantage that many Greek migrants suffered because of the socio-political conditions that prevailed for a considerable numbers of years in Australia. Such conditions included the indifference and non-responsiveness of social and health care institutions (including the aged sector) to the needs of Greek migrants. The lack of institutional action in responding to and accommodating Greek migrants' (and other ethnic groups') needs created a stressful and a crisis-like living environment - particularly at times of illness, whether or not they (migrants) required acute or chronic care services.

After many years in Australia, many Greeks still speak English with difficulty or not at all, and their health is perceived - and

experienced - to be far worse than that of mainstream population groups. They reported the highest rate of disability of all other ethnic and mainstream population groups. The majority of Greek aged are pensioners. If and when needing depended care this group will be vulnerable to serious disadvantage if unable to access Greek ethnospecific services in their old age.

Chapter Three discusses Bourdieu's main theoretical constructs as the methodological underpinning that guided my approach to critical ethnography. In this chapter I also discuss research processes that I adopted and which are specific to the Greek culture in so far as they mediated equitable interactions and relationships and vigorous dialogue between myself and the Greek participants. In Chapter Four I discuss how I undertook critical ethnography in a Greek ethnospecific nursing home.

Chapter Five is the first chapter that presents data and is mainly descriptive. Its purpose is to show that the Greek ethnospecific nursing home and its context is a distinctly unique, meaningful and stimulating cultural context for the elderly residents who live within it, a context that would be difficult or impossible to achieve in mainstream institution.

Chapter Six discusses carers' and residents' relationships and care practices, and illustrates that power relationships and interactions are mediated not just by 'Greek culture' but by the relationship of the dominant culture (that is constitutive of the nursing home structure) and agents' within embodied dispositions (habitus).

Chapter Seven critically examines the hierarchical structure of the nursing home - its processes and practices, mediated as they are by the larger society's symbolic, cultural, political and professional systems which are embedded in the structure field and actioned by agents' embodied dispositions (habitus). Chapter Eight discusses some of the competitive struggles that members of professional and non-professional staff were engaged in between and amongst themselves and with relatives over defining whose voice and capital (including the 'rules of the game') would have legitimacy in the nursing home. The relationship of culture,

structure and agents actions are made visible. It is also revealed that when an institution's culture, structure and agents are constitutive of each other, in multiethnic contexts, they have the potential to dominate and exclude all other agents who had little or no part to play in their constitution. It is shown, too, that the interruption of the relationships between Greek culture, structure and agents' action in the home related to the institutions adoption of mainstream institutional structure and capital. This served to limit the Greek ethnospecific space and rendering it at the lower levels of the hierarchy. That in turn produced a working context where asymmetrical power relationships operated against Greek-speaking staff, residents and relatives alike. Ethnic, gender and educational distinctions (class) and stratifications were instrumental in the dominance of mainstream capital, that rendered Greek workers, elderly and relatives vulnerable in their struggle to satisfy their interests and needs.

Finally, Chapter Nine incorporates concluding critical reflections and comments on the findings that make visible how 'normal' processes and practices in socially stratified institutions mask and perpetuate socially structured domination and injustices that reproduce power relations and interactions which serve the interests of dominant cultural groups in society. Similarly it reflects on the kind of ethnospecific care that can be provided in such environment and proposes that its greatest strength derives from the Greek carers whose habitus[11] improvised their practices in using their embodied Greek family model of cultural lay care.

[11] According to Bourdieu (1990), habitus refers to"[t]he practices of members of the same group or, in a differentiated society, the same class, are always more and better harmonized than the agents know or wish, because, as Leibniz again says, 'following only (his) own laws', each 'nonetheless agrees with the other'. The habitus is precisely this immanent law, *lex insita*, inscribed in bodies by identical histories, which is the precondition not only for the co-ordination of practices but also for practices of co-ordination"(Bourdieu 1990:59, Translated by R. Nice). Please see pages 87-89 in text, and 170-171 in text and footnotes for a more detail discussion of habitus.

CHAPTER TWO

BACKGROUND TO THE STUDY: GREEK-BORN-FROM YOUNG MIGRANTS TO AGED ETHNICS-WITHIN A HISTORICAL SOCIO-POLITICAL AUSTRALIAN CONTEXT

Introduction

The objective of this chapter is to make visible Greek migrants' (as an 'ethnic group') historical subordinate position in the hierarchical social order of Australian society. I endeavour to speak about them as dynamic, responsive and active agents, at the same time making visible the social conditions that mediated and ultimately disadvantaged their life chances[1] in Australia. This historical contextualisation also aims to illustrate the *cumulative* effects of years of disadvantage - effects that now bear heavily on Greek migrants in their old age.

The discussion advanced in this chapter has the additional purpose of situating the Greek ethnospecific nursing home - and the people within it - in the broader historical, socio-cultural and political Australian context that helped to shape them. The discussion will also help to reveal how mainstream symbolic systems[2] and socio-cultural, political and economic discourses and processes continue to

1 For the purposes of this study 'life chances' is taken to mean a person's/group's control of or lack of it over necessary resources (material and existential), to maximise the achievement of important life goals (see also Crompton and Gubbay 1977).

2 Symbolic systems: 'are classification systems built upon the fundamental classification logic of dividing and grouping items into opposing classes and hence generating meaning through the binary logic of inclusion and exclusion. This logic of symbolic systems builds an ordered set of fundamental dichotomous distinctions, such as race/common, good/bad, high/low, inside/outside, female/male, distinguished/vulgar and [in this case ethnic/Australian, aged/young, English-speaking/non-English-speaking and so on] undergirding all of our mental activities (Swartz (1997, pp. 84) Symbolic systems can be thought of as forms of "vertical classification" where connections between the cognitive logic of polarity and the social logic in exclusion and inclusion are established' (Schwartz 1981). The binary logic of symbolic classifications suggest that ingroup/outgroup relations can be grounded in a cognitive dimension. They are overlapping social and cognitive distinctions. Schwartz, (1997) states that according to Bourdieu this is a fundamental property of all symbolic systems, not just those in primitive mythology or religion; it is operative in science and philosophy where the contemporary secular mind would least suspect its presence (Swartz pages 82-92) see Bourdieu, 1990: 87-88.)

dominate and permeate even ethnospecific institutional practices in spite of the adoption of multiculturalism.

Greeks and reasons for immigration.

Modern Greece as a sovereign country was the outcome of the war of independence from Ottoman rule 1821-29. Prior to independence, Greeks were living not only in what is known today as Greece, but also in other places that were considered Greek but were occupied by Turkey or colonised by Britain and Italy. Many Greeks also lived in the Balkans, Russia, Egypt, other European countries and Asia Minor.

In 1922, the Greeks in Asia Minor were overrun by the Turks and this led to 1. 25 million Greeks then living in Turkey seeking asylum in Greece and other countries around the world, one of which was Australia (BIPR 1991). Today, many Greeks consider themselves *Greek* even though not born in Greece, holding Greek citizenship or having lived in Greece. For example, in this study some of the home's residents were born in Turkey, Egypt, Albania and Cyprus. Nevertheless, they all spoke Greek and considered themselves to be Greek. The diversity and heterogeneity of Greeks as a group is indisputable. However, Greeks in Australia are usually seen as an 'homogenous' group by the dominant society, with only Greeks who were born in Greece or Cyprus officially recognised (and statistically recorded) as Greek.

From 1922 to the late 1950s rural sector Greece suffered enormous economic hardship as a result of earlier wars, and the mass influx of Greek refugees following the 1920s defeat of the Greeks by the Turks in Asia Minor (Bottomley 1979:43; Panoutsopoulos 1988:24). Poverty, social disruption, and political instability were exacerbated further by the devastating Second World War and the subsequent civil war (see also Kapardis and Tamis 1988; Storer 1985; Price 1975). The economic calamity suffered by Greece's rural sector could explain the reason why between 76% and 90% of post-Second World War Greek immigrants to Australia had rural backgrounds (Piperoglou 1988; Tamis 1988; Moraitis 1977).

The general devastation of the country had lead to severe poverty leaving people with little hope for improvement in their living standards without some drastic action on their part. Personal losses due to war had not only personal and family consequences but also social consequences, as they affected kin and community relationships and interactions in such a way that some people felt compelled to leave the country hoping to heal their psychological wounds. Economic devastation, social disruption and political instability in Greece motivated many Greeks to seek better life chances in other countries. The majority of Greeks left their birthplace with the thought that they would return after a couple of years. They naively nurtured the belief that in Australia, by hard work, it was possible to accumulate moderate wealth within a short period of time and return to Greece.

Pre-Second World War Greek immigration to Australia

While Greek immigration to Australia was recorded as early as 1887, mass immigration of Greeks to Australia took place between the 1950s and late 1960s. It is important to differentiate between pre-and post-Second World War Greek immigration to Australia as the establishment of homogenous communities was the result of chain migration[3], among many other factors contributing to the nature of Greek communities in Australia.

An exposition of some characteristics of the host society and its attitudes towards foreigners, migrants in general and Greeks in particular, can provide the context within which migrants had to struggle in order to 'make it' and to build their lives. Such an exposition helps to: make visible, validate and legitimate the experiences of migrants; to make visible their valiant struggles, often against a hostile social and occupational environment; and make

3 Chain migration took place before the second World War amongst Greek migrants who sponsored their siblings, relatives friends and often acquaintances from their villages or islands to came to Australia. In this way they established homogeneous communities who contributed to the nature of Greek communities in Australia. This occurred because at the time while immigration was restricted, and at certain times suspended for Greeks, they were, however, allowed to sponsor people to come to Australia.

visible their social suffering4 (Kleinman 1997) as well as their successes in a British/Australian-dominated environment. Such an examination is fundamental also to revealing the social injustices that were perpetrated against (non-English speaking) migrants despite the political rhetoric of a 'fair go for all'. Although Australia presented itself as a democratic and liberal society, it was nevertheless influenced and driven by racist ideologies and theories of the time. Consequently, 'foreigners' (other than British migrants) were viewed with suspicion and fear, as being racially and culturally inferior (notably to British/Australians), and hence as a threat to Australia's national cohesion (Cope *et al.* 1991). A preoccupation of the Australian government of that era was to pacify and to reassure the mainstream British/Australian populous by designing policies ensuring the homogeneity and cohesion of Australian society despite the presence of foreigners! The aim of Australia was to construct a racially and culturally homogeneous nation modeled on Britain and by using racial and cultural criteria to either stratify groups in terms of superiority and inferiority, or to exclude some groups (for example, indigenous Australians) altogether (Stratton

4 Social suffering: Kleinman, et al. (1997) 'brings into a single space an assemblage of human problems that have their origins and consequences in the devastating injuries that social force can inflict on human experience. Social suffering results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems. Social suffering is shared across high-income and low income societies, primarily affecting, in such different settings, those who are desperately poor and powerless. This is not merely a statistical correlation, but a causal web in the global political economy'. (Introduction, IX-X). refers to suffering as a social cultural economic phenomenon that is silenced, misrepresented or reconstructed by different cultural representations and metaphors and by powerful and institutional processes in the name of 'normality. Often bureaucratic responses which are aimed to resolve human suffering end up intensifying it. Kleinman adds that 'How we "picture" social suffering becomes that experience, for the observers and even for the sufferers/perpetrators, What we represent and how we represent it prefigures what we will or will not, do to intervene. What is not pictured (as in the case of migrants Greeks and other non-English speaking ethnic groups) is not real. Much routinized misery is invisible; much that is made visible is not ordinary or routine. The very act of picturing distorts social experience in the popular media and in the professions under the impress of ideology and political economy. A major preoccupation in the Western tradition has to do with the incommunicability of pain, its capacity to isolate sufferers and strip them of cultural resources, especially the resources of language'. Kleinment, for example, explains how powerful groups in society can manipulate cultural processes by the use of language to mask and silence suffering and suit their interests. 'Medicine is a powerful bureaucratic transformer of the existential, the moral, the aesthetic, even the religious sides of suffering. and in the 1990's, especially, the kind of bureaucratic transformation medicine enacts is to remake sufferers as consumers and to transform death and fear into commercial stakes and financial opportunities (XX). Kleinman states that 'It is not that concern with discrete issues such as disease eradication, control of crime and violence, and intervention in poverty has been lacking in the administrative discourse of planing and policy or in the search that informs them. (Far from it!) But because of the manner in which knowledge and institutions are organised in the contemporary world as pragmatically oriented programs of welfare, health, social development, social justice, security and so on, the phenomenon of suffering as an experiential domain of everyday social life has been splintered into measurable attributes. These attributes are then managed by bureaucratic institutions and expert cultures that reify the fragmentation while casting a veil of misrecognition over the domain as a whole because is seen as a whole it would be too threatening?) (XXV).

1998; Adams 1997; Jupp 1991; Edwards and Read 1989; Marcus and Rasmussen 1987).

The first Greeks in Australia

In 1829 the first Greeks arrived in Sydney, Australia. They were seven young sailors from the island of Hydra, convicted for piracy by the British and sentenced to be transported to Australia. Pardoned in 1836, five of these young men returned to Greece while two remained in Australia.

The first Greek woman to migrate to Australia was born in 1810. She was married to Major James Henry Crummer, the commandant of a British garrison occupying the Ionian island of Kalamos. When her husband was posted to Australia in 1835 she accompanied him. During the gold rushes in the 1850s, about 350 Greeks arrived to work in Victoria. Many returned to Greece, while some moved to Melbourne and elsewhere (Gilchrist 1992; BIPR 1991).

Up to 1881 Greeks were not differentiated in colonial censuses. It has been estimated that by 1881 there were 515 Greeks in Australia; about 250 lived in Sydney and a smaller number in Queensland. Prior to 1900 there were very few Greeks in other colonies in Australia (BIPR 1991:1).

The 1901 Commonwealth Census recorded 878 persons whose birthplace was Greece. The number of Greeks in Australia increased steadily and, by the outbreak of the First World War, in 1914, there were 2,000 Greeks living in Australia. Most of them came from the Ionian or Aegean islands. As a result of chain-migration a number of Greeks from the islands of Kythera, Ithaca and Kastellorizo settled in Australia. Most Greeks from Kythera settled in New South Wales (in 1940 there were 2,000 Kytherans in New South Wales). Migrants from Ithake settled in Melbourne and those from Kastellorizo settled in Perth. Smaller groups settled in Sydney, Brisbane and Darwin. Only small numbers came from the Greek mainland and from Turkish-ruled provinces; some also came from Cyprus and Asia Minor (Gilchrist 1992:78).

White Australia immigration and assimilation policies and their effects on Greek immigrants.

Before 1900 people came to Australia from diverse backgrounds and countries. Whites and non-whites including Asians were arriving in the colonies of Australia (Stratton 1998). When Australia became a Federation in 1901, one of the first pieces of legislation passed by the new Federal parliament was the *Immigration Restriction Act.* 1901. Its main purpose was to keep Japanese, Chinese and other Asian-looking people out of the country.

This was the foundation of Australia's long-standing 'White Australia' immigration policy, with its restrictive definition of who was considered white, mainly people of British, Irish and, to a lesser degree, of Northern European origin who were considered desirable 'white' immigrants to Australia. After the Second World War, the definition of 'white' was extended by the then Labor Minister of Immigration, Arthur Calwell, to include Southern Europeans (Stratton 1998).

The inception and enforcement of the 'White Australian' policy was predicated on the assumption of the racial (and, consequently, cultural) superiority of whites (British and Northern European), and was supported by reference to the 'scientific' racial theories of the time. According to Stratton (1998:12):

> The purpose of the White Australia policy was to establish an Australian national population that was, as far as possible, exclusively 'white' and preferably 'British, or 'Irish', in origin.

The assumption at the time was that race determined culture, and culture was understood to be commonly shared, static and homogenous among a particular group of people; as such, a homogenous racial population would ensure a culturally homogenous nation (Stratton 1998).

Australian national policy placed great emphasis and weight on national cohesion (Cope, *et al.* 1991) and excluded (whether by omission or by official sanction of the White Australian policy) any

conception of ethnic (or gender) diversity (Bottomley 1979) - even though, at the same time, Australia was ethnically and racially diverse (Adelman *et al.* 1997b; Jamrozik *et al.* 1995)

By its nature, the official policy of White Australia encapsulated and enforced the *Anglophone* and *Anglocentric* nature of Australia and its social and institutional organisation. Assimilation and the dominance of British culture was a 'natural' consequence. Any immigrants to Australia were expected to assimilate fully to mainstream culture until the official declaration of multiculturalism in the early 1970s. In the meantime, migrants who did not assimilate according to expectations were perceived as not being committed or loyal to Australia and hence a threat to national cohesion. Perceptions of this nature persist to this day and are responsible for many of the difficulties that immigrants continue to face.

Southern Europeans (including, for the purpose of this study, Greeks) were not well accepted, since they were perceived as more alien than the British, Irish and Northern Europeans (Sherington 1980). Racially speaking, Greeks were located at the lower end of 'white' racial purity because of their darker skin colour. Their culture, was also considered more alien and more difficult to accept. This situation was common even as late as 1960s and 1970s (personal experience). Stratton (1998), speaking about post-Second World War migration, explains:

> Arthur Calwell's migration policy had expanded the meaning of 'white' from its previous limited application to northern Europeans [...]. Thus northern Europeans (Nordic and Germanic cousins) even though they still were considered aliens were sought out for recruitment and many were offered assisted passage to come to Australia, before a full Southern European migration eventuated (Stratton 1998:46),

Nevertheless, Arthur Calwell, the Immigration Minister from 1945 until 1949, still thought that 'two wongs do not make a white' (Stratton 1998, p. 58) - a play of words to express the maximum that 'two wrongs do not make a right'. Although, at the time, Calwell was speaking of Asians, his sentiments could easily have applied to

Southern Europeans, including Greeks. For example, well might he have said, 'two wogs do not make a white either'.

Greeks' (like other immigrants') marginality and subordinate position in society were assumed and reflected, even in daily interactions between immigrants and mainstream society, as illustrated by the names they were called marking their 'otherness', such as 'wogs', 'dagos' and 'greasy Greeks' (Stratton 1998). In the health care setting, there are references made to 'Greek backs' (in the case of back pain), 'Mediterranean gut ache' (in the case of abdominal pain), 'ethnic heads' (in the case of headaches) 'malingerers', as well as people with 'low pain threshold' and other derogatory terms (Kanitsaki 1998; Johnstone and Kanitsaki 1991; Ellard 1970, 1972; Portelli and Jones 1969).

The social conditions of the time, and intolerant, hostile community attitudes towards 'undesirable' foreigners, forced Greeks to assimilate in order to survive. The force of the Australian community's xenophobia resulted in many Greeks attempting to change their mannerisms and to avoid speaking Greek; many also anglicised their names to disguise their identity to avoid the stress of being targets of community hostility. For example, names like Lekatsas were changed to 'Lucas', Laleklosto to 'Lawler', Maurokefalos to 'Black', and so on (De Stoop 1996).

Prior to the Second World War, Greek women were not encouraged to enter Australia. Greek men either went to Greece to marry and then returned to Australia, or they married British and Irish women in Australia, thus facilitating their assimilation into the dominant culture. Many men had left their wives and families back in Greece and, in several instances were not able to reunite with them until they developed some degree of economic security. Many families were not reunited until post-war commercial shipping was normalised during the 1946-1947 period. Meanwhile, these men were financially supporting their wives and families in Greece.

Prior to the Second World War, Australia's industrial sector was not sufficiently developed to accommodate immigrants searching for work. This forced several Greeks to develop businesses in a variety

of sectors in turn enabling them to offer employment to many other Greeks. Fortunately, the free and liberal nature of Australian society at the time was conducive to this. Nevertheless, for many Greeks, it was impossible to find work forcing them to gather together and travel anywhere in Australia to get work, sharing their 'meagre earnings' (Tsounis 1988:18).

Migration was restricted and, often, when the country faced economic hardship, was prohibited, particularly to Southern Europeans. Chain-migration, however, continued because sponsored immigration was allowed. Also, individuals who could afford £40 (a considerable amount of money at that time) were allowed in (Harvey 1988). According to Gilchrist (1992):

> Greek immigrants were often viewed with some suspicion, even with hostility or contempt, at least until the newcomer could communicate effectively in English. [...] For most of the Greek settlers, their initial years in Australia had been an endurance of alienation. John D. Comino would write: "no-one can deny that a Greek coming to Australia suddenly finds himself in a strange and unknown world. Language, customs, social traditions, manners, occupations, sanitary arrangements, church, law, administration - everything is different". Most settlers did adapt to the strange land from sheer necessity, but to those accustomed to traditional village or island life the process was difficult and the cultural shock profound. Despite the alienation and the exhausting toil, life in Australia was not all oppressive: there was freedom to move and to deal, there was honesty in the public service and in courts, and a reasonable level of public health and security. And any threat of war seemed far away (Gilchrist 1992:366-67).

For much of the First World War, Greece remained neutral and one would not expect that Greeks in Australia would have been adversely affected as a result. Indeed, Greeks in Australia openly declared their support for the Allied cause, giving no cause to the Australian government and community to regard them as possible enemies. However, according to Gilchrist, Greeks were not:

> entirely shielded [...] from destructive violence against their shops by Australian hooligans venting their resentment against Greek neutrality. The Australian government would support the Allies' partial blockade of a neutral and hungry Greece, and would secretly ban Greek immigration and suspend

> naturalisation. As a precaution in case King Constantine should lead his country into alliance with Germany, the Australian authorities would also conduct a secret census of Australia's Greeks (Gilchrist 1992:368).

The secret census (conducted during the period of Greek neutrality *viz.* 1914-1917) revealed the number and distribution of Greeks in Australia, information that otherwise, perhaps, would not have been known as Greeks were not differentiated in the censuses of the day. It was found that there were 2200 Greeks in Australia (BIPR 1994:2). The vast majority were shopkeepers, waiters, cooks, or shop assistants who worked for Greek proprietors all over Australia. A substantial number were cane-cutters in Queensland. Others worked in smelters at Port Pirie, and a relatively small number worked in mining, seafaring, skilled trades or farming. There were two priests, only one doctor and one engineer that time (Gilchrist 1988).

The pre-Second World War Greek communities established the fundamental infrastructure of Greek community organisations and brotherhoods in Australia that later received and supported thousands of post-Second World War Greek immigrants to Australia. By the end of the nineteenth century, Greek communities had been established in Sydney and Melbourne. This was evidenced by the establishment of a Greek Orthodox church in both cities, and Greek language press producing weekly newspapers in Melbourne. Subsequently news papers were also produced in Adelaide, and the first Greek book published in Australia in 1916 (Gilchrist 1988).

By 1921 there were 3,654 Greek-born people in Australia. Chain-migration had helped to form small homogenous communities of male shop keepers (85% of the total Greek population was male) (Tsounis 1988). Even though a series of government regulations between 1924 and 1936 severely restricted the number of Greeks permitted to settle in Australia, by the time of the 1947 Census there were 12,000 Greeks living in Australia. By 1940, around three-quarters of all Greeks in Australia were from one of the Greek island groups, and at least half of them were from the three islands of Kythera, Ithaca and Kastellorizo (Price 1963).

The 1947 Census showed that 38% of Greek migrants lived in New South Wales, 22% in Victoria, 15% in Queensland and Western Australia and 8% in South Australia (Harvey 1988). Their occupations tended to be the same as those characteristic of Greek settlement (already described above). There was, however, an increased number who were self-employed - that is, from 45% in 1921 to 57% in 1947 (Gilchrist 1988).

Post-Second World War Greece-born settlement in Australia

Greece was caught up in the Second World War. As soon as the German occupation of Greece was ended, Greece was immediately occupied by British forces. A subsequent struggle between pro- and anti-Communist Greek factions led to a devastating civil war that ended with the defeat of the communists in 1949.

Greece was encouraging its people to leave. At the same time, Australia was in a position where it urgently needed young and healthy people to work in its developing industrial sector and to help increase its population. Thus, during the period from 1947 to the early 1980s, 250,000 Greeks entered Australia (BIPR 1991).

The first post-Second World War Greeks to Australia were from Cyprus and Egypt, amounting to about 5,000. Between 1947 and 1952 only 8,000 Greeks came to Australia from mainland Greece, mainly through the sponsorship of the families of those who had migrated to Australia prior to the war and who wanted to protect their kin from the Greek civil war.

In 1947 Australia opened its doors to immigration as the ambit of its White Australian policy was extended to include southern Europeans, and was actively encouraging people to come to Australia.

Immigration patterns, however, continued to indicate that Australia's need for immigrants and order of preferences were racially and culturally based until the repeal of the White policy by the Whitlam Government in 1972 (Stratton 1998; Adelman *et al.* 1997; Jupp 1991; Bottomley 1991). According to Jupp (1991):

> From simply assuming that the British were superior to all others, public opinion moved towards grading people of different appearance and culture in terms of their superiority and inferiority to each other. The notion of a 'tree of life' was widespread, with Australian Aborigines on the lowest branches and northern Europeans on the highest. Such ideas were widespread, until the 1940s (Jupp 1991:110).

Jupp (1991:69) explains that:

> All immigration from outside the United Kingdom and other English-speaking countries such as New Zealand, Canada or the United States, had been discouraged during the first 150 years of Australian colonisation.

Although exceptions were made, the preference for British migrants was clear. Their reception to Australia and the settlement assistance available to them differed considerably from that experienced by and available to Southern Europeans. British migrants were automatically eligible to hold public service positions, while other immigrants had to wait until they became Australian citizens (Adelman *et al.* 1997; *A Fair Go For All* 1996; Jambrozik *et al.* 1995; Castles 1988; Australian Institute of Multicultural Affairs 1982; Galbally 1978).

Immigration to Australia reflected both the need for migrants and the racially and culturally based fears that were encapsulated in the White Australia Immigration Policy. For example, so long as the inflow of British subjects, (who shared with mainstream Australians allegiance to the Crown and common racial and cultural origins), satisfied Australia's need for immigrants, Australia could afford to restrict other peoples - even though many countries had large numbers of people wanting to migrate. British emigration, however, started to slow down as conditions in Britain improved and as complaints against Australia were sent back home by British migrants depicting Australia as an undesirable place to migrate. By the 1960s, the Australian government became concerned about the slow down in migration, prompting it to allow other 'less desirable' migrants to enter the country in much greater numbers than before, and to look elsewhere for the recruitment of migrants.

Assisted passage for Greek migrants to Australia commenced in 1952. However, it is estimated that between 1945 and 1982, only 30% were given assisted passage under a signed contract binding them to live in Australia for two years (Jupp, 1991; Tsounis 1988). If they wished to leave Australia prior to the expiration of the contract, they had to repay the cost of their original passage. The majority of Greeks came with just a suitcase and were financially devastated. If they had wanted to return, they could not since they could not save enough money to pay back the Government within such a period, let alone to pay for their return fares to Greece. In contrast, by 1965, 80% of British immigrants were assisted to migrate under various programs - without any binding contract (Jupp 1991).

The greatest number of Greeks arrived in Australia between 1961 and 1966 and, by 1971, Greek migration had reached its peak. Forty-seven per cent of all Greeks who arrived in Australia settled in Melbourne.

The decline of Greek migration started from mid-1970s onwards. As the turbulent internal political affairs of Greece settled, Greece developed into a modern European country. Since the 1970s, the number of Greeks departing Australia has exceeded arrivals. It was estimated that, overall, 20% of Greece-born migrants who arrived in Australia between 1947 and 1987 returned to Greece (Harvey 1988).

By the mid-1970s, the Greeks had established a strong and vital community in Australia. The foundations of this community were laid down by its pre-Second World War immigrants. Its strength rested on organisations established by both Greek-born and their Australian-born (and educated) children. Today, the Australian-Greek community is characterised by its well organised church parishes around the country, Greek primary and secondary Greek schools, welfare and philanthropic organisations, hostels and nursing homes and hundreds of brotherhoods, reflecting the diverse and homogenous groups of Greeks in Australia. Another important element of the Greek community in Australia is the Greek media and, in particular, the recent development in Melbourne of two 24-hour Greek radio stations. These radio stations entertain and keep the Greek community in touch with current events and issues with

accurate, current and relevant mainstream information. It is only now, in the late 1990s, that many Greek-born people feel for the first time that they can participate in the everyday affairs of the mainstream Australian community.

The community 'glue' that holds Greek people in Australia together is their shared history, religion and language, as well as their common experiences which include their oppression as immigrants in Australia. But most important in this respect are the Greek church, Greek schools and Greek media facilities that have been developed in Australia through the years by consistent and hard work, often against enormous difficulties and barriers that had to be overcomed (Tsounis 1988; Marsh 1983; Hearst 1981).

Post-Second World War assimilation and integration policies and their effects on Greek immigrants in Australia

While the Greek community's strength arguably reflects the lack of assimilation and integration of many Greeks in Australia, it could also be said to reflect the lack of choices available to them and which disadvantaged them within mainstream Australian society. Marked as 'ethnic' (other), many were marginalised and excluded from the dominant society. They tended to be labeled automatically as unskilled labourers, even if they had educational qualifications (which, in most cases, were not recognised [Jambrozik *et al.* 1995]). Unable to speak English, and/or often under-educated, poor and without social networks and support, many found themselves located at the bottom of Australian society. Accordingly, they found themselves undertaking the mostly manual, heavy, dangerous, repetitive and boring work, with inadequate financial rewards. Married women with young children, unable to access child-minding facilities, had to organise their lives in ways that would fit in with the demands imposed on them by working full-time in jobs of necessity. Or they worked at home, (piece work) often without the support of an extended social network or shared community, and raising a family at the same time (Moraitis 1979, 1972; Galbally 1978; Henderson 1975). Frequently, married couples did not see each other until the weekends, as they worked sequential shifts to enable them

to cope with family demands. Consequently many couples became estranged under the social conditions they had to endure.

The lack of assimilation and integration into mainstream society by many Greeks also reflects their resistance to and reaction to the lack of action and neglect of the Australian government with respect to them during the years when they desperately needed help. Assimilationist policies legitimately absolved government (particularly local government) from accountability and responsibility. This was because mainstream society, including Government, expected Greeks (and other migrants) to completely assimilate and learn English (but, again, with minimal assistance) (*A Fair Go for All 1996*; Jamrozik *et al.* 1995; Galbally 1978). Such unrealistic expectations for migrants provided government (and the dominant community by default), with scapegoats to blame for the failure of migrants to assimilate while, at the same time, they were using them as factory fodder for Australia's industrial sector.

Until as late as 1972, the Australian Government actively supported and upheld a policy of 'assimilation' or, as Gordon (1964: 85) describes it, 'Anglo-conformity'. On this, Bottomley (1979:8) further comments that 'Australian policy makers have always intended that our migrants should fit in with our British heritage'.

Successive Australian governments' assimilation policies emphasised two main themes: (i) dispersal, and (ii) non confrontation (Martin 1971). The theme, of dispersal, in this instance aimed at discouraging 'ethnic grouping in particular places of employment or particular institutions' (Bottomley 1979:8). The theme of non-confrontation, on the other hand, aimed to provide 'some sort of ideological support for a policy of assimilation' and 'to support arguments against any need to alter or adapt existing societal structures to meet the pluralistic needs and requirements of non-Anglo Saxon immigrants' (Bottomley 1979:8).

These policies not only tolerated, but actively supported ethnocentric (ethnospecific to people of British background) industrial and institutional practices, including those relating to the provision of (ethnocentric) health and education. Institutions in these sectors

were not expected to change or make any adjustments to provide for the needs of migrants. This was because, among other things, it was assumed that since such services existed they would be equally accessible and relevant to all. Conveniently, governments and public services at the time remained passive and blind to the plight of immigrants.

In this atmosphere, any concentration of ethnic groupings was perceived as a ghetto rather than the result of the dominant society's exclusionary social practices, and/or another way of using their cultural strengths to support their survival and/or being and experiencing life while still being committed to the nation. Such ethnic group concentrations, however, fueled hegemonic suspicions and negative representations of migrants which further disadvantaged them. One such suspicion in relation to migrants was the so-called 'Greek Conspiracy Case' of 1978 (Hage, 1998; Jamrozik *et al.* 1995; Bottomley 1979; personal memory), in which many Greek pensioners were accused of fraud and charged with conspiracy to claim social security benefits unlawfully. A number of doctors and lawyers were implicated and also charged. Federal Police broke into the homes of many Greeks in the middle of the night and arrested 180 people for their alleged crime against the Australian state. Newspapers all over the country were accusing the Greek community of fraud against 'their' nation. Meanwhile, Greeks pensions were suspended pending the court cases being heard.

This situation brought enormous distress and shame to the Greek community in Australia, and also sharply reminded Greek migrants of their subordinate position in Australia's social hierarchy. Further, it reminded them that they were under surveillance and still, after many years in Australia, not trusted or considered to be equal or loyal citizens. They remained aliens, outside of the mainstream community, as if they were not tax payers like everyone else who worked. After ten years of court cases and millions of dollars wasted, not one of the pensioners or professionals was convicted (Jamrozik *et al.* 1995). Meanwhile, some of them were ruined financially and socially and many of the pensioners were reduced to living in poverty and some died feeling shamed in their community and Australian society.

The pressure on migrants to assimilate had its deleterious effects in the context of Australian health care services. It was, and is, not uncommon for immigrant patients (in this case Greeks), whether aged or not, to be 'blamed' for not speaking English and for being 'culturally different'. Their health and care beliefs and practices were, and are, disregarded and often poorly understood. This situation affects their access and equity in relation to health care services and the quality of health care received (see, for example, Kanitsaki 1998, 1996, 1994, 1993, 1989, 1988, 1983; *A Fair Go for All* 1996; Macintyre and Dennerstein 1995; Lopez and Fazzalori 1995; Moss, 1993; Alcorso and Schofield 1992; *Health Department Victoria 1992, 1991;* Responding to a multicultural society: Issues and strategies for nurse education 1991; *Report of the Ethnic Aged Working Party* 1987; *Australian Institute of Multcultural Affairs* 1986; Marsh 1983; Hearst 1981; *Australian Institute of Multcultural Affairs* 1982; Galbally 1978; Moraitis 1978, 1972; Cox 1972; Retchford 1972).

While health professionals were encouraged by peers and academics alike to try and understand their immigrant patients, and to deal with a presenting problem from the patient's point of view, few had managed to achieve this. Some were even hostile toward the thought that they (i.e. health professionals) should be more accommodating. During the late 1970s and early 1980s, for example, when multiculturalism had replaced assimilation, I encountered enormous resistance and aggression from many of the groups of health professionals I had been asked to address on the issue of immigrant experiences, cultural differences and ways that professional care givers might respond better to the health needs of Greeks and other immigrant patients. These groups typically asked such questions as: 'Why can't immigrant patients learn the language [English]?', 'Why can't they conform?', 'Why don't they comply with treatment?', 'Why do they have to have so many visitors?', 'Why don't they keep to visiting hours'? 'Why do they have to bring their food into the hospital?' However, as I recall, none of the health care professionals acknowledged any responsibility for the failure of 'the system' - or of themselves - to understand and respond better to the needs of immigrant patients.

Questions asked were hostile or shrouded in cool and at times cruel indifference; issues of justice were never raised or considered. On one notable occasion, intense anger was evident when one of the participants related an anecdote involving an elderly Italian woman who could not speak English well, but who was nevertheless able to communicate her rudimentary needs. The woman had apparently asked for a slice of bread to have with her lunch, an Italian dietary norm. The nurse, however, refused this simple request informing the woman to 'eat like all the others in the ward' and that 'we never give bread out with lunch'.

As assimilationist, and later integrationist, policies prevailed and found ongoing Government support, so did the assumption that 'minority' ethnic groups would automatically adopt the language, lifestyle and other aspects of the dominant 'majority' group (i.e. Anglo-Celtic Australians) (Sherington 1980; Bostock 1977). Thus the ideal of assimilation became firmly embedded in the subconscious and later the conscious British Irish decent Australian (BIDA) mind to the point that 'cultural diversity' came to be viewed predominantly as a 'disability', and 'cultural difference' as a human 'flaw' or 'fault' for which individuals (i.e. those who had this 'fault') were to be blamed (Bostock 1977). In this climate, then, it is not surprising that the Government and its health care institutions totally missed the point: that it was *they* who had the responsibility to adapt the health care system, including the relevant government policies and regulations, to meet the needs of the culturally diverse society it was serving, and not vice versa - a point which was later publicly conceded with the arrival of multiculturalism in Australia.

Despite the pressure to assimilate, and the incredible social suffering this caused, Greek immigrants nevertheless managed to sustain their core cultural values as did other immigrant groups (Storer 1985), thus preserving their cultural and ethnic identity (Tsingas 1998; Kapardis and Tamis 1988; Evangelinides 1980; Bottomley 1979). Their culture and their communities sustained them, provided support and helped them to survive years of hardship and isolation in Australia.

Greek migrants and their self -help

Despite experiencing material improvements in comparison to their situation in Greece, many members of the Greek community in Australia felt that their social, cultural and psychological well-being was undermined. As a community, they felt abandoned by both the Greek and Australian governments of the time.

Giamiadaki (Γιαμιαδακη) (1980), expressed this concern and called upon Greeks in Australia to take care of themselves. He offered his views on how all Australians could live as equals in a multilingual and multicultural society in the following way5:

> Οι αποδημοι ειναι ενα κομματι αμοσπασμενο απο την μητερα Ελλαδα με την οποια τους συνδεουν μοναχα νοητοι και συναισθηματικοι εθνικοι δεσμοι. Αποτελουν τη στρατια του αποδημου ελληνισμου, η οποια πρεπει να ΑΦΤΟΣΥΝΤΗΡΗΘΕΙ, να ΑΦΤΟΕΠΙΒΙΩΣΕΙ. Να διαμορφωσει δικους της στοχους. Να διανοιξει δικους της δρομους. Να προγραμματισει τη δικη της δραση. Να αγωνιστει και να τερματισει στο ξενο εδαφος, το οποιο ειναι πολυ ανομοιο απο εκεινο της Πατριδας και πολλες φορες αφιλοξενο και εχθρικο.Το επισιμο Ελληνικο Κρατος και οι κρατικες Υπηρεσιες – οχι ο ομοιοπαθος με μας ελληνικος λαος – μας εχουν ξεγραψει, οπως εκανε ενας παρεδρος επαρχιακου χωριου. Οταν πεθαινε η ξενητεβοταν κανενας, τραβουσε μια χαρακια πανω στο ονομα του, για να μην τον συμπεριλαμβανει πια στις στρατολογικες και τις φορολογικες καταστασεις! (Γιαμιαδακη 1980: 24–25)

5 Giamiadaki (1980) The Greek migrants are a broken part from mother Greece. The only thing that connects them are sentimental and intellectual national bonds. Greek migrants must support themselves and must survive. The must formulate their own goals and to open their own directions. They must program their own actions. To struggle and to finalise at the foreign land which is dissimilar from that of their own country and often is non hospitable and hostile. The formal Greek nation and its services - without the same experiences as the experiences of Greek migrants - they have wiped us out from their memory, the way the president of a village, that when someone died or emigrated he would draw a line over his/her name. This was so that they would not be included anymore in the list for national service or taxation purposes. (Giamiadaki 1980:24-25).

The logic thing to do is to create a co-existence and to work together. That is to have a multicolour and surviving multiethnic society. In such a society in which 1/3 of its population has different linguistic, psychological and civilisation bases, it is called for the creation of situations that benefit not only the co- existence of difference, but their maintenance and promotion. This is so as to with time and with integration assimilation results and not the subordination of one over the other (Giamiadaki 1980:143)

> Το λογικο ειναι να δημιουργηθει συνυπαρξη και συνεργασια, οπως η αρμοια σε χρωμα και σχημα σΠενα ψηφιδωτο. Δηλαδη, μια συμβιουσα πολυχρωμη (πολυεθνικη) κοινωνια. Σε μια τετοια κοινωνια, της οποιας το 1/3 του πλυθυσμου της εχει διαφορετικο γλωσσικο, ψυχολογικο και πολιτιστικο υπεδαφος, επιβαλλεται να δημιουργηθουν αναλογες καταστασεις, οι οποιες να ευνοουν, οχι μοναχα την συνυρπαξη των διαφορων, αλλα και τη διατηρηση και προωθηση τους, εως οτου, με τον καιρο και την αναμιξη επελθει φυσικα η συγχονεψη και οχι η υποταγη του ενος στον αλλο. (Γιαμιαδακη 1980: 143)

Both the desire of Greek communities to retain their identity and their resistance to assimilation policies enabled them to use at least two strategies to achieve some of their goals. One was to establish a strong Greek community with complex infrastructures to sustain their dignity, identity and humanity and provide support to the community. The other was to establish organisations that made visible government neglect of the Greek community and advocated for their rights (Zangalis 1997). The aim was to ensure that the government took its appropriate share of responsibility in the provision of relevant services in relation to ethnic groups and thus avoid perpetrating the perceptions of migrants being 'dependent victims'. By 1971, it was estimated that, of the 174,128 Greeks who had migrated to Australia between 1952 and 1974, a high proportion (59.5%) were employed as labourers or process workers (Bottomley 1979). A survey ten years later (1981) gave little cause for optimism, showing that, of those Greeks who had migrated to Australia after the war, 49.8% were still employed as labourers and process workers and only 2.8% were working in professional or technical positions and only 4.7% held managerial positions (Storer 1985:10).

These figures represent a sorrowful outcome for the post-Second World War Greek immigrants to Australia, one which could be aptly described in terms of them having leapt out of the proverbial frying pan and into the fire. It will be recalled that these immigrants had left Greece in search of a more prosperous and more comfortable life for themselves and their children. Instead, they found themselves living a life characterised by excessively hard work with poor

monetary reward, stress, illness and, in some cases, even abject poverty (Henderson 1975). These Greeks are the aged of today and in the coming years face the possibility of finding themselves in health care settings that are culturally and linguistically alien and inappropriate and often unsafe for them. In the process, the Greek community continues to struggle against existing federal, state and local government policies in order to overcome barriers that traditionally have obstructed or delayed appropriate development in this area (see the Greek Welfare Society's records and government submissions in March 1983; Moraitis 1978; Zangalis 1997).

A second aim of the established community and advocacy groups was to ensure that children of Greek migrants entered mainstream educational institutions to gain relevant educational qualifications and thus improve their life chances. While much has been achieved in this area, this has not come without a cost. On the one hand, the first generation (because of the social conditions they had to endure) virtually sacrificed themselves for their children and, on the other, their resistance was (and is) interpreted by the dominant culture (and sometimes their own children) as unwillingness to mix and integrate, which further stigmatised them and excluded them from mainstream participation.

After 30-40 years of life in Australia: The situation of Greek-born population in Australia in 1991

At the time of the 1991 Census, there were 136,028 people in Australia who were born in Greece, and 151,082 people born in Australia with at least one Greek-born parent. (This figure does not include Greeks who identified themselves as being Greek but who were born outside Greece). The Greeks are the second largest (after Italians) of the non-English speaking background groups in Australia (BIPR 1991).

The post-Second World War Greek immigration evened out the previously existing imbalance in numbers between the sexes. As mentioned, prior to the Second World War the Greeks who arrived in Australia were mainly men, in 1901 the ratio of males to females, for example, being 12:1. By 1981, this changed to 106 males per 100

females and, by 1991, this ratio was slightly lower again. Another difference in the pre-and post-Second World War immigration pattern is the area from which Greeks emigrated. Most of the pre-war Greeks came from the islands, while post-war migrants came mainly from Peloponnese, Epicures, Macedonian, Crete, Lesvos in addition to other places outside Greece (Kringas 1988). These were also differences in relation to the areas they settled. In 1947 57% of Greeks lived in metropolitan areas: Post- Second World War immigrants, however, chosen, or more to the point were directed, overwhelmingly to live in industrialised metropolitan areas. In the 1996 Census, 95% of Greeks lived in Melbourne (Tsingas 1998). Greeks also were concentrated within particular suburbs. For example, in 1991 Melbourne Greeks represented more than 4% of the population in suburbs such as Northcote, Oakleigh, Brunswick, Richmond, South Melbourne, Collingwood, Whittlesea, Preston, Coburg and Prahran. In Sydney, similar numbers lived in Marrickville, Canterbury, Rockdale and Botany. In Thebarton, in Adelaide, Greeks constituted almost 12% of the population (BIPR 1991).

Educational achievements

42.1% of Greece-born people aged 15 and over (both before and after arrival in Australia), had left school before the age of 14 7.9% within this cohort had never been to school, females exceeding males. By comparison, 15.1% of the total Australian population left school before the age of 14, and only 0.9% had never been to school. Furthermore, 16.7% of Greece-born females remained at school beyond age 17, compared with 23.6% of Greece-born males. By comparison, 28.5% of Australian-born females remained at school beyond 17 of age, and 30.7% of Australian-born males (Bureau of Immigration and Population Research 1991).

Of the total Australian population aged 15 and over, 38.8% held some form of educational or occupational qualification, compared with 20.3% Greece-born of the same age group. The proportion of this later group with post-secondary qualifications was 3.4%, compared with 12.8% for the total Australian population.

Of the Greece-born population, 7.5% received basic or skilled vocational preparation in comparison to non-English speaking countries (11.9%). Australian-born (13.9%) and the total overseas-born (16.6%). Again, males (24.2%) were more likely to have obtained some form of qualification than females (15.6%). The most noticeable difference between males and females was in the skilled vocational area: 10.1% of males as opposed to only 2.1% females. When comparisons are made between males and females in their attainment of post-secondary qualifications, however, the differences are minimal: males 3.8% as opposed to 3.1% of all females. The proportion of Greece-born with post-secondary qualifications, however, was only 3.4% compared with 12.8% the total Australian population (BIPR 1991).

English proficiency

A self-assessment of English proficiency by Greece-born people aged 5 years and over indicated that 4.4% spoke English at home compared with 21.9% for other people born in non-English Speaking (NES) countries. Greece-born people (60.5%) reported that they could speak English 'very well' or 'well' and over 33% reported that they could speak English either 'not well' or 'not at all'. Of the people from NES countries, 58.3% spoke English 'very well' or 'well', 19.5% spoke English 'not well' or 'not at all'.

The proportion however of Greece-born persons in the 65 years and over age group who spoke English 'not well' or 'not at all' was 61.6% higher than other migrant groups of similar age. In this age group, only 2.9% reported speaking 'English only'. Of the Greece-born who reported speaking English 'not at all', 70% were females. In the 65 years and over age group, 26.9% of females spoke English 'not at all' compared with 8.9% of males (BIPR 1991).

Among the Greece-born aged 5 to 14 years, 85.4% spoke Greek at home. Figures for other age groups were: 15 to 44 years 88.4%; 45 to 64 years, 93.4%; 65 years and over, 89.8%. The proportion who spoke Greek at home ranged from 99.0% in Tasmania to 94.5% in Victoria. Western Australia had the smallest proportion 80.1% of Greece-born who spoke Greek at home (BIPR 1991).

Employment and life chances

In 1947, over half of the Greeks in Australia were either self-employed or employers. By comparison, more than 75% of immigrant Greeks who arrived after the Second World War were labeled as unskilled and destined for factory work. Thus, by 1981, only 24% were self-employed and in that year, 50% of Greeks in Australia were employed as labourers or process workers. By 1991 that percentage had increased slightly, with a total of 55% of all Greece-born persons aged 15 years and over in the occupation category of labourer (BIPR 1991).

There were some differences in employment between the Greek males and females and between Greek and Australian females. For example 60% of Greek women were employed as labourers and related workers', compared with 11.2% of women in the total Australian population, while 58.8% of Greek men the same job category. Significantly, only 10.2% of all Greece-born in Australia were employed as managers and administrators. The Greece-born people were also under-represented in the professional and paraprofessional category-6.2% compared with 19.2% of the total Australian population (BIPR 1991).

Significant differences were to emerge in the social status and occupational positions of pre- and post-Second World War Greek immigrants to Australia (Bottomley 1979). Those who immigrated to Australia before the Second World War, for example, achieved considerable wealth and status within the Australian community. Of this group, 71.6% were in the catering industry, the majority as business proprietors, compared with only 7.7% employed as labourers and machine operators (Price 1963). By contrast, the plight of Greeks who immigrated to Australia after the Second World War (i.e. between 1952 and 1974) was to be one of ongoing economic repression, lower class status and social disadvantage and suffering, despite initially receiving enormous support from their pre-war Greek immigrant counterparts (Sherington 1980).

Income

In 1991, the proportion of Greece-born immigrants with an income of $16,000 or less was 55.5% compared with 49.7%. of the total Australian population. There were also differences between men and women. The proportion of Greek males earning $16,000 or less being 45.4% was much smaller than Greek females' proportion of 66.2%. The proportions of male and female Greece-born earnings $16,000 or less are significantly higher than both the male and female totals of the Australian population and the Australian-born, overseas-born from non-English speaking countries and overseas born from English speaking countries populations. The proportion of Greece-born people in the $3,001-$25,000 income group was 69.6%, compared with $57.5% of the total Australian population. In the $25,000 and over income group, the Greece-born had a lower proportion (14.2%) compared with 22.6% of the total Australian population.

The income status of Greece-born males and females did not vary much between the States, with the exception of South Australia, where the median income was 22.6% lower than the Australia wide-median (BIPR 1991). The above statistics make it clear that Greece-born people, particularly women, are financially disadvantaged in comparison with the total Australian population, and that, even after 30 to 40 years in Australia, their life chances and social standing has not improved in any significant way.

Home ownership

At the time of the 1991 Census, the majority of Greece-born Australians (83.0%) owned or were purchasing a home, which coincides with the findings of Tsingas's (1998) research on Greeks in Victoria. This is a higher proportion than for the total Australian population and overseas-born people (both 68.1%). The Greece-born also had a smaller proportion who were paying off their home (17.0%) than the total Australian population (27.1%) and overseas-born (26.5%). It can be seen, then, that although Greece-born people were earning less money, they nevertheless succeeded in purchasing

their own homes. This, however, was not without considerable personal cost.

Many Greece-born people had two key priorities: to own their own home, and to educate their children - both pursued for the purposes of enhancing the life chances of their children. Many low-income Greeks, however, acquired their home at the expense of placing their families under considerable financial hardship during the years of purchase. Even when homes were paid off, however, families remained financially stressed. While obviously being a financial asset, the family home does not provide a regular income, nor does it generate wealth. Thus, while many low-income Australian Greeks may be regarded as having more financial security than those (non-Greeks) who do not own a home, they do not necessarily enjoy nor have a better standard of living than others on low incomes (Minichiello *et al* 1992).

Religion

According to the 1991 census, 93.5% of Greece-born Australians stated their religion as Greek Orthodox, 0.5% as Catholic, and 0.4% as Orthodox Macedonian. 0.4% reported a non-Christian religion, including 0.3% Islam. The great majority of Greece-born people (96.3%) identified as Christians, compared with the total Australian population (74.1%). Only 0.9% of Greece-born reported having no religion, compared with 12.9% the total Australian population.

The situation of second-generation Australian-born with one or both parents born in Greece

At the time of the 1991 Census, there were 151,082 people who reported they either one or both of their parents had been born in Greece. As most Greece-born people in Australia came to this country during the 1950s and 1960s as young adults or children, it is not surprising that 90.0% of the second generation Greeks were aged under 35 years in the 1991 Census.

Significantly, the second generation Australian-Greeks have achieved as well educationally as the general Australian population.

For example, 36% of second-generation Greeks have obtained an educational or occupational qualification (compared to 20.0% of the Greece-born population, 36.6% of the Australian-born population, and 38.8% of the total Australian population). Second-generation Greeks have also achieved higher levels of post-secondary qualifications - 15%, compared to 3.4% of the Greece-born migrant population, and 12.8% of the Australian-born population (BIPR 1991). The differences between second-generation females and males in the attainment of educational or vocational qualifications were high - females 37.2% and males 36.3%, compared to 31.0% for all Australian-born females and 42.5% for all Australian-born males. The proportion of second-generation females who had obtained a post-secondary qualification (16.1%) was higher than males (14.0%) and higher, too, than all Australian-born females (13.5%)(BIPR 1991). (Figures for the achievements of all Australian-born males were not available for comparison).

Retention of Greek language by the second generation is high, with females learning and speaking their parents first language at a slightly higher rate than their male counterparts. Variation in Greek language retention differed significantly from state to state. Those who spoke English at home ranged from 16.8% in Victoria to 44.4% in Western Australia. Of those who spoke Greek at home, the lowest level was in Western Australia (41.9%) followed by Queensland with 54.0%. The highest proportion of second-generation Greeks who spoke Greek at home was in New South Wales (77.0%) (BIPR 1991).

It is evident from the above data that second-generation (Australian-born) Greeks have gained access to educational institutions and have succeeded in improving their life chances in Australian society. Whilst second generation Australian Greeks are better prepared educationally than first generation Greek immigrants to Australia, whether they have achieved occupational parity with their British/Australian counterparts - particularly with respect to positions of power and influence in core of Australian institutions - is a another matter entirely. Indeed, according to a Federal Government report on *Access and Equity* published in 1996, only six per cent of all people of non-English speaking background (including second generation groups) were found to have achieved

such positions of power and influence in Australia's core institutions. As Stratton (1998), who has undertaken an extensive examination of race, multiculturalism, and discourses on national identity in Australia, remarks:

> the pluralism allowed to those groups distinguished as ethnic, the term which since the advent of the policy of multiculturalism has been substituted for race, sometimes with the most surprising results, is limited to the cultural sphere. The political and legal spheres remain, in unalloyed fashion, dominated by British, and not even continental European, premises and institutional forms. Indeed it is remarkable how little the fundamental assumptions of government have changed since the advent of the policy of multiculturalism. How little ground has been given by those who have traditionally held power in Australia (Straton 1998:10-11).

The educational success of second generation Australian-Greeks has provided a great deal of pleasure and pride to their parents. However, in some families, it has also been the cause of disharmony and alienation as the cultural and social gap between children and parents became unbridgeable.

Under policies of assimilation and integration, Greeks, like other immigrants, were expected to offer their hard work, but without being visible or vocal. It was their silence that was valued, not their presence as people who could enrich Australian society. Thus the majority lived marginally, excluded from full social participation. Although they were not able to participate fully in the dominant society, they were not, however, silent or inactive. Their social pain and suffering (Kleinman, 1997) did not stop them from pursuing full and active membership of Australia society or from standing up for their rights. This struggle was, in turn, picked by the next generation.

Once they had become acquainted with the dominant culture and learned its social skills, the children of first-generation Greeks and, to a lesser degree, first-generation Greeks themselves, became the bearers of the Greek community's social suffering. Social inequalities and neglect of the rights of immigrant Greeks became visible to them. The resistance of migrant Greeks to meaningless assimilation provided first hand experience to their children revealing to them

the working and social conditions that supported their exclusion from mainstream society. These experiences, and the dependence of their parents on them, made transparent to these children the social inequalities which had burdened their parents disproportionately compared with others members of the dominant society.

The intolerant and neglectful stance adopted by social and public service agencies of the day made visible to the children of Greek immigrants the crisis context within which their parents used to live daily, creating in many a moral outrage. The Greek community, through their educated and linguistically proficient members, came to champion ethnic rights at a time when few, if any, ethnic voices were heard. Two of the most effective and visible Greek organisations that helped (and continue to help) the Greek community in Australia and particularly in Victoria are the well-known Australian Greek Welfare Society, established in 1972, and the Australian Greek Society for Care of the Elderly, established in 1976. These organisations, among many others, led the way in championing the Greek community's unmet and urgent health care and social needs. They continue to advocate for the provision of relevant services, particularly those serving the needs of the fast growing Greek-aged population.

Even though government, institutional administrators and health professionals had more than three decades to anticipate and be prepared to meet the needs of ageing Greeks (and those of the ethnic ageing population in general), much remains to be done.

Very little, if any, desperately needed help and understanding was given to Greek immigrants by the Australian government and society during their first years of settlement. It is my belief (supported by Tsingas's 1998) that if the newly arrived Greek immigrants were given appropriate assistance towards enhancing their life's chances (such as through learning English and having a chance to gain a formal education), now, in their old age, they might be in a better social position and more able to negotiate their health care needs like other members of Australia's aged population.

Once again, the long-term cumulative effects of governmental neglect and social marginalisation of Australia's Greek immigrant population becomes evident through the plight of contemporary aged Greek Australians who, for reasons already alluded to, have remained culturally and linguistically Greek. Although, in the last eight to nine years, some improvements have been made in mainstream health care institutions and health care delivery services, it is likely that, due to the economic constraints associated with policies of economic rationalism, and Greeks as a vulnerable group in society will be adversely affected. The recent return to assimilationist and racist political discourses reminiscent of the 1950s and 1960s - and which advocate the old-style British nationalism and universal service provision - could place the interests of ethnic-aged in general and Greek-aged in particular even more at risk.

The Greek-aged in Australia

The age demographics of the Australian population is changing. According to the Australian Bureau of Statistics (1996), there are almost 4 million overseas-born people in Australia, of whom 2.5 million speak a language other than English. It has been estimated that people from non-English speaking background comprise 15% of Australia's population aged 65 years and over, and it has been further estimated that this figure could rise to 25% by early next century. Nupert (1997:217) states that '[i]t was estimated that while the Australian-born population aged 60 years and over will increase by 25 per cent between 1981 and 2001, the corresponding increase for the overseas-born will be 110 per cent'.

By the year 2001, Australian society will have three million elderly people; of these, 660,000 will have a non-English speaking background, representing 62% of all overseas-born immigrants (Australian Institute of Multicultural Affairs 1986).

At the 1996 Census, the Australian population was 17,749, 524. Of those, 4,397, 314 were born overseas, with 2, 168, 690 being born in English-speaking countries (ESC), and 2,228,624 in non-English speaking countries (NESC).

The Greek population (next to the Italian population, which ranks the largest) remains the second-largest non-English speaking background ethnic group in Australia. The Greek-born numbered 126,520, of whom 41, 834 were aged 60 and over. A break down of figures from the 1996 Census of Population and Housing enumerating the Greek-born population, Greek-born aged, and Greek-speaking nurse professionals in Australia are set out in *Table 1* below. *Table 2*, in turn, presents a break down of figures enumerating Greek-born aged in Victoria together with projections of the Greek-born aging patterns up to the year 2031.

	Greek -aged 60+	Total Greece-born	Greek-speaking professional nurses
NSW	13, 832	41, 155	137
Victoria	18, 756	61, 683	215
Queensland	1, 841	4, 467	13
South Australia	5, 085	12, 605	42
Western Australia	1, 518	3, 454	6
Tasmania	191	627	8
Northern Territory	166	1,124	3
ACT	445	1, 405	3
TOTAL	**41, 834**	**126, 520**	**427**

(Source: Australian Bureau of Statistics (1996) Census of Population and Housing).

Table 1: Greece-born aged 60+ and Greek-speaking professional nurses in Australia

As depicted, Australia's Greek-born aged population is expected to increase proportionately between 2001 and 2016, while the number of aged 65 years is expected to peak around 2017. However, the number of 'Old' old (the 'fourth aged') aged 75 and over will continue to increase (Tsingas 1998). In the intervening years, demand for ethno-

specific aged care services for Australia's Greek-born-aged are expected to increase, with demand outstripping supply (see *Table* 2).

Tsingas (1998) estimates, that between 1996 and 2016, the total Australian aged population will increase by 59%, compared with 154% for the Victorian Greek-born population for the same period.

Statistics and projections of Greece-born aged population in Victoria

According to the 1996 Census, the Greek-born population aged 65 and over in Victoria comprised 19.1% of the Greek-born population compared to 12.0% of the total Victoria population aged 65 and over. According to the Bureau of Statistics, the total age-65-and-over Greek aged in Victoria in 1996 was 11,845. Tsingas (1998) estimates that this indicates an increase of 55% from the 1991 census. The ageing patterns illustrated above are attributable in part to the nature of Australia's immigration program of the post-War period. The proportion of ageing Greek people within the Greek community will be much higher than the proportion of aged within the total Australian population. This is indicated by the fact that 33% of the Greek-born population in Victoria in 1996 were aged 65 and over.

It has been calculated that, between 1996 and 2016, Australian-Greek aged in Victoria (aged 75 and over) will increase by about 450%, peaking around 2017 (Tsingas 1998). This projection shows that over the coming years there is and will continue to be a profound need for linguistic and culturally relevant aged care services to provide for the aged Greek-born community in Australia.

The projections given in table 2 below also shows that aging Greek-born males presently outnumber the women of the same cohort. This situation will no longer apply by the year 2006, however. After that date, it is projected that women will significantly outnumber men in all old age cohorts, especially the 'fourth age'. Particular attention needs to be given to the situation faced by aged Greek-born women as they are more financially and socially disadvantaged, as it will become evident in this chapter, than aged Greek-born men, and aged Australian women generally.

Year		1996	2001	2006	2011	2016	2021	2026	2031
65-69 Male		3472	4426	4855	4140	3075	239	-	-
%		57.5							
65-69 Female		2568	4046	5027	5042	4190	3147	-	-
%		42.5							
70-74 Male		1631	3058	3899	4277	3647	2709	2109	-
%		54.9							
70-74 Female		1342	2411	3799	4720	4734	3934	2955	-
%		45.1							
75-79 Male		660	1314	2463	3141	3445	2938	2182	1699
%		49.7							
75-79 Female		668	1201	2157	3400	4224	4236	3520	2644
%		50.3							
80+ Male	579	616	1077	1996	2719	3131	2897	2312	
%		38.4							
80+ Female		930	967	1420	2722	4014	5273	5853	5530
%		61.1							
65-74 Male		5103	7484	8754	8417	6722	5103	2109	
%		56.6	53.7	49.8	46.3	43.0	41.9	41.6	
65-74 Female		3910	6457	8826	9762	8924	7081	2955	-
%		43.4	46.3	50.2	53.7	57.0	58.1	58.4	
65-74 TOTAL		**9013**	**13941**	**17580**	**18179**	**15646**	**12184**	**5064**	
%		**76.1**	**54.7**	**95.1**	**101.7**	**-13.9**	**-33.0**	**-72.1**	
75+ Male	1239	1930	3540	5137	6164	6069	5079	4011	
%		43.7	47.1	49.7	45.6	42.8	39.0	35.1	32.9
75+ Female		1598	2168	3577	6122	8238	9509	9373	8174
%		56.3	52.9	50.3	54.4	57.2	61.0	64.9	67.1
75 + TOTAL		**2837**	**4098**	**7117**	**11259**	**14402**	**15578**	**14452**	**12185**
%		**23.9**	**44.4**	**151.0**	**297.0**	**408.0**	**449.0**	**-7.2**	**-22.0**
65+ Male	6342	9414	12294	13554	12886	11172	7188	4011	
%		53.5	52.1	49.8	46.0	42.9	40.2	36.8	32.9
65+ Female		5508	8625	12403	15884	17162	16590	12328	8174
%		46.5	47.8	50.2	54.0	57.1	59.8	63.2	67.1
65+ TOTAL		**11850**	**18039**	**24697**	**29438**	**30048**	**27762**	**19516**	**12185**
%		**55.0**	**52.2**	**108.0**	**148.4**	**153.6**	**-7.6**	**-35.0**	**-59.4**

Source: from Tsingas (1998:18)

% denotes the expected five-year percentage change in Victoria's Greek-speaking aged population

Table 2: Projections Australian/Greek population in Victoria aged 65 years and over: 1996 - 2031

Compounding this problem is the likelihood that many of these women will outlive their spouses, and will progress to an age where, as the years pass, illness and disability will increase, necessitating the provision of residential care.

Research on Greece-born aged migrants in Victoria: the Tsingas study

During the year of 1997-1998, the Australian Greek Society for Care of the Elderly commissioned a research study of the health care needs and status of aged Greeks in Victoria. This study entitled Forty Years Later: A Demographic and Needs Analysis Study of Victoria's Australian Greek Elders (by Tsingas 1998) was the first of its kind, and remains the only comprehensive investigation of contemporary Greek aged in Victoria. As such, in the current discussion, it will be used extensively to present a picture of the Greek aged in Victoria and to contextualise those who have become residents of the ethnospecific nursing home which is the site of this study.

Tsingas' (1998) study reveals that, while the Greek aged may have changed in a number of ways while living and working in Australia, on the whole they have retained the Greek cultural practices fundamental for the quality of their life and dignity. Tsingas's research also reveals the cumulative effects of the past disadvantages experienced by ethnic Greeks as well as the multidimensional jeopardies which many still face.

Tsingas (1998) used multiple sites and, by diverse means, obtained a list of names of 700 Greek-born elders from all regions of Melbourne. From this list he randomly selected 261 elder to participate in interviews; of these, 250 agreed to participate. Tsingas also consulted with service providers and local governments in all regions of metropolitan Melbourne and rural Victoria. This he considered important in order to gain understanding of the issues pertaining to the provision of and access to Greek specific aged-care services (Tsingas 1998).

According to Tsingas (1998) 96.5% of those aged Greeks were living in the metropolitan area, and 3.5% in rural areas. In Melbourne, they were concentrated in the cities of Yarra, Whittlesea, Darebin, Manningham, Moreland, Brimbank, Stonnington, Monash and Port Phillip, comprising in these municipalities approximately 5% of the total aged population. It is thus evident that the highest concentration of Greek aged is to be found in working-class suburbs.

This is not surprising, since, as is already discussed the majority of Greek immigrants were sought to provide physical labour and work in the Australian manufacturing industry.

Research similar to that undertaken by Tsingas involving an individual ethnic group would help to provide a comprehensive understanding of the kind of health care services needed and which ought to be the subject of formal planning and policy implementation. This is evident when one examines Tsingas's (1998) study, which illustrates the similarities and differences between Australia's Greek-born and general aged populations, as well as the differences amongst the Greek-aged and specific issues of concern to the Greek-born aged. These kinds of issues and distinctions - vital as they are - are not visible in the kind of general research otherwise available. Tsingas's findings illustrate the kinds and extent of current Greek cultural practices employed by the Victorian Greek aged and which they prefer. Without employing Greek-speaking staff and making other changes, mainstream health care services and institutions will be unable to cater for the cultural and linguistic needs of Greeks and which are vital to their quality of life. Indeed, throughout the years, only limited adjustments to try and accommodate the needs of the immigrant populations of Australia are evident.

Health and well-being of Greek aged migrants in Victoria

The Greek population in Australia has been identified as having a longer life expectancy than Australians in general (Donovan 1992). Mortality rates however, do not reveal the state of health and well-being of the Greek population. While Greeks may live longer, they seem to suffer or experience illness states that seriously affect the quality of their life. Greeks, as an ethnic group, report the highest rate of disability and handicap. While in this sense, women and men are worst off than other groups Greek women significantly report higher disability and handicap rates than Greek men (Donovan 1992).

Aged Greek women generally were found to have poorer health than men, and to be confined to home for health reasons at a greater rate than men. According to Tsingas (1998)

> [f]eelings of loneliness correlate with a decrease in active leisure, as they correlate with decreased mobility and self-rated health. The older people are, the poorer their health, the lower their involvement in active leisure, the less frequently they attend elders' clubs, the fewer visitations to and by their children, other family members and friends, the more elders are to experience social isolation (Tsingas 1998:103).

More women than men lived alone and/or with relatives, felt isolated and lonely and rated their health as only poor or fair. For example, 66% of aged women rated their health as poor or fair as compared with only 49% of Australian Greek aged men (Tsingas 1998) In this category, both Greek aged men and women exceeded the proportion of Australian aged who rated their health as poor or fair (36%). A significant 30% more aged Greek women, than aged Australian women, rated their health as poor or fair. It is recognised that personal rating of health is extremely important as it may not only be a predictor of mortality but also an important indicator of a person's well-being and quality of life (McCallum et al. 1994).

Greek aged suffer from a high rate (40%) of musculoskeletal system problems such as back problems, arthritis and osteoporosis. Tsingas (1998) compared his research results with those of the 1988 ABS study entitled 'Domestic Care of the Aged in Australia'. It was found that Greek people had a 10% higher level of musculoskeletal system diseases and a 17% higher loss of sight (see also Donovan 1992).

Young and Coles (1992:147) also found that Greek men and women, while they had only a low to moderate use of hospitals, had a very high use of doctors and a very high use of sleeping tablets and tranquillisers. Women however, had also a very high use of pain relievers, while men had moderate use.

D'Espaignet and van Ommeren (1992:219) reported that 'between 89% and 96% of disabled women born in Asia and the Middle East, Greece, Italy and Yugoslavia reported being handicapped. This

compared with about 82% for Australian-born women'. The authors found that 90% disabled men born in Greece reported being handicapped, compared with 80% of disabled men born in other places. It was Greek-born men and women, however, who reported the highest level of disability of any group. Greek-born women's disability exceeded by 34% that of Australian women generally, and Greek-born men's disability exceeded by 22% that of Australian men (d'Espaignet and van Ommeren (1992:221). While the health of Greek aged women appears to be and is perceived to be worst than that of Greek men, Tsingas, found nevertheless, that 79% of Greek aged men received support from their spouses compared with only 41% of aged women.

Greek aged are not as cushioned by extended families as is popularly thought; in some cases they have less family and fewer social networks than other Australians. It is highly likely that many Australian-Greek aged women will find themselves in the future alone and without support, and this especially needs to be taken into account by health policy makers and planners, and the Greek community.

Factors that were found to be associated with poor health among the Australian-Greek aged were loneliness, poor adjustment to retirement, partner's poor adjustment to retirement, gender, abuse, income dissatisfaction and lack of a sense of safety (Tsingas 1998). Factors which were found to be associated with better retirement outcomes were higher English proficiency, higher education level, better spouse/partner adjustment to retirement, having someone to talk to, having more home help, better self-rated health, and satisfaction with income.

The linguistic, social and cultural mainstream exclusion of Greek immigrants and the social suffering which that exclusion has brought them is now embodied in the Greek aged. Their bodies and the cells of their bodies have memorized and feel the agony and pain of past crises and ongoing daily stresses of subtle humiliations, barriers and struggles in making a dignified living in a land that often made them feel they did not belong. Now that they are old, memories cannot be controlled. The bodies and minds of the Greek

aged now show in physical, social and cultural ways the traces of their long-term wear and tear and social suffering as second-class 'ethnic' citizens.

As stated previously Greek migrants suffered profound difficulties. Yet their difficulties and disadvantage went unacknowledged until the release in 1978 Galbally Report of the Review of Post-arrival programs and Services for Migrants. This report reveals the failure of successive governments' assimilation policies which marginalised migrants and alienated even those with many years of residence in Australia. This report and subsequent studies and inquiries, found that Government support services specific to migrants were almost non-existent, to counteract the discriminatory policies and regulations in the areas of employment, law, workers compensation and immigration, provision for the learning of English language to non-English speaking migrants was inadequate. Few opportunities were given to migrant workers by their employers for promotion or advancement - a situation that was neglected even by the unions (*A Fair Go for All* 1996; Moss 1993; Marsh 1983; Martin 1978; Henderson 1977). Such neglect and discriminatory practices sealed NESB migrants torturous journey towards old age.

Preparing for old age was not a priority for Greek-born migrants when they arrived in Australia. But even if it had been, the question remains: how could they escape the situation they found themselves in without education and command of the English language in a anglophone and xenophobic country? Government efforts were less than effective in assisting those migrants to prepare for their own old age. Nevertheless, it is not hard to imagine the kind of life the Australian Greek aged (and the aged of other ethnic groups) would have had to endure without the benefits they were to receive due to the struggles of various ethnic advocacy groups, making sure the plight of non-English speaking migrants was placed on the government agendas.

Retirement is a significant event for the Australian Greek aged. With the advent of industrial restructuring during 1980s (Jambrozik 1995; Greek Welfare Society 1989) many, women in particular, lost their jobs. Most, effectively too 'old' and without sufficient English

skills for retraining, remained unemployed. Many Greek-born aged, were faced prematurely with problems of finance, isolation, boredom, and poor access to services and to a broader range of activities. Today, almost 90% of Victoria's Greek aged depend on Government pension for their existence, compared with 62.7% of Australian aged (Tsingas 1998).

Greek aged migrants' cultural practices in Victoria in 1998

Greek aged in Victoria seem to have retained a number of core cultural practices that helped them to have a sense of identity and meaningfulness in life. Official policies of assimilation or integration into Australian society had no positive outcomes. Rather these contributed to their isolation and exclusion up to their old age. It seems that Australian Greek aged in this study have adjusted the best they could rather than being assimilated or integrated to their Australian socio-cultural environment.

Tsingas (1998) reported that a number of Greek traditions have been maintained by Greek-born aged in Victoria and continue to be of great significance contributing to their quality of life.

Using questions exploring what Greek culture meant to them, Greek aged identified a number of aspects of culture, all of which were considered significant (eg between 82% and 99% 'high' and 'very high' in importance). These cultural aspects included communication (Greek language) (99%) food (96%) attending Greek Orthodox church services (86%), celebrating Greek festivals and holidays (92%), and maintaining customs and traditions (98%). 86% indicated that it was important and very important to them to know and discuss news from Greece, and 86% placed a high importance on telling stories about Greece. 76% thought it was important to very important to read Greek newspapers; 81% gave the same rating to listening to Greek music, and 82% to attending Greek community clubs and associations.

Meaningful cultural and social practices that enhanced their quality of life were found to be centered around the home and to involve family members. Activities such as gardening were highly valued

and practised. Gardening and the production of vegetables and fruit without the use of chemical substances considered damaging to health was considered by them to be an art. Such activities gave them pride and acknowledgment of their skills, consistently denied to them while working as unskilled labourers.

The sociability of Greek aged and their strong desire to find and experience a meaningful social interaction context was evident by their high rate of attendance at Greek 'elderly citizens' clubs. This reflects the high desirability of the aged to be with other Greeks where they feel linguistically and culturally 'in place' (Bottomley, 1992) and free to communicate and interact, share their experiences, understand and support each other. Within such a meaningful context the aged can re-create a sense of company (παρεα) and enjoy conversation (συζητησις), enjoy a meal and drink together, - practices so loved and so often enjoyed in Greece. The aged were found to love sharing meals together and engaging in meaningful games such as ταυλι (backgammon), cards and bingo.

Their club gatherings created a familiar Greek cultural context and ambiance within which each member felt they were in place. The activities they engaged in were once practised in Greece in cafes (καφενια), village or town squares and each other's homes. These activities provided meaningful and satisfying opportunities for them to engage in vigorous discussion about any kind of topic, and otherwise, socialise as they shared food and drink in pleasant company (παρεα). Tsingas (1998) found, however, that even in 1998, there were a number of limitations regarding the frequency with which clubs were used by the Australian Greek aged. For example, hiring fees were becoming a problem, and the restricted opening hours of venues were limiting the time spent in this desired activity by the aged Greek. These limitations forced many back home, where they spent most of their time.

It was found that the Greek aged had a high preference for walking; 77% were found to walk regularly as compared to 28.5% of Australian aged overall. They walked primarily for pleasure rather than exercise, their walking being more social in nature. They would

walk in company with friends and their walking was usually purposeful such as visiting a friend or relative to have coffee to go shopping or to church. In Greece there were defined days and times when the city and town people used to promenade (περιπατο/βολτα) on a particularly beautiful street where they would meet friends and where the young would flirt with each other. It was a great pleasure to be among so many people, relaxing, taking an interest in each other, sharing news and gossip. In rural areas they had walked everywhere as they went about their business, but they would also walk purposefully for leisure and sociability. Walking thus emerged as a meaningful activity.

Other activities which rated very high among the Victorian Greek aged were watching television, listening to Greek radio, reading Greek newspapers, listening to Greek music, and working or relaxing around the house. The home provides the social centre of their world. In Tsingas's (1998) study, 85% indicated that they spent either all or most of their time at home, with the rest spending up to half their time at home. And 70% indicated that they did nothing but spend time relaxing. While embroidery was a traditional Greek female activity, it was found that only one in ten Greek women in Victoria did embroidery; aged Australians in contrast were slightly more likely (4.5%) to undertake such activities as arts, crafts and hobbies (Tsingas 1998).

Tsingas (1998) also found that Greek aged views and attitudes towards such mainstream recreational pursuits as golf, lawn bowls and/or tennis were much the same as British-Australian aged views about traditional Greek recreation activities such as ταυλι (backgammon). Indeed, mainstream recreational pursuits had little meaning or significance to Australian Greek aged; to expect them to engage in these pursuits is thus tantamount to expecting them to engage in something that is both meaningless and insignificant. Engaging in such activities could be perceived as having a significantly negative effect on their dignity and perceived quality of life. Playing tauli, on the other hand, is an activity imbued with cultural meaning and significance for them.

Tsingas's (1998) findings also indicated that Greek aged visited and received visits from neighbours and friends including Australian neighbours and friends. They, however, were not prepared to ask them for help if they needed help; asking for help beyond their family circle was considered to be inappropriate and embarrassing. They felt more at ease asking their children to assist them, even though they did not wish to burden their children. Indeed they relied on their spouse or partner and their children for any assistance needed. This included filling out forms, clarifying matters with institutions, all bureaucratic business with mainstream society, and assistance with home chores and personal care if they suffered from disabilities (Tsingas 1998).

The proportion of aged living alone increases as spouses die and as they reach the age of 80 and above. For example, 11% of those aged 65-69 lived alone, in comparison to 42% of those aged 80 and over. In this 'Old' old age cohort the majority are women. It is a well known that women tend to live longer than men, but in addition to this, traditionally Greek women married men who often were much older than themselves. Consequently, Greek women find themselves alone when they are likely to require assistance and support as - i.e they age, become disable and their health deteriorates. The proportion of women age 65 and over living alone was more than double that of men of the same age group (29% compared with 12% for men). And men over 65 were more likely than women of the same age group to live as a couple or in a family situation (62% compared with 40% for women). This situation is also reflected in the general Australian aged population, where women outlive men and more women end up living alone.

Significantly, the Greek aged seemed to rely more on their children than their spouses for individual social, cultural, psychological and emotional support. Tsingas (1998) found for example, that the aged confided in their children in relation to their personal concerns and issues, while they consulted more with spouses about family and household issues. They celebrated major and significant events with their children, and their children were their trusted friends and fostered in them a sense of social purpose and worth. For many, their children provided also the bridge to mainstream society. They

also had frequent contact with their children, with the exception of 5% who had never had contact with their children (Tsingas 1998).

It is noted here, however, that a high number of Greek aged (63%) did not have family members with whom they could share common interests, and many (46%) did not have friends with whom they could share common interests such as going to church, attending elderly groups, walking, visiting and socialising.

Ethnic aged who have difficulties with the English language experience social isolation and thus are unable to form wide social networks and meaningful relationships within mainstream society. Further more, the ability to establish and maintain social contacts with individuals outside the immediate family depends on a number of factors: language, opportunities to come into contact with people who share common experiences and values, and opportunities to participate in social and recreational activities. Their dependence on their children is far greater than what might be expected within their culture in general.

In addition to this, many have left their families and social networks behind them (in their country of origin) and consequently their networks in Australia are smaller rather than larger as is/was generally assumed. Those who have joined their children in Australia late in life may be more isolated because of cultural differences within the family, which may bring about problems with communication and understanding between them. Further to this, these aged people are required to adjust to a new culture and society at a time in their lives when such adjustment is most difficult (Barnett, 1988; Ethnic Aged Report 1987; AIMA 1985; Hearst 1981; Moraitis 1979).

Reliance on family, therefore, does not necessarily signify harmonious or satisfying relationships but could well be a source of stress. Immense responsibilities are placed on spouses, in particular on women children and whether they are wives, daughters or daughter-in-law. These felt responsibilities may create a stressful context were children and parents feel excessive pressure because of the limited choices they have, particularly if ethnospecific service

provision is inadequate to meet their needs. Significantly, Tsingas (1998) found that 8% of Victoria's Greek aged were living in abusive situations, exposing the myth of Greek family unity, care and sacrifice.

Creative initiatives are required, then to ensure that beneficial informal family support is retained and that non-beneficial or stress-producing informal family support is replaced by formal support. Similarly, provision should be made for the special needs the aged may have and for which the family cannot provide (or by the provision of which the family is overburdened).

Greek aged migrants and access to mainstream health care services in Victoria

According to Tsingas (1998), access to existing mainstream services remains unequal for the Australian Greek aged living in Melbourne. He indicates that Australian Greek aged make use of community-based support services two-and-a half times less than their Anglo-Celtic counterparts. Contributing to this relative under-use are the difficulties the Greek-aged experienced with communication because of poor English language skills on their part, and because of inadequate Greek language provision by service providers - poor education, and unfamiliarity with the types of services provided. At the same time they faced cultural barriers in that service providers were found not to have adequate policies and program designed to facilitate access for Australian Greek aged. Therefore, according to Tsingas (1998), these programs virtually excluded Australian Greek aged from mainstream support services. For example, in the City of Darebin, Melbourne, Victoria, Australian Greek aged comprised 6.3% of the total municipal aged population; the home care services they received, however, accounted for only 1.7% of the total. At the same time, the city's non-ethnic aged (65% of the total aged population) accounted for 75% of home care Services used. Greeks are also under-represented in the use of formal services. A 1993 Royal District Nursing Service (RDNS) study of home nursing and ethnic communities indicated that the Australian Greek aged were under utilising their services. Only 1.84% of RDNS' patients were

Australian Greek elder, even though they comprised 2.3% of the total Melbourne population (Tsingas 1998:32-33).

In recent years, Victorian local government authorities have been given the responsibility to provide for their municipalities' populations. And yet they were found to have inadequate and unreliable data on Australian Greek aged, while some did not keep any data at all identifying the ethnicity of their clients (Tsingas 1998). Aggregate research results or data collection assume that ethnic aged are homogenous. Such assumptions mask and neglect ethnic diversity and, as such, the needs of different ethnic groups, which may well differ in their nature and intensity. Tsingas (1998) found that accountability mechanisms were lacking and service provision was based on the universal assumptions of program planners in the local municipalities.

These findings correspond with the Australia-wide findings reported in 'The ethnic older persons strategy' (1995) and by Moss (1993) These studies also found that, generally, institutions and program providers did not understand, or had erroneous understandings about, access and equity principles and thus such principles were not translated to policies or institutional procedures. This seems to be a continuous and general problem, as most statistical data available are aggregates which are of little use to specific ethnic communities or to health policy developers. A good example of the aggregated data relating to this thesis are the statistical overviews commonly provided by nursing homes in Australia. On examination, there are no data given in these reports that can shed any light on access and equity or the situation of Greek aged in mainstream or ethnospecific institutions as neither is referred to in the figures given (AIHW 1995-1996; AIHW 1996-1997; 1998). Such data are not only of little use but also can mask important differences between and within ethnic groups.

Tsingas's (1998) research, in contrast clearly indicates the differences that exist among the Greek aged that aggregated research does not reveal. Tsingas makes visible extremely important characteristics and practices of the Greek aged that rightly could be considered essential for policy planners, institutional administrators and service

deliverers in the area of aged care. He reveals Greek ageing patterns, and characteristics that would help to indicate the kind of supportive aged care services that might be required, and when. His findings make visible not only the disadvantages suffered by both Greek aged men and women in relation to the mainstream community, but also the severe disadvantage that Greek women in particular suffer in contrast to Greek men and the mainstream community (including aged women).

Caring for the Greek-aged: issues and concerns

Some contest that the needs of the ethnic-aged are being met — and that they are receiving needed support (see for example, McCallum 1990). Even, so, the question remains of: who is providing the support that the ethnic aged need, and under what circumstances? What quality of care/services is given to the ethnic-aged by informal sources? And what of those who live alone, have no family or other social support networks to care for them? What of those who have family, but are estranged from them or do not want them to care for them? In the case of the Greek aged, the above questions are equally valid and whether they prefer at all times and under any circumstances to receive support from informal or other sources.

Mykyta (1988), for example, reported that the use of services by ethnic groups (including Greeks) increased dramatically in an Adelaide area when services were made more culturally relevant and appropriate (including the employment of bilingual staff). Mykyta (1988) concluded that if they had the ability to employ more bilingual staff the services would have had a higher number of ethnic users.
Mykyta (1988) found that services which offer relevant and appropriate help were utilised. But in the face of services which cater only or mainly to mainstream culture and language, the aged fall back on to family members who are often themselves overburdened and disadvantaged. On the basis of the Adelaide experience and other related anecdotal evidence (for example, the extent to which demand exceeds supply for places in Greek ethnospecific nursing homes and hostels (St Basils Homes 1998; Inquiry Into Planning for

Mykyta (1988) found that services which offer relevant and appropriate help were utilised. But in the face of services which cater only or mainly to mainstream culture and language, the aged fall back on to family members who are often themselves overburdened and disadvantaged. On the basis of the Adelaide experience and other related anecdotal evidence (for example, the extent to which demand exceeds supply for places in Greek ethnospecific nursing homes and hostels (St Basils Homes 1998; Inquiry Into Planning for Positive Ageing 1997) there is considerable room to speculate that, if the same effort was exercised in mainstream Victorian institutions and services, a similar rate of utilisation of services would be realised.

Historically, Australian Greek aged, even when younger, depended on their children to help them with numerous tasks. This was essential because of the dominance of English language and British-Australian culture and social processes which made their language, knowledge and interests beyond the factory floor irrelevant and thus excluded them from active participation. Even when still very young their children often assumed the responsible roles expected of their parents demonstrating greater ability than their parents to deal with mainstream social systems and everyday life situations. The socio-cultural conditions which created parents' dependence on their children not only tended to reverse parent-child roles, but also made parents feel useless and helpless and lacking in skills. With time some parents gained a degree of independence (e.g. shopping, paying their bills, banking) but they remained dependent on their children for activities requiring understanding of how bureaucracies worked and personal confidence. Dependence on their children continued and, indeed, became even more pronounced as they aged.

Lack of access to and participation in the construction of formal support services, combined with on historical dependency by Greek parents on their children in Australia and Greek cultural expectations that family members should help each other, produced a situation where Australian Greek aged had little choice but to rely heavily on their children. But this informal (lay) family care, while in some cases desirable, is also difficult to maintain, particularly within disadvantaged groups. The mainstream Australian

population sees formal services as their right and asks for them. However, among Australian Greek aged, a general lack of knowledge of the availability of these services still exists. In addition, inadequate provision of relevant and meaningful services by mainstream institutions, as well as cultural and communication difficulties, including a lack of familiarity with these types of services, and problems arising from inadequate policy development and service delivery, are all key factors which influence lack of utilisation of these services by the Australian Greek aged (Tsingas, 1998; Inquiry Into Planning for Positive Ageing, 1997)

Despite myths referring to extended family and the availability of adult children to care for the aged, Tsingas's (1998) found that Greek aged had no more adult children than Australian families in general. While they have a strong sense of family, changes in the family structure and strength of family relationships in some instances have undermined traditional aged care practices. An area where enormous pressure and conflict could arise might be in families where children have married outside the Greek community. In these circumstances, it is unlikely that cultural understandings of the nature that the aged are used to or might expect would be forthcoming. It is likely that their traditional needs, values and cultural practices would have lost their significance among their children and thus such needs are less likely to be addressed within the family network. Australian Greek aged strove to educate their children and sacrificed themselves so that their children could have better life chances than themselves. They were generally successful in this but often to their own detriment. The success of their children often brought with it upward social mobility and the adoption of values, cultural practices and life styles which exclude first-generation Australian Greeks from their children's lives and interests.

Australia's present free-market economic climate, together with the projected cost of supporting its increasingly ageing population, has created a general government attitude which could lead to further disadvantage for the most disadvantaged elderly in our society. While, like most Australians, the Greek aged prefer to be cared for in their own homes, this does not mean that they prefer care at home

under all circumstances and under any conditions. Policy-makers need to take into account the heterogeneity, particular circumstances and diversity within the Greek community and formulate flexible policies which promote relevant provision for their needs. Appropriate support and resources are made available to those aged who can and wish to stay in their home for care; but it is equally important to ensure that the burden of care does not fall upon the most vulnerable members of the Greek community, the women, who ultimately would themselves require formal support and care.

The idea of universal basic human needs embedded in liberal notions of health services disguises important cultural differences among service users. This inevitably diminishes the access to and quality of care that culturally marginalised people receive. Often their needs can go unrecognised and their basic human rights violated, under the guise of universal health care which nevertheless is designed and provided by the most powerful in position of dominance over those who require care. While they may oppose certain practices by their resistance, dependent and vulnerable people, often cannot succeed in changing practices that perpetuate their position of disadvantage.

The Greek aged in Victoria occupy a vulnerable and disadvantaged position. This is because the dominant society within which they live, functions on linguistic, cultural and institutional processes and practices which exclude those who do not or may only partially fit the 'system'.

Tsingas's (1998) findings show that, at least in Victoria, ethnospecific aged care services are vital, must be maintained, and better targeted, ensuring the well-being of aged Greek Victorians. However, it is also imperative that ethnospecific nursing homes are critically examined in order to make visible their processes, practices and relevance situated as they are within mainstream aged care provision infrastructure defining the language, culture and processes of aged care institutions. The aim of this study is to provide such a critical examination.

CHAPTER THREE

RESEARCH METHODOLOGY AND METHOD ETHNOGRAPHY AND CRITICAL ETHNOGRAPHY

Introduction

The thesis provides a critical ethnographic account of a Greek ethnospecific nursing home. In this chapter, attention is given to discussing the methodology of critical ethnography and the method used to advance it. Attention is also given to explicating the choice of critical ethnography as a research approach for the purposes of this study.

Methodology

Critical ethnography has its origins in traditional ethnography. In order to gain an understanding of the distinctive nature of critical ethnography and how it might be distinguished from traditional ethnography, I first consider the nature and practice of ethnography *per se*. I then discuss some of the criticisms that reveal ethnography's weaknesses, that the use of critical ethnography attempts to overcome.

(a) Ethnography

Ethnography is integral to the qualitative methodological research culture of the social and human sciences. Its use as a research method is increasing across many disciplines. Ethnography's popularity derives from its research processes that reflect a more flexible and encompassing conceptualisation of human behaviour and social processes than that which often informs positivistic research processes. From the outset, it has enabled ethnographers and other scientists to pose a challenge to disciplines that attempted to explain complex human behaviour, social practices and processes in causal and reductive forms.

Marcus and Fisher (1986:18) define ethnography as 'a research process in which the anthropologist closely observes, records, and engages in

the daily life of another culture - an experience labelled as the fieldwork method-and then writes accounts of this culture, emphasising descriptive detail'.

Ethnography and its research practices rely on theoretical assumptions that take for granted as 'true' at least the following:

(i) society and culture exist as objects external to the researcher,
(ii) social and cultural processes and fields occur as 'natural' phenomena, and
(iii) because of this fieldwork is scientific so long as certain predetermined research processes or techniques are followed.

Conventional ethnography as developed and legitimated by Malinowski in the 1920s comprised some essential processes. These processes requires that the researchers live and learn the language of the people they are studying (usually groups of people considered at the time as 'primitive' and with 'intact' integrated societies). The researcher would engage with the everyday life of their subjects (the 'field' of the research) for a long period of time. The ethnographic researcher in the field would participate in the everyday 'normal' life of the people and would hold formal and informal discussions or interviews with the people, but in particular with informants considered to be the 'knowers' of their culture. Such discussions, participatory observations and other information gathered from different sources would be thickly described and documented in the field.

The naturalistic framework of ethnography permitted ethnographers to move away from hard positivism while simultaneously retaining many positivistic dualistic concepts considered essential in claiming scientific authority. Thus, dualistic theoretical positions (such as objectivism versus subjectivism) continued to be seen in oppositional terms in social research, with objectivism being scientifically privileged over subjectivism. This was - and is - reflected in the way the researcher's role is constructed in the field: that is, the researcher is expected to observe the field as a detached, neutral outsider while concurrently participating as a subject (albeit objectively).

Such binary theoretical oppositions are also reflected in and sustained by the ethnographic processes which relates to gathering and interpreting data from an outsider's perspective (etic) and from an insider's perspective (emic) (de Laine 1997; Bernard 1994; Leininger 1985). It is argued that dyadic approaches are necessary in order to strengthen the scientific validity or 'truth' of ethnographic accounts. This indicates that such processes are taken-for-granted and that the 'naturalness' of dualistic theoretical positions is accepted and acted upon rather than challenged. Swartz, for example, explaining Bourdieu, proposes that the macro and micro dimensions of social structure, practices and processes 'are always translated into the internal logic of fields' (Swartz 1997:128), and that the 'habitus' of social agents' always mediate culture, structure and action in field practices. Indeed, historically, research approaches which deviated from these naturalistic and positivistic views of the world were perceived by some social researchers as being particularly susceptible to adverse positivistic scientific scrutiny, and thus constituted a risk that only few would dare to take (Denzin and Lincoln 1994; Hammersley 1990).

While scientific naturalistic approaches may facilitate the avoidance of reductionism and simplified explanations of human behaviour, social practices and processes nevertheless concealed the political and situational nature of ethnographic research as well as its power/knowledge (Foucault 1980, 1972). This is made possible, for example, by taking for granted that everyday human and social practices and processes are unproblematic and 'naturally' produced. Thus ethnographic research that does not problematise and critically examine taken-for-granted practices permits both the continuation of the misrecognition of such practices and the invisibility of other, deeper human and socio-cultural processes which are political and self- interested in nature (Bourdieu 1990; Thomas 1993).

Further, the imposition of cognitive binary divisions in research led to the construction of scientific and social dualisms that embodied superior-versus-inferior sets of values (traditionally, values associated with human properties) which, in turn, encouraged analogous social classifications, distinctions and stratification. For

example, objectivism was considered superior to subjectivism, mind to body, logic and rationality to intuition and irrationality, and control to emotionality. At the same time, such properties were not perceived to be distributed universally among all human beings. Indeed, they were ascribed according to gender - and race-based conceptions. So it was determined mainly by traditional philosophies (men) and other scientists that males were in various ways superior while women, children, and black people were inferior. (Gaines 1992; Code 1991; Harding 1991; Schiebinger 1989; Fernando 1988; Friedlander *et al.* 1986; Whitehead and Conaway 1986).

Traditional philosophical and scientific binary concepts, with their implicit meanings have been challenged from a number of scientific quarters over and, more recently, from groups of people who were colonised, constructed and represented as 'others by Western (mainly white men) scientists (Stanfield II 1994; Denzin and Lincoln 1994; bell hooks 1994; Young 1990). In addition, theoretical assumptions upon which ethnography is based have been/are challenged by sections of communities (women, ethnic, indigenous) who experience in their daily lives the effects of scientific discourses, produced by the use of such research methods, that claim truth and universality but often exclude the experiences and understandings of vulnerable groups' about social and cultural processes (Denzin & Lincoln 1994; Stanfield II 1994; Clough 1992; Bourdieu 1980).

According to Clifford and Marcus (1986:9)

> '[e]thnographic work has indeed been enmeshed in a world of enduring and changing power inequalities, and it continues to be implicated. It enacts power relations. But its function within these relations, is complex, often ambivalent, potentially counter-hegemonic'.

While, some ethnographic work has been counter-hegemonic, in the main its effects have been to support the status quo-until, that is, it was challenged by women, black, ethnic, and some mainstream scholars (Vidich & Lyman 1994; Fonow & Cook 1991; Agger 1998; Stanfield II & Rutledge 1993; Stanfield II 1994; Clifford & Marcus 1986; Van Maanen 1991).

Ethnography in recent years has come under scrutiny and has been criticised not because it is failing to be scientific but because it seeks to use a scientific model. Its commitment to describe rather than change the social world has been criticised; the relationship between ethnography and people studied has been seen as exploitative, and its capacity to represent human behaviour and social reality has been challenged.

Criticisms of traditional research methods, including ethnography, have opened up a space where researchers can create new and/or modified research approaches (i.e. Street, 1992; Bourgois, 1995; Scheper-Hughes 1992) that would, in effect, improve social sciences and take into account the political nature of knowledge production (Denzin & Lincoln 1994; Stanfield II & Dennis, 1993; Code 1991; Harding 1991; Bourdieu 1990; Foucault 1980).

b. Critical ethnography

In this I have extended the boundaries of ethnography to those of critical ethnography. This I have achieved by combining Bourdieus' critical analytical concepts of *capital, habitus* and *field* with Greek forms of speech to guide my research method.

In view of the criticism of conventional ethnography as indicated above and, particularly, as it relates to ethnographic representations of groups who are vulnerable and usually excluded from full participation in mainstream society, the use of conventional ethnography for my study has been inappropriate. My aim is not only to describe and interpret the nursing home culture, processes and care practices as the canons of conventional ethnography dictate, but to problematise and critically examine such practices. The research approach is therefore openly political and moral in nature. According to de Laine (1997:124), the aim of a critical ethnographer is:

> not to describe a vision of the world as carefully as possible to give to outsiders an insiders view, but rather to subject the insiders view [practices and institutional processes] to critical analysis for an understanding of the manifestations of political,

social and material disempowerment (as the ethnographer sees this).

Until recent years critical ethnography was not used commonly and therefore its processes have not been well developed. For example, Willis's (1977) critical ethnography embedded within a Marxist framework does not specifically outline the research method. The method, however, becomes implicit in the reading of the ethnographic account he presents. Street (1992) explains for example, that the development of critical ethnography was in its infancy at the time she undertook her 'Critical ethnography of clinical nursing practice'. She thus took the opportunity to develop a critical perspective which she considered useful for her study. She however, also indicated that a full participatory approach to research might not be possible. In Street's case the research participants were women nurses (that is, professionals, not ethnic, or from non-English speaking background); who nevertheless were more comfortable and productive with an oral rather than a written research culture.

In this study I adopt a critical ethnographic research method that is grounded in ethnic and critical sciences, as both have opened spaces to incorporate previously excluded aspects in research processes. In ethnic studies, criticisms identify not only problems which may arise in research because of representation, but also issues relating to the use of research methods that have emerged from different societies and cultures. Both are likely to increase the relative power differential between researcher and participants and distort field practices and processes (Stanfield II 1994). For these reasons, calls have been made for the development of new or modified research processes and methods which are relevant and which emerge from the ethnic groups one studies. Similarly, Bourdieu (1990, 1993) Swartz (1997) call for the practice of a reflexive sociology. That is the flexible use of methods and the critical examination of social practices and processes (including scientific and scholastic practices) for concealed 'self interest' and for the power relationships which sustain such interests. Swartz (1997:119) explains that:

Field analysis calls attention to the social conditions of struggle that shape cultural production. Even the seemingly most neutral or ivory-tower cultural practices are, according to

Bourdieu, embedded in systems of social as well as intellectual distinctions.

The critical ethnography I used here is designed to incorporate the Greek cultural conversational processes involved in group process as follows: **(i)** Κουβεντα (kouvenda), **(ii)** συζητησις (sizitisis), **(iii)** κουτσομπολιο (koutsombolio) and **(iv)** σχολιαζω (sxoliazo`). These are Greek forms of speech which I used in group and individual discussions in the field as part of the logic of group formation and discussions. They will be explicated later in this chapter. These group and individual cultural conversational processes foster the description of shared meanings, social processes and practices, as well as critical examination of taken-for-granted practices and behaviours in the nursing home.

Further, I brought forth, scrutinise and subject to systematic rigorous reflection my own research methods and processes, as well as those of the value-laden social world we live in. This, Thomas (1993:16) suggests' can be achieved by 'challenging "truth" in ways that subvert taken for granted ways of thinking'. This is because the most profound differences found among conventional critical sciences stem from their 'ways of seeing' the social and physical world we live in. For example, metaphors which reflect mechanistic, organic and static social structures orient researchers to view, interpret and classify social processes in particular ways. Similarly, scientific metaphors will also influence researchers' stances regarding social 'reality' and 'truth', as well as what it is possible to achieve.

Critical perspectives guiding my use of critical ethnography

Thomas (1993:33) maintains that:

> [c]ritical ethnography begins from the premise that the structure and content of culture make life unnecessarily more nasty, brutish, and short for some people. Women exercise less social power and receive fewer social rewards than men, the poor are disadvantaged socially for cultural as well as economic reasons, black urban males go to prison disproportionately more often and die younger than their white counterparts, each confront problems that derive from their cultural [subordinate] position.

He further explains that critical ethnographers start their research investigations from a standpoint that is premised on critical realism. It is assumed that social and human practices provide images and metaphors in 'which various forms of social oppression constitutes what is to be known' (Thomas, 1993 :34).

Ideas, beliefs, ideologies and values create meanings which construct "social subjects, concepts of "gender", "race" "ethnicity", "age" and 'class", scientific and professional discourses and other social entities. These and other entities constitute the invisible but 'symbolic' meanings that have the power to stratify people either as individuals or groups and accordingly, distribute social power and resources that privilege some while disadvantaging others. The justificatory bases upon which such distributions occur are difficult to recognise (or are often misrecognised); they are assumed to be 'normal' as they are embodied through inculcation in the process of socialisation. These bases, however, relate to and reflect not only the social position (class) one is born into, but as a woman or man and as member of a particular society and social group (ethnic, black, and so on) within a society (Thomas, 1993; Bourdieu 1990; Young 1990).

My overall research approach is informed by Bourdieu's social analytical framework comprised of symbolic, social and cultural *capital, habitus, field* and *reflexivity*. Bourdieu emphasises that all social life is mainly practical and, as such, has its own practical sense or logic. He emphasises the examination of what people do in everyday life without losing sight of the wider patterns of social life. Social practices take place in time and space and, as such, cannot be abstracted from their context and historical and temporal generation without being reified. He argues that human beings are an integral part of their environment and the circumstances that confront them and, while they are not entirely determined or controlled by them, neither are they entirely free from them (Bourdieu 1990). From

childhood people learn to live within their social environment and gain practical cultural competence within it, a social identity and a sense of social position in the social space they occupy. In other words, people gain a 'feel for the game' or a 'sense of practice' or 'practical logic' (Jenkins 1992:70). Such practical logic is taken for granted and practised unconsciously[1] (even though Bourdieu does not deny conscious action) by strategic improvisation as the circumstances may demand. People do not follow cultural rules but generate improvised strategies to confront everyday life, such improvisations are made possible because of their embodied 'habitus'. This implies that people have developed cultural competence to such a degree that they have embodied it, and, unconsciously, as they confront the impending and necessities of everyday life, or new situations employ strategies and improvise to adjust, resist, change or conform, in order to achieve their varied goals and interests.

Bourdieu according to Swartz, (1997) posits that self-interest underlies all human action and all social and cultural practices. He posits, everyday taken-for-granted assumptions are "misrecognised" as a logic of "disinterest". The assumptions which underlie everyday taken-for-granted practices, however, are 'misrecognised' and thus go unexamined. This situation permits the concealment of such interests that serve the more powerful in a hierarchically, non-egalitarian and inequitable constructed society. According to (Swartz, 1997:43) Bourdieu's theory stresses, 'the active role that is played by taken-for-granted assumptions in the constitution and maintenance of power relationships'. Bourdieu argues that self-interest is the basis on which all practices rest, and particularly, practices in the cultural sphere. Swartz (1997:34) explains that 'Misrecognition is a key concept for Bourdieu; akin to the idea of "false consciousness" in the Marxist tradition'. Misrecognition thus signifies 'denial' of the economic and political interests that are inherent in a set of practices

1 Bourdieu's understanding of the unconscious and conscious states of human beings is not that they are oppositional; rather Bourdieu conceives of them as the ends of a unconscious conscious continuum (Bourdieu 1990)

(Swartz 1997:43). Symbolic practices are masked interested practices which, by presenting themselves as "disinterested" deflect attention from their partiality.

Bourdieu (1990, 1997, 1993) explains that groups and individuals in a society who are able to transform self-interest so that it is seen as disinterest thus accumulate *symbolic capital,* and are the groups who retain an advantageous position in society. Symbolic capital however, is "denied capital". This is because it disguises its underpinning "interested" relations, thereby giving legitimacy to such interested relations. This is the dominant culture – the cultural arbitrary[2] which usually is misrecognised by the subordinate classes. Because of the dominant culture's singular legitimacy, subordinate ('different') groups and their members stand in different relationship to it than do dominant groups by the mere differences in class habitus (and here I include groups from different cultural and linguistic backgrounds) (Jenkins 1992:112). This situation exists because social systems (particularly the education system) inculcate people with the dominant arbitrary culture that sustains social inequalities, while presenting themselves as legitimate, 'natural' and equal. These social systems do not recognise the power of privilege that is translated into 'merit' and that derives from the fact that all individuals set out in society with different cultural endowments (Jenkins 1992:111). Thus people, by accepting the legitimacy of arbitrary culture, use their subjective knowledge and expectations to consider their objective future from their social location, which is often limited. The degree of limitation will depend on the social location of the person or group. Thus their future is misrecognised as legitimate and this, in a sense, acts to inhibit their construction of alternative and more 'objective' considerations of the social world (Jenkins 1992:113).

2 Cultural arbitrary: culture is arbitrary in two senses, in its imposition and in its content.What the notion of abitrariness denotes here is that, other than as the result of an empirically traceable history, culture cannot be deduced or derived from any notions of appropriateness or relative value. All cultures are equally arbitrary – this is an implied critique of the notion of culture with a capital C – and in the final analysis, behind all culture lies the arbitrary sanction of 'pure de facto power' (Jenkins 1992: 104-105).

Bourdieu (in Swartz 1997) expands Marx's concept of economic capital to incorporate other non-economic forms of capital. These include social capital, (eg. significant social relationships) cultural capital (e.g. legitimate knowledge of various kinds, language, etc,) and symbolic capital (prestige, fame, status).

Capital is thus a form of purchasing power that can be both material (economic) or symbolic. Power relationships are constituted by the accumulation of economic and cultural resources, which, as they are objects of value, represent symbolic power. Bourdieu makes distinctions between different kinds of capital (such as religious, cultural and symbolic capital) to illustrate how power relationships are maintained in society and in particular social, institutional and disciplinary fields. However, Bourdieu argues that these different forms of capital are not equally distributed socially. Rather, they are the bases upon which social distinctions and social stratifications are made.

Thus Bourdieu views culture as power, as it is variously manipulated and constructed to produce objects of value /resources which are forms of capital (cultural, social, moral, scientific, etc.) and in turn representations of symbolic power. He proposed that cultural objects of value/resources become capital when they function as a "social relation of power" by becoming objects of struggle as valued resources" (Swartz 1997:43).

Bourdieu's expanded notion of capital includes resources such as language, verbal ease and language skills and characteristics (e.g. accent), general cultural awareness, information about schooling and other social systems, scientific knowledge, aesthetic preferences, and educational credentials. Resources which form capital in particular societies have power that is irreducible; but capital can be interchangeable with other forms of economic and non-economic capital. Capital also has relative weight in different social fields and, according to its volume and composition, is ranked within the hierarchy of a field, along with agents who possess such capital (Bourdieu 1991:230-31). Such fields are competitive and may have certain autonomy in their construction, but exist nevertheless within the larger social space constituted by different fields.

It may be useful here to consider by way of example the concept of capital and how that may operate within and across ethnic groups. In this particular case, in a Greek nursing home - amongst the Greek women carers, between them and women who are both professional and of the mainstream, and between men and women overall. What objects of value/resources within the nursing home field function as social relations of power and thus become capital? Do symbolic practices that present themselves as disinterested actually promote particular interests? As the nursing home is located within an ethnospecific field of power but is framed within mainstream fields of power,[3] one can examine the kinds of fields generated within it, and kinds of conflicts and competitions that emerge between agents within the relative power forces of the field. How is symbolic capital (and thus symbolic power) gained in the nursing home in relation to carers, residents, professionals and managers, and in relation also to mainstream social fields. A critical examination can also be made to show how this works in a society where, in the first instance Greek culture and language has been classified as subordinate relative to mainstream culture and English language.

As legitimate power, symbolic capital can be used to gain social advantage as well as social control and domination, and to legitimise demands for recognition, deference, obedience, or the service of others (Swartz 1997:43-44).

Bourdieu argues consistently that social life "must be understood in terms that do justice both to objective material, social and cultural structures and to the constituting practices and experiences of individuals and groups" (Postone, *et al* 1993:3).

3 According to Bourdieu and Wacquant (1992:229-300) 'field of power means the relations of force that obtain between the social positions which guarantee their occupants a quantum of social force, or of capital, such that they are able to enter into struggles over the monopoly of power, of which struggles over the definition of the legitimate form of power are crucial dimensions' A field is, at the same time, a space for conflict and competition, over what capital is to dominate. (for example, nursing authority in a professional field, administrative authority in a bureaucratic field, and so on) and over the power to decree the hierarchy and 'conversion rates' between all forms of authority in the field of power. Bourdieu & Wacquant 1992:17-18) expalin that ...a field consists of a set of objective, historical relations between positions anchored in certain forms of power (or capital), while habitus consists of a set of historical relations 'deposited' within individuals' bodies in the form of mental and corporeal schemata or perception, appeciation, and action.

Bourdieu, for example rejects the dualistic concepts of objectivism[4] and subjectivism,[5] arguing that each generates a partial, fractured view of social reality. He sees other such dichotomies in the opposition of positivistic and interpretative approaches to research, micro and macro analysis, the participant and the outsider observer, and theory and method. Bourdieu's view is that each opposition offers vital insights about social life but each on its own only offers a fragmented, partial and skewed view of social life. Using Bachelard's dialectical reason (which differs from that of Hegel and Marx), he argues that since these divisions 'have social foundation but... no scientific foundation" they need to be transcended and integrated into a broader knowledge framework (Swartz 1997:55). He insists that such divisions and the problems that arise from them are not just epistemological but also social and political. Further, he argues that variations of dualisms originate both from underlying struggles among social scientists for power and recognition and from the larger society's class and status group divisions (e.g. ethnic, race, gender, etc.) in the social order (Swartz 1997:55). Bourdieu proposes that in transcending objectivism and subjectivism, a broader integrated knowledge is developed, which he calls "general sciences of practice".

Bourdieu attempts to overcome oppositional and hierarchical classifications by his formulation of the three central concepts of *capital, habitus* and *field,* concepts that allow him to bring larger social and cultural forces into play in relation to daily practices. Accordingly, these practices are played out, manipulated and

4 Objectivism/subjectivism: For Bourdieu explanations that highlight either the macro or the micro dimensions to the exclusion of the other simply perpetuate the classic subjective/objective antinomy. Bourdieu aims to transcend this dichotomy by conceptualizing action so that micro and macro, voluntarist and determinist dimensions of human activity are integrated into a single conceptual movement rather than isolated as mutually exclusive forms of explanation. He thus proposes a structural theory of practice that connects action to culture, structure, and power. This theory undergirds his key concept, habitus, which along with cultural capital has become one of his conceptual trademarks. Bourdieu constructs like Bachelard an epistemological consciousness for the social science that transcends but incorporates within a broader framework the partial views of what he calls "subjectivism" and 'objectivism" Objectivism: Bourdieu means all those forms of knowledge that focus on the statistical regularities of human conduct. Both his key concepts Bourdieu considers both forms to be partial accounts of knowledge habitus and field display a similar movement of though. Habitus transcends traditional dichotomies of subjectivism/objectivism and field situates individuals, groups, and institutions within a broader matrix of structuring relations (Swartz, 1997:35)

5 Subjectivism: Bourdieu means (Swartz, 1997:35) all those forms of knowledge that focus on individual or intersubjective consciousness and interactions.

organised, by individuals who improvise strategically but unconsciously in relation to their field positions as agents. These practices are mediated by the *habitus* of these individuals, and encapsulate their interests (which, in turn, constitute social structures and, according to the general effects of their social structures their social life).

Bourdieu's concept of *'habitus'* illustrates the close interconnectedness of culture, individual action and structure and how they simultaneously and continually constitute each other as they are embodied in and make themselves visible through individual dispositions and practices within socially constructed and relational *fields*. Bourdieu developed his concept of 'habitus' in an attempt to transcend objectivist and subjectivist oppositions and 'oppositions between theories that grasp practice solely as constituting, as expressed in methodological and ontological individualism (phenomenology), and those that view practice solely as constituted, as exemplified by Levi-Strauss's structuralism and the structural functionalism of the descendants of Durkheim' (in Postone, *et al.* In Calhoun, *et al.* 1993:4).

According to Bourdieu, when analysing and seeking to understand social life, theoretical impositions serve only to distort and dichotomise social life and practices. This, in turn, distorts understandings of social life and human beings. Postone *et al.* In Calhoun, at al. (1993:4) present Bourdieu's concept of 'habitus' in the following way:

> Bourdieu treats social life as a mutually constituting interaction of structures, dispositions, and actions whereby social structures and embodied (therefore situated) knowledge of those structures produce enduring orientations to action which, in turn, are constitutive of social structures. Hence these orientations are at once "structuring structure" and 'structured structures"; they shape and are shaped by social practice. Practice, however, does not follow directly from orientations, in the manner of attitude studies, but rather results from a process of improvisation that, in turn, is structured by cultural orientations, personal trajectories, and the ability to play the game of social interaction.

According to Bourdieu's definition, the dispositions represented by the habitus are 'durable' in that they last throughout an agent's lifetime. They are also 'transposable' in that they may generate practices in multiple and diverse fields of activity, and they are 'structured structures' in that they 'inevitably incorporate the objective social conditions of their inculcation' (Johnson 1993:5).

This implies that habitus is classed, cultural and gendered, and also that it brings together in the agent's embodiment and conceptions epistemological dichotomies in relation to social reality as 'subjectivism' and 'objectivism' which, individually, fail to account for what Bourdieu refers to as the 'objectivity of the subjective' (Johnson 1993: 4).

Using the concept of habitus in social analysis, one cannot follow objectivist or subjectivist lines of inquiry without fragmenting and distorting social reality. Rather, one is required to view the field of inquiry as relational, dynamic and mutually constitutive cultural and structural fields mediated by the 'habitus' of individuals. For Bourdieu, the external (objective) social world and the internal (subjective) individual world are one, as on itself constitute each other and both are interdependent in relation to their existence, development, progress and changes. Bourdieu thus maintains that, in order to overcome the oppositional discourses of society and individual, theoretical knowledge and practical knowledge, and culture and structure, sociology ought to analyse society as psychoanalysists do human beings. Accordingly, he developed a *reflexive sociology*, a sociology that turns back on itself to critically examine the social sciences, including the interests their assumptions and practices serve. The scientific field itself is structured by forces in terms of which scientists struggle to improve their positions. At the same time, science aims to analyse peoples' conceptions that construct their social reality, while recognising (and pronouncing) that those conceptions often represent a misrecognition of that social reality. Bourdieu argues equally, that scientists' constructions of their own reality, their field and their motivations to behave like scientists often lead them to misrecognise that reality. Bourdieu emphasises that the development of reflexive sociology is not meant to attack or

denigrate social science, but to help develop 'good social sciences' (Swartz 1997).

In revealing the interests served by practices in particular social and relational institutional fields, dominant discourses and social practices are also revealed. In addition, it is argued that by critically examining human behaviours and social process and practices, structured social classifications and distinctions that are legitimate and taken-for- granted will also be made visible, as well as the interests they serve.

Bourdieu has been criticised by some on grounds that the concept of 'habitus' is deterministic insofar as human behaviour is concerned. Others, however, see that 'habitus' plays a mediating role in eliminating antinomies such as objective/subjective, scientific/non-scientific, theory/practice and so on. 'Habitus,' Bourdieu argues, allows for creativity and the active and inventive capacities of human beings (or unconscious and conscious strategies in particular fields of struggle), but without attributing them to a universal mind. According to Bourdieu, 'habitus' is the result of a long process of inculcation, beginning in early childhood, which becomes a 'second sense' or a second nature.

Bourdieu maintains that agents should not be seen as acting in a vacuum, but within sets of objective relations. These relations take place within different, structured and hierarchically-organised social fields each located within ' "a *field of power*" defined with respect to the internal dynamics of a class' that also translates to the larger social order (LiPuna, in Calhoun et al. 1993:16). In the case of the Greek nursing home, while class is vital intra-culturally and inter-culturally, culture, ethnicity, and language, take a special relative position within a dominated multicultural society in terms of Bourdieu's notion of 'objects of value/resources as symbolic capital and power. Further, complexities arise within the nursing home as gender, age, disability and the relative institutional hierarchical positionality of the nursing home agents intersect. Thus the fields of the nursing home are constructed not only by vertical but also by horizontal social classifications and distinctions that make the field very complex, multi-layered and multi-dimensional.

Fields, according to Bourdieu, refer to economic, educational, political, cultural, institutional, professional, scientific and other fields and subfields.

> 'In any given field, agents occupying the diverse available positions (or in some cases creating new positions) engage in competition for control of the interests or resources which are specific to the field in question' (Johnston 1993: 6).

A field thus does not reflect or express the world views of the class or group that produces it, but rather the struggles that agents engage in to defend and improve their positions, interests and or material and symbolic advantages within the field. Social fields for Bourdieu are constituted and shaped by relationships of power or forces - generated in relation to the positions structuring the field and mediated by habitus. The position an agent occupies within a field results from the interplay of the individual's habitus and her/his place in the field according to the distribution of relevant capital (Bourdieu 1990; Calhoun *et al.* 1993; Swartz 1997).

Field practices and the interests they serve, however, are often misrecognised and, unless such misrecognitions are made visible, then social change is difficult and social domination remains unrecognised and legitimate Swartz (1997) explains how misrecognition works:

> According to Bourdieu, actors by and large "mis-recognize" how cultural resources, processes, and institutions lock individuals and groups into reproducing patterns of domination. The task of sociology is to unveil this hidden dimension of power relations. Bourdieu thinks of the practice of sociology as *socioanalysis,* where the sociologist is to the "social unconscious" of society as the psychoanalyst is to the patient's unconscious. The social unconscious consists of those unacknowledged interests that actors follow as they participate in an unegalitarian social order. Since, according to Bourdieu, it is the misrecognition of those embedded interests that is the necessary condition for the exercise of power, he believes that their public exposure will destroy their legitimacy and open up the possibility for altering existing social arrangements. By exposing those underlying interests that bind individuals and groups into unequal power relations, sociology becomes an

> instrument of struggle capable of offering a measure of freedom from the constrains of domination (Swartz (1997:10)

The visibility of 'misrecognitions,' therefore, is a critical first step towards self-awareness that may foster action to bring about a break away from reproductive cultural practices which consequently can lead to social change.

Dominant ideologies, values and beliefs inculcated in the young through socialisation and schooling help to maintain social distinctions and classifications that privilege some at the expense of others. While hegemonic forces help to maintain the status quo, they equally hold the seeds of resistance and transformation.

Giroux (1983:90) criticises Bourdieu for omitting to consider that culture is "*both* a structuring and transforming process". Giroux maintains that "Davies captures this dynamic in his comment, "Culture refers paradoxically to conservative adaptation and lived subordination of classes to other classes and to opposition, resistance, and creative struggle for change" (Giroux 1983:90).

Bourdieu argues, however, that the concept of 'habitus' incorporates improvisation and strategic practices which do not exclude resistance. Resistance may be more apparent and forceful in situations where great discrepancies occur between different groups (particularly cultural and classed groups) or according to individual mediating habitus, culture and social structures. This situation was apparent in the Greek nursing home and this approach theoretically informs my analysis of resistance' there.

It is recognised that people, generally speaking, as active, thinking agents, have the potential to recognise the 'misrecognitions that Bourdieu refers to, through critical thinking and reflection. According to Silone (1937, cited in Walzer 1987), every society's dominant and hegemonic cultural ideologies which are inculcated in its young also contain the seeds for critical human reflection, and illuminate the discrepancy between social theory on the one hand and social practice on the other. Hegemony itself, once critically

reflected upon, holds the potential to subvert its own practices and effects of power and domination. Silone states:

> ...by taking seriously the principles taught us by our educators and teachers. These principles are proclaimed to be the foundations of present-day society, but if one takes them seriously and uses them as a standard to test society as it is organized... today, it becomes evident that there is a radical contradiction between the two. Our society in practice ignores these principles altogether... But for us they are a serious and sacred thing... the foundation of our inner life. The way society butchers them, using them as a mask and tool to cheat and fool the people, fills us with anger and indignation. That is how one becomes a revolutionary (Silone 1937 cited in Walzer 1987: 42).

Thomas (1993:18) explains that "[c]ritical thinking addresses this failure by not assuming the reality of "facts" and by recognising that revelation is not merely announcing, but is instead a juxtaposition of and dialogue about alternative images". The taken-for-granted every day social world is reflected upon and juxtaposed with other ways of being or images of life in the pursuit of what is possible rather than being accepted for (and the researcher being content with) what it is. Bourdieu consistently argues for reflection in research and the construction of social sciences for the purpose of making visible the social illusions which we construct to serve our interests in the cause of developing 'good sciences'.

Critical methodological analytical research processes: The guiding logic of my research method

Bourdieu emphasises the use of flexible research methods and is opposed to methodological rigidity, which he considers to be very limiting and distorting of "good sciences".

Broadly speaking he supports the use of three general methodological analytical research processes that use his analytical research concepts of *capital, habitus* and *field.* Their use is intended to unveil taken-for-granted practices that conceal self-interests and the power relationships which sustain them. While Bourdieu relates his research processes to intellectual and artistic work, it is my view that such processes are profoundly relevant and could be (and were)

used as the guiding logic of my research method (described in the following chapter) in the study of the Greek nursing home. These processes are as follows:

1. 'Research must relate the particular field of practices to the broader field of power'. In the case of this study, it can be perceived that the Greek nursing home is embedded in the ethnospecific field of power that is dominated by and/or competes with mainstream health care fields of power within which aged care is a subfield. In turn ethnospecific aged care institutions and services are a further subfield of mainstream aged care.

2. 'Research should identify the structure of objective relations between the opposing positions occupied by individuals or groups or individuals as they compete for cultural legitimation"(Swartz 1997:142). Here, objective relations of power in the Greek nursing home can be examined critically in relation to relative positions in the institutional field. This reveals the objects of value /resources (capital) that agents in their relative field positions compete for or come into conflict over for the purpose of gaining capital or power. This kind of examination would also make visible the translation of external capital forces (to the home) which mediate nursing home practices and processes.

3. 'Research must analyse the class habitus (brought by agents to the respective positions) and the social trajectory (or life chances) they pursue within the field of struggle' (Swartz 1997:142). Here, again, within the nursing home field, class *per se* can be analysed intra-culturally and inter-culturally as it relates to the larger society and it translates into nursing home practices through the power of symbolic systems that bring into equation ethnicity, gender, culture, language, education, and so on (Swartz 1997:142).

The above broad research processes framed my research method and were applied via the use of the Greek speech forms indicated above, and in the use of relational and political analysis of my data. All three processes are revealed in the structure and presentation of the whole thesis and, in particular, in my research findings presented in Chapters 6, 7 and 8.

The logic of incorporating Greek forms of speech as research processes

'Full participatory' group research approaches have been advocated as the most appropriate processes to be used in critical studies (Street 1992; Lather 1986). Full participation, it is argued, eliminates most of the problems a researcher is likely to be faced with and criticised about. For instance advocates of such processes argue that issues of objectivity, validity and researcher/participant power relations can be overcome in such a way that the project overall can stand scrutiny and ethical evaluation. Thus, ideally, one would aim to use fully 'emancipatory' and 'liberating' research processes. There are, however, practical and cultural reasons that can be brought against the use of a 'fully participatory' research approach.

I entered the field with the expectation that a modified (partial) participatory approach would be used (subject to participants' preferences). A full participatory research approach was problematic for a number of reasons, (i) it could be an imposition upon the participants, and so distort realities rather than unmask them (Stanfield II & Denis 1993; Bourdieu 1990; (ii) it could be difficult to achieve because of shiftwork and timetabling, as well as demands on staff, who would have to invest much time in the project over and above that given to their routine commitments and responsibilities; and (iii) equally, I felt that I could not study the whole institution using full participatory group research in the time available to me.

I did not wish to impose any particular systematic programmed research processes, developed in particular social and historical context, that may not have been appropriate to the people and context I was studying. I was concerned about the effects that an unfamiliar research process might have on participants. Members of groups would have to follow certain rules, and a 'game' that they were not familiar with. As a (Greek) cultural 'insider', however, I was aware and somewhat comforted that group discussion (which I planned to use), debates and critical interrogation were 'normal' processes of everyday Greek life. My approach, I suggest, was emancipatory because my participants could 'freely' form and

interact in groups in their way, and use speech as they did in their own language; it would be their own speech form and the way they played the game best. Furthermore since I understood these spoken and unspoken forms of communication and interaction, I was able to participate fully in the group. I was not leading or guiding the group; each participant took culturally appropriate roles as the situation warranted. I was a participant in everyday discussions and took part as a member of the group. I was guided in these speech forms by the purpose of my research, but also by knowledge of cultural expectations and standards of Greek culture in relation to my own background.

Greek speech forms

Four forms of everyday Greek speech that are extremely informative were used in my research process. These speech forms can be used simultaneously or alternatively in a conversation by different actors. They are:

(i)	Κουβεντα	(Kouvenda)
(ii)	Συζητηση	(Sizitisi)
(iii)	Κουτσομπολιο	(Koutsombolio)
(iv)	Σχολιαζω	(Shxoliazo/sxolia)

(i) ***Kouvenda*** usually refers to informal conversation between people, friends, neighbours, groups of people and relatives. It usually takes place in a relaxed friendly atmosphere, and acknowledges shared understandings. Participants share narratives which can range in scope, length and depth.

(ii) ***Siztisi*** means that agents are searching together to reach different understandings through critical and reflective talk. *Sizitisi* usually refers to more formal discussions of specific issues of concern. *Sizitisi* can include vigorous and interrogational discussion and debate and usually involve groups of people, friends and neighbours. Often antagonistic speech is purposely used to push agents to unveil masked cultural meanings and reveal misrecognised self-interest. This type of speech often involves problem-and-conflict-solving processes. Once a person becomes an accepted member of the group, they are automatically included in

the group's discussions and conversations. Members frequently utilise an interrogatory form of questioning to clarify issues, to tease out interests and concerns, and to make evaluations and judgments about themselves and others and their social interactions and practices.

(iii) ***Koutsombolio*** refers to informal, usually negative social criticisms which are considered too harsh to be addressed directly to the person who is the subject of the criticism. Koutsombolio usually reveals a group's cultural and social expectations and standards, (including individual behaviour), and usually occurs when there has been some transgression of these expected standards in the judgment of the speaker. *Koutsombolio* reveals both the cultural norms and behaviour that is considered inappropriate outside these norms. Such discussions create openings for visualising and understanding the hidden cultural and social power relations and human interests which are concealed within everyday taken-for-granted practices and assumptions.

Koutsombolio is considered a feminine discourse and is usually associated with negative judgments about people. The use of koutsombolio itself is considered as inferior speech type and is a negative activity that is discouraged. Often, koutsombolio is not employed up front by members of the group if it is considered inappropriate; but it will be conducted with someone else not directly involved with the issue or concern. Usually, the gist of such discussions are passed on to others eventually to reach the person or group implicated. This speech form (which includes shxolia, discussed below) usually brings pressure to bear on individuals and/or organisations who, for whatever reason, have attempted to resist conforming with the status quo. Not all individuals, however, engage in koutsombolio, and a man is rarely accused of being a koutsombolis (gossip). In this study this kind of speech was often conducted in corridors and behind doors, but also during individual interviews.

(iv) ***Shxolia*** usually refers to more formal cultural and social criticisms. These can be positive or negative in nature and are considered to be more balanced and controlled criticisms than those

made in koutsombolio. To engage in sxolia implies that one has free or leisure time to do so. This form of speech has a hidden elitist and gendered connotation: it invites respect and implies that high class and usually men *shxoliazoun* while lower class and women *koutsombolevoun*. Often, however, koutsombolio and *shxolia* are seen as social criticism in the vernacular (McLaughlin 1996). Such criticism often becomes public knowledge (often with relevant effects and consequences). Through this circulatory action of *koutsompolio* and *shxolia*, I had an excellent opportunity to gain substantial insights of the nursing home and its people/relationship and realities that were masked by taken-for-granted everyday practices.

Thus the methodological premises that informed my research method were based on a combination of Bourdieu's analytical social constructs, Stanfield's ethnic studies, and the logic of the quotidian Greek speech forms described above.

Reflexivity

Bourdieu calls for reflexivity, which he considers necessary in the practice of 'good science'. His concept of reflexivity, however, while it incorporates a variety of its interpretations also differs in the sense that it is aimed at collapsing all social dualities constructed for the purposes of social, academic and/or scientific domination.

The researcher is thus encouraged to follow reflexive practices so that an 'objective' account of social practices can be presented - but not, as is commonly understood, as the universal or authoritative account. Bourdieu considers that such aspirations among scientists themselves reflect their search for epistemological sovereignty. A search for objectivity which seeks to ensure an absolutely objective and unbiased point of view on the object of study ultimately reflects the scientist's desire for domination. Bourdieu calls for researchers to objectify the motivation for seeking objectification and critically examine such intentions (Swartz 1997; Calhoun *et al.* 1993)

Reflexivity in socio-cultural analysis

According to Bourdieu, social scientists and the social sciences are products of their social world and, in particular, of social conditions

relating to time and social position and/or class. Embedded in fields of power relationships, scientists, like other individuals, do not operate without interest in a value-free world. Objectivity cannot be claimed, not only because the scientists themselves are immersed in the world they attempt to study, but also because there is no such thing as social objectivity external to the individual (Swartz 1997; Stanfield II, in Denzin & Lincoln 1994; Bourdieu 1990; Harding 1987).

Bourdieu also argues that theoretical representations or the use of received (abstract) category is inappropriate to understanding social practices. His concepts of *habitus, field* and *capital* result in the requirement to investigate practices without preconceived theoretical classifications as practices are shaped by field and local social structures which are mediated by agents and their habitus in a struggle for advantages.

Systematic and rigorous reflective thinking is seen as essential in the investigation of social life. According to Bourdieu, however, objects for reflection are not restricted to researcher and her/his relationship with the participants and the research methods. Such concerns are similarly expressed by feminists, ethnic scholars and those in the critical sciences generally (James *et al.* 1997; Swartz 1997; Roderick 1986; Denzin & Lincoln 1994; Stanfield II & Dennis 1993; Calhoun *et al.* 1993; Reinharz 1992; Harding 1991; Code 1991;). The difference with Bourdieu's calls for reflexivity is that he focuses on social science itself. Thus in the case of this study, reflexivity is required to be turned on (social research processes as I have) the discipline of nursing itself and on transcultural nursing[6], as, like

6 Transcultural nursing has been conceived as a comparative field of study and practice, but needed a theoretical and research base to explain and predict nursing as a discipline and to guide nursing practice. The theory of Culture Care Diversity and Universality was viewed as the major theory to explain much of the phenomena related to transcultural nursing accounting for diverse and similar cultures in the world. The idea of caring to serve people worldwide and to help ameliorate and improve human conditions and lifeways was an important direction for transcultural nursing's founder. Transcultural nursing has been developed in 1950s by a world leading nurse theorist who had also a degree in Anthropology namely Madeleine, M. Leininger. In early 1960s Leinginger asserted that anthropologically, and from a nursing view, Homo Sapiens needed care to survive. At this time neither anthropologists nor nurses took this stance. This belief led Leininger to develop transcultural nursing, with human care as the central focus and important phenomenon of nursing. She viewed caring as a humanistic mode of being with others to assist them in times of need or to help them maintain their well being or health. She believed that caring activities and processes could lead to cure, but especially to healing human ills or conditions. Humanistic expressions of compassion, touching, comforting, assisting,

social sciences, they reflect the interests of the discipline - and myself as researcher and nursing academic.

Struggle for objectivity and reflexivity

While it is essential that reflexivity is rigorously used in order to reduce some of the problems associated with conventional ethnography, it is also critical that the research methods used permit such reflexivity and a critique to be made.

Reflexivity for Bourdieu does not mean introspection but ongoing analysis and control of the categories used in the practice of social sciences. Thus reflexivity does not focus on the individual but on the relevant science or professional cognitive structure that shapes the respective scientific field (in this case, nursing).

Bourdieu argues that scientists are blinded by their own professional ideology that stresses neutrality, universality and objectivity. He proposes that these ideals represent scientific weapons and interests in the struggle for intellectual recognition. At the same time,

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supporting, and many other care constructs needed to be fully discovered inductively and understood in diverse naturalistic environmental contexts. Leininger was aware that these humanistic care expressions could be easily overlooked, devalued, or misinterpreted. Or if studied by positivistic approaches it would be reduced to numbers without meaning. Leiniger asserted that while care as concept is universal its meaning, patterns and practices was culturally constituted and embedded. Human care with a transcultural focus had to be systematically studied with a comparative and interpretive focus to help people regain their wellness and to prevent unnecessary illness. She realized that nurses relied too heavily on biophysical and psychological explanations with virtually no awareness of how culture could influence nursing care. She identified culture care as a glaring need, a missing dimension of nursing. She began to study care and caring from a transcultural perspective, drawing on nursing and anthropological insights. Leininger considered care as the essence of nursing and as central and distinct phenomenon that made nursing what it is or should be (Leininger, 1993:4-6) Leininger united culture with care within a new conceptual and theoretical frame of reference and thus began to give nursing a much broader and relevant view of the nature of humans than was possible with a traditional mind-body perspective. Transcultural care knowledge was needed to expand nurses' worldview as well as their need to develop culture-specific care practices for quality-based services. Culture-specific care was predicted to bring client satisfaction, early recovery, or meaningful death experiences. Leininger contents that culture care is important because human care is usually deeply embedded and takes on meanings within the worldview, social structure factors, language, cultural values, and environmental contexts of different cultures . The discovery of the fullest dimensions of the meanings and patterns of care must be studied within a holistic culture perspective. Leininger's nursing theory of culture care diversity & universality generates knowledge that can help nurses appreciate the covert aspects of human care within specific cultural structures and values. Leininger advocated a transcultural nursing care that would have a global perspective. That is, that the body of nursing knowledge and practices would emerge had to have worldwide relevance rather than a local or parochial scope. Leinigner argues that as the world continues to change to intense multiculturalism, nurses must realize their need for transcultural care knowledge if they are to be effective in their nursing practices with new immigrants, especially those from cultural minorities, and with peoples whom they have never seen or heard about in the past. (Leininger, M. (Ed.) 1991, 1993). Transcultural nursing therefore was challenging the nursing profession and their traditional nursing practices

scientists fail to recognise how their own interests are shaped by the competitive logic of their own cultural fields. He suggests that the scholarly 'outsider' objective, universal, neutral view is fundamentally political for it involves a quest for power. Bourdieu attempts via his reflexive stance to relativise claims of epistemological sovereignty, a sovereignty that emerges as truth but which without exception embodies the specific (Swartz 1997:275). In the case of studies which involve ethnic and culturally different people, women, and blacks, the problems with social sciences which Bourdieu identifies can have serious implications. For example, researchers who are located in dominant fields and cultures not only will differ in their habitus but will use social science processes which have emerged in and are shaped by the dominant culture.

Bourdieu's social reflexivity is therefore most relevant to my study. It is relevant because his reflexive stance explains, how easily misrepresentations of social life can be constructed by scientists. It also explains how at least in part, people who share and view the social world through similar 'lenses' may also see the social world in similar ways (researchers and participants) and thus represent the group they study in a less distorted way.

Elements of Bourdieu's reflexivity

Swartz (1997) explains that researchers and social scientists are encouraged to use Bourdieu's three main steps of reflexivity for the purpose of doing 'good sciences' and not for the purpose of achieving a universal sovereign truth. These reflexive steps, which I have followed as far as possible, are, I believe, evident in the way the entire thesis is presented. Swartz (1997) explains Bourdieu's three steps as follows:

1 The researcher is required to develop an awareness of and control of the values, perceptions, dispositions and attitudes that he/she bring to the field. A critical awareness is needed of his/her social location (including gender, ethnicity, class, and colour in their a particular socio-historical context) and of the lenses through which the social world in viewed - and how the researcher may project in the field of inquiry. Bourdieu however, is not as concerned about this aspect in his reflexive sociology, he is more concerned that

researchers give critical attention to the reflexive aspects outlined below.

2. Reflexivity for Bourdieu means being sharply aware that sociology (in my situation, nursing and transcultural nursing) is itself a symbolic production situated amongst the fields of human and social science and politics, both of which compete to define the discipline (in this case nursing and transcultural nursing). Reflexivity thus requires an awareness that one's intellectual or scholarly position represents strategies in the struggle for recognition, in this case myself as a scholar, researcher and nurse academic. Thus it is imbued upon me to recognise that my research is motivated by practical interests and my need for scholarly recognition. This awareness is also required in order to minimise any likely projection of a position of intellectual struggle in the field.

3. The third and most important aspect of reflexivity (and one unique to Bourdieu) is the one calling for the examination of epistemological and social conditions that foster social/scientific claims to objectivity. Bourdieu suggests that requirements of objectivity that encourage the outsider's or scholarly point of view require a break from practice. That is, in order to be able to have such a view, the researcher needs to remove her/himself from practice in order to study it. This, Bourdieu argues, requires leisure time and money and, therefore, such an objectivist view is associated with privileged economic status. He also argues that this requires an epistemological break with practical knowledge, that distorts it.

Thus the scientific view of the social world offered by a variety of means, models, strategies and research methods (including statistics), does not reflect the engaged actors in the field or their logic of practice. The scholarly mode of understanding the social world transforms practical knowledge to theoretical knowledge which is systematic, precise and timeless. However, failure to distinguish between practical and theoretical knowledge leads researchers to bring together theoretical practices and practical action and thus commit what Bourdieu calls 'intellectual fallacy' (Swartz 1997:274). This means that the practical and dispositional character of practice is misrepresented because the researcher puts his/her scholarly view

in the mind of the agent, or this view is projected on to ordinary activities. Such scholastic logic disrupts and distorts the practical logic of agents engaged in practice, replacing the logic of practice with unreal and unrelated theoretical logic that misrepresents the social reality and symbolically does violence to such reality by its domination. Therefore Bourdieu calls for the objectification of objectification for a double step backwards in reflexivity - to ensure that the objectification of the field and the methods by which the field is objectified are themselves objectified by the researcher and critically examined for their effects on the field.

As already stated the above three steps are necessary in order to achieve 'good social sciences'. Nevertheless, Bourdieu believes that a fully reflexive view cannot be achieved because researchers and scientists can never reach a point where they recognise the self-interested-nature of their practices. For Bourdieu, no 'absolute' standpoint outside of fields of struggle is conceivable, even if one decides to have no viewpoint. So reflexivity is a matter of degree. Bourdieu believes that by exposing the underlying social conditions of intellectual practices at best one may hope to escape, at least partially, 'from ideology into a more objective grasp of social life' (Swartz 1997:276).

It has been argued by some that criticism requires critical distance, the removal of self from the partial and situational conditions which motivated the reflective and critical insights in the first instance. No-one lives or exists in a value-vacuum such that they are able to claim neutrality. The demand for distance, objectivity and detachment may suppress the motivation to reflect and criticise. At the same time, it also encourages a type of intellectual dishonesty by forcing the self to divide to become 'double'. This double self - one committed and involved, the other dispassionate, uninvolved, watching and reflecting and considered the superior self - can produce a situation of self deception. We can convince ourselves for example, that emotions which arise in the field such as love, empathy, fear, anger, disgust, sorrow and pity (as well as self-interest) do not raise or can be controlled to such a degree that they have no influence on the processes of our thinking. What is required in Bourdieu's conception, however, is to ensure that the researcher

seriously and consistently attempts to be fully aware and critically reflect on such objectifications and the lenses from which he/she views the social world, for the purposes of controlling the impositions of his/her own interests on the field.

Bourdieu warns that 'the social propensity to theorise or to intellectualise' has the effect of permitting the researcher to, on the one hand, claim an 'external and superior point of view' on practice and, on the other, to suppress the recognition of their own interests which motivate them to seek an objective view (that is, to accumulate symbolic capital, the process of which involves 'inferiorising' or reducing the value of other views) (Swartz 1997:275).

Equally important in Bourdieu's reflexivity is for the researcher to recognise how the participants perceive the researcher's position(s) in the field and how that might affect their relationships. I found that it was vital to acknowledge rather than attempt to suppress the diversity of emotions and judgments that automatically arose as a result of my being a participant in the field.

Such conscious, acknowledgment is vital if the researcher is to be able to control the imposition of her/his own interests in the field. The critical examination of emotions and judgments reveals the researcher's values and beliefs and the positions from which they speak. Also, emotions and judgments, if they are allowed to speak, will compel ruptures in the thinking and examination processes of the researcher. Such breaks will open spaces for giving consideration to other unnamed possibilities and to constant juxtaposition and critical examination of different participants' perspectives, processes and practices as observed in the field.

Checking and verifying data in the collection process.

A particular difficulty when undertaking critical ethnography is that everyday practices which contain mechanisms that conceal rather than reveal self-interest and power relationships (and which shape cultural practices) may go unnoticed. A flexible research method is

essential because questions of interest may not be able to be answered until considerable background information has been collected.

As a critical ethnographic study, my work is exploratory and critical and not designed to 'test' a preconceived view. I started with a broad statement of the problem under research, not with propositions or hypotheses which predicted what I was going to find or show. Questions asked in the field more often than not were interactive and directed at encouraging participants to direct questions back at me. I was aware, too, that in critical research what matters is the way researchers 'zoom in' on aspects of the topic rather than the questions they ask (Thomas 1993), and that questions be framed in such a way that the researcher can dig deeply into the subject matter under investigation.

The researcher observes and discerns the gaps in what is said (the on-stage rhetoric and backstage actions), and teases out contradictions and the competing demands of daily existence that the people involved must resolve or cope with (Thomas 1993). Data sources in this study were not limited to human beings; I also included documents and any other relevant material.

I was continually alert to capture data and additional resources that provided details and nuances of cultural meanings and practices. At the same time, I was constantly aware of my own engagement as I visualised what might be underneath each multi-dimensional layer of the nursing home social field in practice. I tape recorded as well as kept field notes of all my fieldwork, recognising that data which might seem trivial at times could be revealing under analysis and upon reflection.

I checked and compared data with a variety of sources to verify it (at least partially). I also referred emerging questions and issues to group participants and key informants. I observed, recorded and analysed the data. I gathered data in a variety of ways to strengthen the accuracy of the data. I often brought data gained from different sources into discussion from different groups and different informants to reveal contradictory perceptions and ideas, and to examine to what degree the data corresponded among informants.

Similarly, I would seek material resources, such as timetables, menus, notices, memos and other documents to resolve points of difference or verify disputed issues. I particularly checked data that seemed at variance with my observations suggested 'cover-ups'.

I felt that it was important to pursue anomalies. Anomalies are difficult to resolve at times and constant vigilance, persistence and sensitivity are essential to discern what might have been rather than what appeared to be. Follow-up questions were critical for digging below surfaces. For example, I interviewed nurse managers on a number of occasions in relation to issues and practices which I had observed and had discussed with participants in general. This I undertook to ensure that I had the point of view of the managerial staff and thus a more detailed picture of those issues and practices in my data collection. I also found that different forms of questioning such as appearing to agree or disagree with the informant or group, or being challenging and confrontational, often allowed insightful glimpses beneath surface appearances. Such questions I found necessary, particularly when informants were giving me what I call 'policy and/or polite talk' rather than saying what was actually happening.

As data emerged, images and counter-images were formed and constantly competed within my stream of thought. Constant reflection was not only desirable but unavoidable. Such images and counter-images raised new questions which sharpened the clarity of my images but which I also took into group discussions for further image sharpening or image changing. Inevitably, such critical ethnographic questioning led me to investigate different social/institutional dimensions which helped to shape the cultural practices and choices of the cultural players. I also explored structural processes guided by rules and regulations, systems of appraisal and reward, systems of communication, employment and dismissal practices, timetables, financial practices and decision-making processes.

Data analysis

The account I offer is not taken to be the only account. This account is one which has been critically examined and reflected by informants through a reflexive critical ethnographic research process which involved my own multiple objective subjectivity constitutive of my own reflexive habitus. This objective subjectivity was a product of experience, of my living and experiencing the effects of Australian and Greek dominant political, economic, cultural and social conditions constitutive of my habitus. The effects of this enabled me to remove, to a certain degree, the veils of misrecognition from everyday taken-for-granted practices, and through a reflective habitus collapse the subjectivist/objectivist antinomies in my research and analytical process. My study thus aimed to interrogate everyday institutional practices and to finally produce a field 'critical tale' (Van Maannen 1988) that does not claim to be the only 'truth' or 'reality.'

It is objective, too, in the sense that it is contextually and relationally bound among people who work together and who have historically-shared experiences, shaped and produced by social and material conditions.

Feeling, thinking, acting in analysis.

Data analysis here required more than the creation of a typology to be imposed on data so that they made sense to us. In the process of my data analysis I was often in anguish and distress. Researchers who are also active members of the research process are also creators of events and interactions. Their involvement emotionally and intellectually, as well as in person in the research field, inevitably affects the researcher, the field processes and the participants' responses. As such, reflection helps to ensure that data collection, analysis and presentation are rigorously examined. Critical reflection makes the researcher think about the project and how the research process may have affected the gathering of some data rather than others and to seek to bridge the gap between subjectivist and objectivist accounts. Equally, by repeatedly thinking of how the data were collected, what was involved, and how they were perceived

and interpreted, and by juxtaposing different views and accounts, one becomes clear of potential knowledge variations in research. By this becoming aware of how one's interpretations can be shaped by taking different sides or perspectives in a situation or field, one also becomes conscious of how not to romanticise or dismiss participants views and their experiences. According to Bourdieu, however, the most important area where reflection is called for, is our epistemological habitus. Thus researchers ask how their study exposes practices that are injurious to human beings but are nevertheless supported by the 'normal' institutional conditions that underpin them, and inquire how these might be subject to change.

Thus the process of data analysis demanded that I face my feelings during analysis and that I examine their influence on me and on my interpretations. Similarly, I needed to constantly remind myself to avoid imposing on the data theoretical notions of professional and transcultural nursing that could distort my findings. This consumed much time, involving as it did comparing, contrasting and juxtaposing the different points of view and images as they related to different agents and to their practical logic in different positions in the nursing home.

First phase analysis

My field data were collected by the use of two languages: Greek was used with Greek staff and English with non-Greek staff. Interviews and group discussions were translated and transcribed into English, and Greek words that had no direct equivalent in English were interpreted to capture their Greek meaning as closely as possible. (These words were also rendered in Greek in the text of the thesis). As I am fluent in both Greek and English languages I did not require interpreters or translators.

I commenced reading my fieldnotes and transcriptions and listening to my recorded interviews and group discussions while in the field. My analytical process, theory developement and research processes were intertwined and continued through my fieldwork. Initially I coded my data using broad thematic labels. Such labels intuitively formed a framework within which more detail contextualised comparative, relational and critical analysis was undertaken.

From time to time I would also distance myself from the data physically to give myself time to think through the different social images and possibilities of their meaning. These different social images relating to the nursing home context, objective structures and different participants' habitus (as expressed in talking, body language, action and practices, and in relation to the field hierarchical agents positions) were juxtaposed. Thus I thought about and critically reflected on what the data, my experiences and my research practices might be revealing.

Equally, much time was spent reading beneath and between the lines of my data as it were, the words and sentences, to try and view their underlying meaning. My research experience was not an easy or painless journey. As I analysed the data the hurt I had felt in the field would at times return. As I felt the hurt, the more I would consciously make myself stand as an observer of my own state in order to scrutinise and systematically reflect upon my feelings, thinking and analytical processes. This made me aware of my most intimate interests and how these interests could be projected onto my findings. What I revealed to myself in the process, however, was that I was sharing similar interests with many participants because of my background and life trajectory. This convinced me that perhaps I had captured some of the practical realities that participants within the nursing home were struggling with. Thus, my findings might offer a situated, partial and local account of a social reality. A voice among many others. I felt a grave moral responsibility towards all research participants but, in the final analysis, I felt a particularly heavy responsibility towards those who seemed to be most vulnerable in the institutional field of power: the residents and carers.

Second phase analysis

De-familiarisation of data was attempted and, through this process, the translation of taken-for-granted classifications and everyday practices and processes into something new. Similarly, I attempted to objectify myself and the research processes I had used in order to reveal how they might have impacted on my objectification of the field. To this end, constant juxtapositions were made of field data

experiences and observations in relation to different images and possibilities that might have played a role in my understandings, evaluations, judgments and distortions of thought.

Defamiliarising the data means that other ways of seeing things become more evident; new images emerge to capture the social reality that the researcher is attempting to translate. For example, the routine morning handovers, in the nursing home among nursing staff and carers can be re-conceptualised as a battlefield for power and domination rather than as an information-sharing event; or as an event where competitive distinctions are made in the pursuit of prestige and status (capital). A clinical teaching event may likewise be viewed as a struggle for status and respect, or a show of ethnic or professional non-professional hostility, and/or a gendered power-struggle for domination. Theses processes, however, cannot occur without being firmly contextualised culturally and historically and within the nursing home context and in a relational form. As Thomas explains, 'the researcher decodes the ways that the symbols of culture create asymmetrical power relationships, constraining ideology, beliefs, norms, and other forces that unequally distribute social rewards, keep some people disadvantaged to the advantage of others, and block fuller participation in or understanding of our social environs' (Thomas, 1993:43) Critical ethnography, however, also aims to bring about change that benefits those most disadvantaged. Thus critical ethnographers attempt to identify 'ways by which alternative interpretations of cultural symbols can be displayed' (Thomas 1993:43)

Language, as a form of power, always communicates one set of meanings while excluding others. According to Bourdieu (1977) the power to give names or labels is the power to organise and give meaning to experiences. Analysis of data, therefore, inevitably names and organises experiences, albeit experiences which have already been interpreted by the informants. Such experiences in the first place are representations of social reality. Those representations are then further reinterpreted and translated by the researcher into something new. Thus, even though I used rigorous reflective processes to avoid serious distortions in the collection and analysis of field data, I had, at the same time, the ultimate power (restricted,

however, by academic expectations) to define and transmit to audiences a 'social reality' in the nursing home. It is important to consider here, however, that the social account I am presenting in this thesis will also be re- interpreted from the readers own particular cultural and personal backgrounds and through the lenses of their own particular social positions.

The representational nature in research of human experiences, behaviour, practices and processes seems to be inevitable. While use of a variety of research techniques may reduce analytical distortions, the potential for mis-representation always exists as researchers are the active creators of their stories. These stories, however, often reveal the 'objectivity' of the 'objective' social conditions experienced and internalised by the participants and researcher alike. From the multiple positions and lenses from which and through which I viewed and interpreted the reality of the nursing home (as declared in the introduction of the thesis), I consider that I had an advantage. Similarly, I consider my field study material and, particularly, the objective social conditions of the field, both of which are accessible to theoretical understandings also to be an advantage. This material and these conditions include the hierarchical structure of the home, staff timetables and their various configurations, and the diversity of agents within the nursing home.

My reflective approach helped me to try and transcend oppositions and dichotomies and the limitations of vision they can bring. Participants' interpretations were compared within groups and between groups and in relation to the institutional structure and processes. Similarly, juxtapositions were made and critical examinations undertaken with different participants during my field work. Such interpretations were compared and in relation to material aspects of practices and processes in the nursing home.

CHAPTER FOUR

RESEARCH METHOD DATA PRODUCTION, COLLECTION AND RESEARCH STRATEGIES

Introduction

In this chapter, site selection, access, ethical considerations and data gathering processes are discussed.

The Planning Phase

Research site selection: A unique socio-cultural field

The selection of 'a Greek ethnospecific nursing home' as my research site was influenced by my background and experience. The site was uniquely suitable for the use of a critical ethnographic research approach. This is because the site was a culturally diverse microcosm within the larger Australia society. This institutional microcosm reflected not only the Greek but also the larger Australian society. Further, its field-specific power relations and hierarchy were rooted in the classification systems which help to sustain and reproduce society (bell hooks 1995; Bourdieu 1990).

At this site, while the staff members were from different cultural and linguistic backgrounds, all residents were Greek, the majority of them from rural backgrounds. All residents were Greek-born or of Greek background 'marked' as 'ethnic' and with 'migrant' status. The predominant 'ethnicity' of residents in this site is a reversal of the situation in health care settings in the larger society. Staff employed within the nursing home reflected the larger society's institutional health care workforce structure insofar as the majority were women. However, there was one significant variation in the Greek ethnospecific nursing home in relation to mainstream employment practices. In mainstream health care institutions, the top levels of the employment hierarchy are occupied by English-speaking British/Irish descent (ESBID) and/or English-speaking background (ESB) staff, while the lower levels of the hierarchy, (e.g. cleaners,

domestics etc.) are mainly occupied by people from non-English speaking backgrounds (NESB). In the Greek ethnospecific nursing home the Executive Director and Board of Directors were from Greek backgrounds while the top nursing management and most of the middle management of the nursing home were ESBID, with several ESB and two Greek speaking registered nurses. At the lower levels of the hierarchy the majority of staff are migrant Greek women (see Chapter Seven).

Investigation of the site offered the potential to reveal whether and how ethnospecific aged care and health care could be provided; and whether Greek ethnospecific aged care and aged health was possible with senior and middle nurse managers being of the mainstream (ESBID) and/or educated in Australia but without transcultural nursing education. (D' Cruz & Tham 1993; Minas 1991; Advisory Committee to the Multicultural Nursing Workforce Project 1991; Kanitsaki, 1988, 1983). Investigating such a site also offered the potential to provide insights regarding the constructions of ethnic boundaries and how socially and institutionally legitimised 'normality' masks both gender and ethnic inequalities and injustices and helps in their reproduction. Insights could also be gained into whether it would be possible to eliminate social inequalities and injustices in ethnospecific health care settings that are - based upon and framed within mainstream institutional structures and government policies.

Bourdieu's concepts of **capital, habitus** and **field** formed the conceptual grid on which my research processes and analysis rest. The use of these helped me to perceive how *structure, habitus* and *culture* stand in a dynamic constitutive relationship; as such, investigation and analysis of the nursing home field required a multidimensional and multilevel research approach. According to this conceptual grid, competition and struggle in a mainly bicultural ethnospecific field relates not only to accumulation of cultural and other capital; it also relates to legitimacy with regard to whose capital is an object of value and thus has symbolic power and should prevail in nursing home practices. This struggle between groups also reveals the power that social symbolic systems invest in binary social classifications that serve to stratify society (such as ethnic versus

non-ethnic, male versus female, lay versus professional, etc.) in serving hegemonic interests. Dominant groups in society achieve domination by legitimating their 'normality' as universal and thus making it central. Such universality is not innocent, however; it acts to subordinate, dominate, and disadvantage non conformity and to classify it as ' other'. It does this by devaluing the 'other' and its forms of capital by making the 'other' particular in opposition to universal and, thus peripheral to the center.

I planned, therefore, to spend considerable time in the field and to talk informally with all people within the nursing home (i.e. personal carers (PCs), domestics, professional and managerial staff, residents and relatives). In this process, I planned to select from among staff and residents general informants and key informants for formal interviews. I also planned to include group discussions in my data collection and scrutiny, but without my playing any role in group formation, structure or configurations. I planned to join groups as they emerged in the nursing home environment. I chose this approach in order to avoid the imposition of an external and unfamiliar influence on group formation and group processes which might act to frame their interactions and discussions (see Chapter Three). Instead I decided to consciously draw on my Greek knowledge and experience (Greek capital) of Greek forms of speech (**kouventa, sizitisi, shxolia** and **koutsombolio**) (see Chapter Three) which incorporate unspoken rules for group processes and social interactions. My Greek capital and habitus thus helped me to recognize that I could unreflectively impose on participants research processes that could not only significantly distort our relationships and interactions (and therefore data collection) but that could also make them feel that they had no control over the process and so place them in a disadvantaged position (Ahmad 1996; Stanfield & Dennis 1993). I also wanted to observe the kinds of social boundaries and closure formations that took place in the nursing home under 'normal' daily conditions, as well as grounds upon which such social boundaries were resting.

The use of bicultural capital (the 'culture of two cultures') to prepare for accessing the research site

Using my cultural capital that I had gained from both the Greek and mainstream Australian cultures, I successfully negotiated and received permission to access a Greek ethnospecific nursing home in Victoria. In this, ethical considerations were taken into account from a bicultural perspective. All formal ethical approvals were received before I started my fieldwork (see Appendices 1&2 the nursing's home ethical approval is included but without details that could reveal its identity), similarly all names used in this thesis are pseudonyms. Once I had started my fieldwork, I attempted as an insider of Greek culture to remain sensitive to cross-cultural ethical issues, and to avoid imposing on participants 'universal' ethical standards that, by their nature, could be seen as potentially harmful to participants. (see Appendix 3).

Research trajectory

The research phases were continuous, overlapping and spiral in nature. The phases can only be distinguished by their increasing focus and persistent doubling back or return to what appeared to be 'normal'. This was done in order to re-examine and reflect with different group and individual participants on what was taken-for-granted and thereby try to make visible underpinning assumptions on which practices were based and thus make participants aware of the interests served. The processes I used to achieve this were based on my own Greek capital and habitus that enabled me to use embodied Greek speech forms and language. Such dynamic speech forms promoted a relational, multidimensional and multilevel field understanding (Swartz 1997). Key features of the stratified nursing home field clearly required a relational and multidimensional research approach to make visible the many and intersecting competing interests. Greek forms of speech permitted debate, dialogue and, often, confrontation and contestation.

In the field: Phase I–Entering the field, situating myself and scanning the terrain

I started my fieldwork as a part-time PhD candidate. This meant that I would go into the field whenever I had an opportunity and when my schedule as a full-time academic allowed me. I tried to spend eight hours per day and be weekly in the field. I also ensured that I varied the days and shifts of my attendance. Because I could not be in the field every week, however, I arranged to spend blocks of times there including during my holidays and my long service leave.

Thus my fieldwork was undertaken both intermittently and over extended periods of time. I carefully planned to cover, over the course of my fieldwork, the different shifts worked by staff at the nursing home between 6.30 am and 12 midnight (i.e. the morning and afternoon shifts and part of the night shift). I also ensured that my fieldwork covered all days of the week (including weekends). In addition I attended some nursing home meetings of staff, residents and relatives at various times of the day, as well as some nursing home organised celebrations and religious events.

During 1995, the first year of my fieldwork, I took the opportunity to spend much time with the then Director of Nursing (DON) as well as two other registered nurses (RNs) who at times were in charge of the floor and at other times relieved the DON. I would be invited to follow them while they undertook their duties; I attended meetings with them and had many unscheduled and scheduled conversations and dialogues with them. Spending time with the DON and RNs provided me with an overview and of their personal perceptions of government policies and residential care standards. Their perceptions of the ethnospecific nursing home, as well as their perceptions of their roles, goals and aims in the delivery of care. They also shared some of their experiences regarding human relations and interactions with the nursing home and Greek community, and with administrators in health departments. As a Greek woman I shared some cultural capital with Greek staff and as a nurse in Australia for 38 years, I could identify with mainstream nurses. My experiences of both cultures through the years served as

oppositional mirrors that reflected on each other. Such reflections were unavoidable and painful as viewing each culture from the opposite position, each culture could be seen as a closed system and as such, both stood ready to disadvantage anyone outside their center. This situation forced me to look for other, alternative ways of being and new possibilities for transformation and to accept nothing as given.

During this beginning phase I also paid attention to general nursing home practices while forming relationships and becoming familiar with other general staff, residents and relatives. I would arrive at the home at different times and stay from between 5 to 10 hours at a time. I observed events and practices, individuals and social groups as they interacted, and relationships as they formed, changed, digressed and/or dissolved over time. Thus I came to observe a battlefield of human needs, interests and desires unfolding in the nursing home.

My first impressions in the field indicated to me that it was important, as I had originally thought, to retain an open and flexible attitude in the use of my research strategies. These first impressions also indicated to me that it was necessary to adopt research techniques or processes that would emerge in context and best permit the staff's and residents' voluntary involvement (in individual and group contexts) without any predetermined constructions being imposed upon them by unfamiliar research approaches or processes (Stanfield II & Dennis 1994; Reinharz 1992; bell hooks 1994). Indeed, I was fully aware that I could further disadvantage the most vulnerable people within the home by the use of research methods that placed them in unfamiliar and disempowering situations and roles.

After some preliminary observations I made the following decisions:
(i) to first observe the production and formation of groups within the home and only then to join them, and

(ii) to use the Greek discursive forms **kouvenda, sizitisi, shxolia, and koutsombolio** during group and individual discussions. These speech forms encourage the active participation of group members

adopting familiar speech roles and create a forum where any kind of questions can be asked (that is, challenging, confronting, provocative and at times accusatory). The employment of these speech forms was aimed at seeking and making visible what was hidden or misrecognised. Their use would continue on a topic in successive group formations until a satisfactory understanding was arrived at.

I became a member of the groups and, through the conscious use of these Greek forms of speech, I was able to ask questions and interact in ways that helped me to maintain the momentum of critical examination and reflection in group discussions and to gain valuable insights with regard to nursing home practices. At this time, too, I selected informants for discussions and interviews from all these various groups and levels within the home in order to hear about and gain insights into the diverse perspectives and experiences of differently situated and institutionally located people.

I planned to use a number of participant observation strategies and in a way that would enhance my understanding of the nursing home field. Wolcott (1994) has summarised some research strategies that I found useful when undertaking participant observation in the field. These strategies are:
(i) observe and record everything,
(ii) observe but look for nothing in particular,
(iii) note paradoxes and
(iv) identify key problems (confronting the residents and the different groups working in the nursing home).

Initial perceptions of my role in the field

My reception at the nursing home was extremely positive and all members of staff welcomed me and appeared to be interested in my research project. In particular, ESBID staff who were the managers of and registered nurses in the nursing home were enthusiastic and extremely supportive of my presence.

The Greek-born staff were polite towards me but kept a certain distance. I felt that, while they were aloof, they were also observing me from a distance and 'working me out'. Initially, on a few occasions, I tried to work with them; but I kept losing them in the

many rooms and secret places of the home, and I felt that they were politely avoiding me. They went about their business without showing any interest in involving me in their activities. On the other hand, ESBID staff (including the Chief Executive Officer) were most receptive, open and eager to assist me and involve me in their activities. At the same time, however, I became aware that some residents and carers thought that, as an academic, I was working for the government and thus they were ambivalent about me and cautious in my presence.

Being a woman, single, and mature in age, my pursuit of a higher degree and my reasons for choosing a Greek nursing home were all subjected to skeptical scrutiny by residents and some staff, and various ulterior purposes were ascribed to me. Many residents, for example, found it hard to understand that I remained single and felt that, a mature woman, I should be engaged in rearing up a family rather than pursuing an academic degree. I sensed the pity that they had for me because I was not married, as some tried to extend their sympathies to me by explaining that marriage was not everything in life. These concerns indicated to me that residents and Greek staff located me historically in the Greek cultural context of their time. There were some who could not comprehend the social value of such a study, while others applauded it. One woman resident questioned my work simply because it was unpaid. As time passed, this particular resident became my greatest supporter in trying to direct me to witness staff activities that she thought were important. I realised that she was eager for me to observe staff who she thought were not very dedicated or who were remiss in attending to the residents' care needs, or whom she considered simply to be lazy.

Gradually participants became less cautious in my presence and more revealing of their inner thoughts and feelings. We reached a point of comfort and unspoken understanding that our interests (political and ethical) were converging. This I believe helped in the research collaboration. Residents and Greek-born staff started to understand my research. They could see me and observe what I was doing as I talked to them, mingled with them and at times gave care to them. Some of the residents started to became active participants and informants in the research process. They would invite me into

their rooms for **kouventa** and/or **sizitisi**; they invited me to sit and eat with them or to watch television and share other programmed activities with them while we discussed different issues and topics of the day.

As time passed, however, I had to become more intensely involved with the activities of the nursing home at the 'floor' level. Greek-born staff become enthusiastic and actively sought me out to observe their activities and to participate in their different group discussions. I realised that they wanted me to actively participate in conversations (**kouventa, sizitisi, shxolia, and koutsombolio**) and evaluate and provide feedback on their care practices and views. I also started to raise more reflective questions that challenged 'normal' nursing home practices. These questions I was able to raise because I had deep experience of and had accumulated capital (as a nurse and in other positions of authority) within the Australian health care system, and also because I was a Greek migrant who had on many occasions felt discriminated against, silenced and marginalised. Often I was asked to take sides in the debates and contestations. They perceived me as a knowledgeable person in regard to both Greek and Australian cultures, a nurse with university status, (a form of capital unique in the nursing home) and also, paradoxically, an unskilled migrant like them. They felt I understood their situation, fears and experiences, their dreams and hopes. But they also indicated that they held a special admiration for me for having achieved what they thought was difficult if not impossible to achieve for a migrant with my background. I felt that they came to see me as a role model, and my presence in the nursing home gave them a sense of pride.

The Greek-born staff members' positive regard for me, and their perception of me as a 'good' woman, helped with regard to research collaboration. It is my belief, however, that this process was also helped by our sharing embodied past history, similar backgrounds, and migrant experience (capital and habitus) that made us feel 'in place' together (Bottomley 1992; Bourdieu 1990). This also helped participants to feel relatively free to raise with me and critically reflect on issues of concern, and to express their concerns and opinions about perceived inter-ethnic conflicts and tensions that

related to staff relations and interactions, residents' care, and institutional rules, regulations and practices.

Issues pertaining to being Greek 'unskilled' rural women, employment patterns, staff interactions and relationships of power were regularly and repeatedly discussed, debated and contested among Greek-born and Australian Greek-born staff. In these conversations the forms of speech referred to above (**kouvenda, sizitisi, shxolia** and **koutsombolio**) facilitated multiple voices to be heard from a number of perspectives and made possible the juxtaposition of different images of the social realities that participants were experiencing and which permeated the nursing home. It was, however, my bicultural capital and habitus that enriched me with insights that, in turn, allowed me to generate pertinent questions and to perceive oppositional and antagonistic symbolic systems and their relative symbolic force as they operated within the nursing home. It was these symbolic systems which seemed ultimately to help to legitimate the nursing home structure and power force field that privileged mainstream capital over Greek capital.

Phase II - Establishing relationships, and field exploration

During 1995 and early 1996 I was in the field during two of the regular staff shifts - that is, the morning shift (starting at 7 am and ending at 3 30 p.m., and the afternoon shift (starting 3 30 p.m. and ending 10.30 p.m. I also managed to be in the field on all days of the week (not the same week) and during all months of the year. In particular, I was in the field on days when Greek religious events were celebrated. This I thought was necessary to get a sense of the complexity and diversity of the nursing home's practices and to capture who and what was influencing the production of culture in the home and whose interests were being served as a result.

During this time I also interviewed several key informants and general informants because of their professional and administrative positions in the home, and others because of their physical locality in the home. I organised and undertook several formal interviews

with the DON, a charge nurse, a Greek-born RN, the switchboard operator, and three residents.

The DON was ever-present, supervising and directing. I thought that, by interviewing her, I might gain some insight in to how she promoted the ethno-specificity of the home in relation to culture, culture care and language use. Further, I thought I might gain a general idea of what issues were concerning the managers and people in charge in relation to managing such a complex environment. By interviewing key resident informants, I arrived to discern their views and main issues of concern. The Switchboard operator 'directed the traffic' as it were, and I hoped that, by interviewing her, I might gain insight into all issues relating to rosters, the transmission of instructions from English speaking British Irish descent Australian nurses to the Greek staff, dealings with relatives, and all the other unspecified events or activities that arose. The switchboard operator was strategically placed at the center of the home. This position enable her to see almost everything that was going on at the home and to hear the conversations that took place generally throughout the home. (This was particularly true in relation to the Greek-born staff and residents, as their discussions, jokes and play were often extremely noisy!).

As a researcher in action within a bilingual and mainly bicultural context, I observed social realities played out that juxtaposed different social and cultural images. Confronted with these different realities, I had to constantly cross and re-cross- ethnic and cultural conceptual boundaries. It was apparent that the Greek ethnospecific nursing home, situated within the larger aged care health sector and mainstream society, became internally, a competitive arena of struggle over whose capital was to be legitimated and thus dominate. Thus Bourdieu's concept of 'field' helped me to map out within the nursing home arenas of struggle involving various types of capital for relative power and privilege, which were reflective of mainstream society, albeit in a confined, legitimated space marked as 'other' (ethnospecific).

Critical reflection was an essential ingredient of my analysis and reconstruction of the social realities with which I was confronted. It

guided me to question these realities, not only as they were brought into conflict within myself but also, based on my past experiences, as I imagined them and relived them from my assumed subject positions. This situation also helped me to achieve the essential criterion of Bourdieu's reflexivity: to critically and continually analyse social categories and to 'control' them by juxtaposition and by attempting to transcend them. At the same time, however, I continued to have reflective discussions with participants and to cross-check common perceptions and expressed experiences between groups and amongst individuals and with available material data in order to transcend the subjectivist/objectivist divisions in knowledge production. My sympathies often lay with all groups of people working within the nursing home, as my diverse but situated experience and knowledges (capital) gave me insight into what it was like to be 'in the shoes' of all members of staff (although not necessarily with a full understanding of what their interests and social realities were).

I found that Greek staff were serious and passionate critics (**shxoliastes**) of nursing home practices and of each other. I also mingled with the residents and their relatives to get to know them. During this time I progressively built trusting relationships with Greek-born and English speaking British Irish decent Australian staff and other non-English speaking background staff learning about them as they were learning about me and the kind of a person I was.

Researcher -participant power differentials: What do they reveal?

I felt that the registered nurses identified with me as an RN–as, I did with them. But I felt they also saw me as an insider to Greek culture and were anxious to share with me their experiences about this complex environment. I thought they wanted - indeed, were eager - to show me that they were practising 'relevant cultural care' in a Greek home and to receive some validation from an outsider. (As this situation was at the beginning of my fieldwork and before I had spent much time with Greek speaking staff and residents, I also felt Greek staff members' reticence towards me may have been due to the fact that they observed me mixing more with registered nurses).

During the time I was more involved with nurse managerial staff than general staff and I became aware of how intently other staff and residents were watching me. It was as if they were trying to work out my loyalties and interests. Their behaviour not only attested to our superficial relationship, but also to a perceived and felt power differential. This also alerted me to perceptions that existed among participants regarding their cultural and social distance, that helped to form social boundaries between them. I felt a danger looming in relation to the potential risks I was taking by crossing established social boundaries and appearing to be friendly with the people on the 'other' side (particularly in relation to Greek groups versus Australian English speaking British Irish decent senior and middle managers).

Registered nurses were in charge of the nursing home. Therefore, it was not only cultural distance that helped in the formation of boundaries between the groups but also the home's managerial structure that disproportionately distributed authority, and thereby materially and symbolically reinforced ethnic boundaries. Thus Greek speaking staff and residents could not entirely take me into their trust while they perceived me to be involved with registered nurse management.

This experience clearly revealed that the nature of the nursing home structure directly affected the formation of power relationships that produced and sustained nursing home conditions. Within such a context, where ethnic groups and individuals compete for capital distribution and legitimisation, the power differential that can exist between researcher and informants becomes obvious as the researcher becomes involved in daily social processes. In this case, nursing home conditions and participants' behaviour indicated that the residents and staff were experiencing a power differential between themselves and managerial staff, which contributed to their feeling uneasy and cautious towards me by association. These experiences provided me with a sharp awareness not only of the power differentials involved, but also of the mobile and unstable nature of such power differentials during the duration of the research process.

I found that participants' perceptions of the researcher and associated power relationships were mediated by their positions in the nursing home's field of power. My behaviour as a researcher and the participants' subsequent perceptions and interpretations were mediated by the nursing home's field of power and participants' projections of how their interests might be affected by what the researcher might do to benefit or harm those interests.

I had to be careful, therefore, about how much time I spent with different participants and how I was interacting with them in order to demonstrate balance and thus minimise their distrust of me. While I was trying to maintain this balance in my involvement and interactions, however, both groups, seemed to be ambivalent towards me. As a result, I felt that keeping my energies focused on maintaining balanced relationships, I was seriously limiting my access to information. I felt that I could not maintain a balanced position and remain, in the perceptions of participants, situated in between groups and, at the same time, achieve meaningful and trusting debates and discussions with general staff and residents alike.

At this time, then, I consciously decided to abandon my attempts at maintaining balanced relationships and interactions and become involved as necessary with floor activities and staff in ways that could help their voices to be heard. This decision was made on the grounds that I thought that carers and residents were more vulnerable than senior managers and had fewer opportunities to access venues where their voices could be heard.

As this situation was emerging, carers, residents and relatives seemed to feel that I was one of 'them' and became more co-operative and outspoken; however, I began to lose senior management's trust and tolerance towards me. At the same time perceptions of power differentials between myself, Greek participants and management shifted in a number of ways, and the behaviour of participants, as well as my own behaviour, changed accordingly.

It seems that boundary crossing holds dangers that are rooted in in-group and outgroup interests that regulate human behaviour that

either help to build or destroy the formation of trustful relationships. While I was able to cross safely the boundaries for a time, this safety was fading away, as I was becoming more informed of detailed nursing home practices and their underpinning logic, which I would often bring for discussion and critical examination to senior nursing staff. Managerial perceptions started to change towards me, as they thought I was involved and interacting with carers, residents and relatives more than they had anticipated or expected from an 'objective' researcher. My research trajectory thus became overshadowed with anxiety, as I was informed that top management in the home was considering discrediting or even interrupting my research project.

Concurrent participant observation

My participant observation ranged from slight to moderate involvement in nursing care activities at various levels (for example, giving care to residents and comfort and advice to relatives, teaching RNs and other staff, and helping domestics and activities personnel). The progression from slight to moderate participation related to the development of my relationships with residents and staff. Equally, it was influenced by my decision to control the degree of my 'hands-on' involvement.

I observed and recorded everything that took place in my presence. During this phase I identified some paradoxes that motivated me to observe more intently and reflexively certain members of staff, practices and events. Even so, my observations continued to include routine as well as unexpected and unpredicted events and interactions between all the different groups and individuals that came in contact with the home.

I followed and observed different individuals for entire days on various days and shifts as they went about their work. While I was observing or working with them we would interact and have discussions and with residents and relatives and/or visitors. I would often ask questions about residents backgrounds, illnesses, responses and behaviours. Similarly, I would ask questions of carers and RNs relevant to their practices at the time in order to gain some insight

into the logic of their practices. I read documents and notices and asked staff for explanations and clarification.

In my study, groups were made up of two or more individuals, the particular number depending on coffee and meal break times and who was working on the particular day and shift. The field was like an irregular terrain, with peaks and troughs, but I would find myself there, either involved directly or listening while staff, residents and/or relatives discussed or argued issues and events. Often they would involve me by asking my opinion or view, or I would ask questions relevant to the conversation at the time. I felt, however, that people were restrained in their interactions with me nevertheless; I felt that they were testing me to find out whether I was understanding of their situation and could be trusted before they would be able to relax in my presence.

During this phase I began discussing with the Greek speaking staff the possibility of interviewing them formally. All agreed and invited me to go to their homes for the interviews, which is where I conducted all formal interviews.

During all three research phases I also interviewed, informally and formally, a number of staff and residents and had discussions and debates with individuals and groups, including (i) Greek-born staff, personal carers and domestics, (ii) Greek Australian-born staff, personal carers, and registered nurses educated in Australia, (iii) Australian English speaking British Irish decent (AESBID) manager of care services and Director of Nursing, (iv) AESBID staff registered nurses and state enrolled nurses, (v) non-English and non-Greek speaking background educated in other countries registered nurses, state enrolled nurses and personal carers, and (vi) residents and relatives. I also formally interviewed the Chief Executive Officer of the nursing home and the president of the nursing home's Board of Directors.

Staff recognised me not only as a researcher, but as a fellow health professional. This situation was inescapable, and one that I managed in a variety of ways. Sometimes it meant that my professional opinion was called upon. I would be asked by registered nurses to

assess residents who had a sudden illness episode. Some of the registered nurses needed validation and reassurance with regard to their assessment. For example, one day I was called by the charge nurse to assess a resident who was exhibiting signs and symptoms of an allergic reaction. The resident's tongue and lips were swollen and her breathing was gradually becoming more difficult. The charge nurse was aware of this woman's condition; she realised that it was perhaps a dangerous situation but was not sure whether she should call the doctor at that particular time or whether she should wait. The registered nurses generally felt very uncomfortable about calling doctors.

I assessed the resident and firmly encouraged her to call the doctor – immediately, as the situation was urgent. I had noticed in previous interactions with medical practitioners that transmitting the urgency or seriousness of the resident's condition was essential if the medical practitioners were to respond with speed.

On other occasions I participated by assisting with routine care such as help with lifting a resident up onto a bed or onto a chair or off a toilet. I would also keep company (parea) and talk to distressed residents, cut their food and feed them, fetch items for them, or take them for a walk or to the toilet, when the personal carers and other nursing staff were busy elsewhere and unable to attend to them at the time.

Occasionally I intervened when I was concerned that treatment of a resident was inappropriate, or because carers had asked me to help them. I would gently help and advise the staff involved. For example, if a personal carer sat a resident with swollen legs on a chair and left them sitting with their feet on the floor, I would explain to the carer why it was important to have the resident's legs raised[1], resting on a chair or stool or with a pillow under them. I thus shared nursing knowledge with the carers which, as carers, they did not have and without which, in such instances, they could not make the judgments required for the benefit of the resident.

1 This is necessary to help venous blood circulate against gravity and thus reduce venous pressure and fluid escape from the veins that causes legs to swell.

During this time I continually tape-recorded events, actions and the interactions of individuals and groups and made notes in a journal about events or behaviours that could not be tape recorded. I also summarised (on computer) my field observations at the end of each shift, including my feelings, reactions and judgments. I critically reflected on my research processes and strategies in action and would adjust or reshape my behaviour and research process within the nursing home context as I considered necessary. I also attempted to review all my own judgments by identifying with each group of people in order to establish their range of perspectives on any specific issue. In this process I undoubtedly drew on my own previous experience of the various social frameworks that people in the home were operating with. This is best characterised as a reflexive activity entailing both imaginative identification with agents and self-conscious reconstruction of the totality from the viewpoint of a researcher. I was imagining myself as a carer, RN, DON or Greek 'ethnic', for example, via my past 'embodiments' within different social conditions and areas of practice that had contributed to the structuring of my habitus. The memories and knowledge from experience would flood my consciousness and, within such a frame and by juxtaposition, I would critically examine all conflicting feelings, judgments and clinical decisions I was observing and experiencing. This often produced new images and possibilities. In this way, then, differing cultural practices set side-by-side broke habituated patterns of thought and feelings to create spaces for new images to emerge and juxtapose themselves. The purpose of such critical examination was to ensure both that I was objectifying my objectifications (Bourdieu 1997) in order to ask why 'objectivity' was sought (for whose interest) and thus remove my intellectual barriers and allow in my thinking different voices to be heard and understand the logic of the varied practices, processes and perspectives that I observed played out in the nursing home field.

I found that, by having my tape recorder on at all times, I captured events and interactions in some form. Often in the nursing home field I had to move from place to place or interact with different people or was involved with different events or happenings. Making notes directly in such a dynamic environment was impossible at

times, and I could not trust my memory to recall events, particularly the exact language used.

When activities in the home were less hectic I would often elect to sit in the nurses' office. This I did because, from here, I could see most events and activities in the nursing home as they took place. I could also sense from noise, voices and movement when some out-of-sight activity, event, discussion, conflict of a heightened nature or break in the nursing home's daily routine was happening, and I could quickly go to the scene.

Phase III - Focus, juxtapositions, verifications and critical examination

The first phases of my fieldwork provided material with diverse voices and images that indicated that a deeper examination of the daily 'normality' or taken-for-granted routines and practices in the nursing home was required. Emerging issues, problems, contradictions and conflicts were used as a basis for discussion in subsequent interviews with the same informants and as additional topics to be discussed with new informants formal and informal interviews. They were also brought to various groups as additional material for discussion, debate and critical examination. This involved doubling up at every step of the process, going back in my own thinking and then back to participants, re-examining the issues of their concern, and bringing to the surface the hidden, underpinning assumptions of taken-for-granted daily practices.

Staff group discussions

The staff were permanently employed but worked in teams on different days and shifts. So while the overall group configuration would change according to who was on duty and when, all members were, nevertheless, participants of their own day/shift groups. Thus all Greek personal carers, domestic staff and 'floor' nurses were discussing (**sizitisi**) issues and concerns in groups and as members of different groups.

Groups would form and have discussions or debates (**sizitisis** and **shxolia**) at the nursing station and over tea breaks. Lunch and dinner

allowed for longer reflective discussions in Greek language (at times mixed with English words and sentences) and even for arguments to develop. On these occasions discussions were usually about residents, relatives, general staff and management relations, management, working conditions, government policies, and private and home life. Often, tensions associated with differing care delivery expectations, staff interactions and material realities such as varying levels of staff skill (and who determined this), staff flexibility, roster patterns and differing amounts of work (or what Bourdieu [1996] calls 'flexploitation'), standards of care and performance were key sources of conflict and causes of an insecure tense and anxiety-filled environment. I always joined, in such discussions, where all Greek speech forms (**sizitisi**, **kouventa**, **shxolia** and **koutsombolio**) of were used and which often helped to expose participants' 'misrecognised' interests (Bourdieu 1990).

When appropriate, I would raise questions to try and reveal unspoken premises that mediated work practices, human interactions and relations, the employment of staff and the running of the home generally. Often, in **sizitisi,** critical reflection challenges and counter-challenges between group members took place. Such discussions were most insightful and revealing. For example, on one occasion, one of the Greek PCs was very angry and was experiencing feelings of injustice in relation to something that had been done to her and her team. She was distressed because the nursing home's other team of personal carers had been selected to work four days a week (something which she wanted to do) and thus her team would now work for only three days a week. The carers considered working three days a week a disadvantage because their earning capacity was reduced and they needed to earn extra money to survive.

They perceived this situation as inequitable and blamed the team selected to work for four days for the injustice that had been done to them. On discussion with the group, however, and on reflection, they realised that if they had been asked first (as the other team had been) which roster pattern they wanted to work out of the two (three or four days a week), they would have chosen as the other team had. They realised that it was not the other team that was the cause of their problem but the roster patterns established by management and

the manner by which management selected who was to work particular roster patterns. This revealed itself when, in the midst of the group's complaints, I asked them to tell me, 'What would you have done if you were asked first by management which roster pattern you wanted to work'? They replied, 'The four days'. Then I added, 'Why then do you blame the other team for the injustice you feel you have suffered'? A long discussion and reflection followed, revealing a number of interests and issues which we further discussed and explored. These related to government policies and funding, the economic management of the nursing home, and carers' perceptions of how management perceived and evaluated them which in turned, the carers thought, influenced roster patterns.

Other group gatherings occurred spontaneously as staff went about their work, and disagreements or unresolved issues from previous events or discussions would be discussed until they were no longer of interest. For example, one day, as I was observing a registered nurse giving residents their morning medications a big argument erupted a few metres away from where I was standing. One of the group members, the **koutsombola**, (using the Greek speech form and interaction of **koutsombolio**) and was also the apparent cause of the disturbance, left the 'argument space' and, as she was passing by, indicated to me and said, 'You should be in the office'! I and the RN went to the office.

We both stood silent, listening to the very loud and angry discussion that continued in Greek over this issue (an issue that was repeatedly discussed throughout my fieldwork). It related to the question of carer competence in delivering care to residents. In this case, one of the younger carers had been informed that three older carers had been evaluating her work and had judged that she should not work in the home. The older carers had taken this evaluation upon themselves and had formed the view that the young carer was caring inappropriately and that she was harmful to them. Another carer (the **koutsombola**) had transmitted this information to a fifth carer, who had then passed it on to the young carer concerned. The argument we had witnessed was the younger carer confronting one of the older carers and accusing the group of three of scheming to make her lose her job. The older carer, however, was denying this.

The younger person then called the carer who had acted as **koutsombola** to the group to verify whether the three older carers had actually discussed her and her competence to provide care. The **koutsombola** verified this.

This particular event continued to be a topic for **sizitisi** and **shxolia** for the rest of my time in the field. This **shxolia** allowed all aspects of the event to be examined according to each carer social realities in order to (and then) make a contextualised judgment as to whether the older carers judgment was right or wrong. These interactive speech forms revealed the Greek-born staff members' cultural care standards and expectations, and ways of dealing with disagreeable situations. They also revealed their anxiety - producing work environment, where they were labelled as 'unskilled,' 'migrant' 'ethnic' women (or as having no valuable capital). Their historical vulnerability as migrant, non-English speaking 'ethnic' women located at the bottom of the social hierarchy, as well as their limited choices, were made visible. Similarly, their insecurities and fears were made visible within this uncertain, anxiety -producing context where they felt they had little legitimate capital or power. These speech forms also served to reveal the inequitable institutional power relations and interactions among the groups, and the nursing home's working conditions that mediated their practices in daily life.

However, I was not able to use these Greek speech forms for group discussions with ESBID and other RNs of non-Greek cultural and linguistically backgrounds. This was because these staff mainly occupied management positions and worked on different shifts, and thus group formation was not possible. Greek speech forms were also inappropriate for use with Australian RN's of British-Irish descent. In these cases I interviewed key informants repeatedly and raised questions with them that had emerged from other staff members and group discussions (for example, questions which aimed to make visible to what extent they shared similar perceptions and experiences among themselves and/or disputed material facts). I also asked questions that I considered at the time would raise managerial awareness of how the carers and residents might be experiencing nursing home conditions. Such questions were aimed at bringing to the consciousness of RNs the different voices in the

nursing home which Greek staff, relatives and residents believed (RNs and particular manager RNs) were not hearing. They were also aimed at providing a juxtaposition of different social realities as they existed in the nursing home, creating ruptures of 'normality' and stimulating reflection.

Residents groups

When out of bed, residents spent most of their time in groups that included members of staff or volunteers, undertaking activities, participating in communal religious and other events, going out of the nursing home on visits or day trips and eating together at breakfast, lunch and dinner times. They would talk with me as I sat with them at meal times or in the television room (μικρι σαλα) in the afternoons, or while I was feeding them or sharing a meal with them or of as I visited them in their bedrooms.

Some residents invited me often to go with them to their bedrooms and have a talk (**kouvenda**) with them and at other times to participate in their group activities. During these activity sessions, the activities facilitator would, as a matter of course, initiate diverse discussions that reflected residents' cultural beliefs and values, their experiences in Greece and as immigrants, and political, economic and social debates and issues which related to the economy, Australia's government, love, the notion of family, care and health. I would often participate in these discussions as a member of the group and, on two occasions, I initiated discussions with the assistance of the activities woman who introduced the topics I had requested (age, care and health).

Residents were brought together for breakfast, lunch, and dinner and to attend a variety of home and community activities. Other meaningful and significant gatherings that involved staff and residents - and often relatives - took place on Greek Orthodox saint days, name days, birthdays, Australian Day and at Easter and Christmas.

Social space in Greek culture (at the time most residents and myself lived in Greece) was demarcated and occupied according to notions of gender. Residents' room occupation reflected the cultural

construction of gendered space divisions and other binary symbolic systems of the culture. The private and intimate was the woman's world and the public and political was for men. Residents would ask staff to place them in certain spaces in the home. The women generally wanted to be in the home's front television room (μικρι σαλα), the kind of private and comfortable space that women were expected to occupy in company with other women. The public, open and not so comfortable or private spaces (where people would pass by and doors would open and close, creating draughts, etc.)–the symbolically dangerous space –was for men to occupy. Men kept out of women's private rooms, and Greek members of staff complied with these cultural expectations and practices automatically and without question. As an observer I could see clearly this particular groups habitus (similar historical background and experiences, class, gender, rural non-professional) in action.

All the men would sit in the foyer of the home, a large open room that was public to all. Several women, however, would also sit with the men. These women were the non-conformists of the nursing home, and they formed a sort of outer circle of the women residents' group. This outer circle, these non-assigned space occupiers or transgressors, were either confused or resistant to institutional and nursing rules and routine practices. They were outspoken and only joined the women's group when necessary (meal times); otherwise, they created their own private space. The following incident illustrates the (culturally) non-conformist nature and agency of these women.

One day I was coming out of the dining room and I noticed a male resident (who could not speak because of the damage he had suffered from a stroke) who had been placed sitting in his wheelchair at a strategic point in the foyer. A woman who also could not speak had been placed in her wheelchair at another spot in the foyer, but a spot with a more limited view than the one occupied by the man.

The space that the man was occupying was public and strategic. He could easily see people who came into the home from outside, the dining room and kitchen, half of the residents' rooms, and part of the room where the activities were taking place (μεγαλη σαλα). The

woman indicated to me by hand movements and the voice sound 'ti ti ti **TI TI TI** ti ti ti ti' (by this time I had learn to know what she was saying by the different tones of her voice). I understood that she wanted me to push the man on the wheelchair to the activities room, because he was lonely. I went to the man and asked him whether he wanted to go to the activities room where all others were. He looked at me and smiled. I thus assumed he wanted to go to the activities room and took him to join the other residents.

I went back to the foyer to join staff who were having a discussion in the nurses' office. As I walked into the foyer, instantly, the woman called to me, hurriedly indicating to me that she wanted me to push her wheelchair to the spot the man had previously occupied. I then realised that I had been tricked by this woman. She had engendered my sympathy towards the man so that I would remove him and so that she could then occupy the strategic spot in the foyer.

This particular woman I observed was a very private person. She did not mix with the rest of the residents, did not attend activities and rarely stayed in the company of others. She knew everything that was going on, however, and she had worked out the personalities of all the people working in the home and used it to her advantage. This resident always ensured that she would occupy central viewing spaces in relation to current activity. She resisted nursing home routines and had developed strategies to persuade staff to overlook restrictions imposed upon her by the powerful forces of the nursing and medical disciplines.

Examples of other activities

Other activities and events that I observed and at times participated in included interactions between staff and residents' relatives, and staff interactions with medical and other health care professionals as they visited or were asked to visit residents.

For example, the son of a male resident came one day to the nursing station were I was sitting with the Charge Nurse of the shift. The son wanted to know why the night staff had removed his fathers' pants and left him in his bed with only a pajama top. He sounded extremely distressed and angry. He added that this may have been

the reason why his father was wandering at night. (His father had been found in different residents' rooms on some nights. Residents were complaining about his behaviour. The staff apparently had informed the son of his father's behaviour, and about the complaints of other residents). The following interaction took place:

CN Your father is incontinent too often. We do not have adequate underpants and trousers to change him.

SON He has plenty of underpants and trousers in his locker. You also can put on him absorbing pads to protect his pajama trousers from getting wet. Why did this not happen at the Australian nursing home he was before?

CN Your father's condition probably has became worse since then.

SON [Irritated and insistent] I want you to leave his pants on him at night!

CN [In a sarcastic tone] Why did you bring him to this home if it was so good at the other nursing home?

OK [I tried to indicate to her not to say anything else inflammatory by pushing my leg against hers as a warning. The son observed this and castigated me].

SON [Addressing me] I saw what you did and you should not try to trick me and throw ashes in my eyes. I know what is going on. [He was intimating that the night staff were too lazy to change his incontinent father]. I brought my father in this home because of the Greek language and culture. Taking off my father's trousers and underpants is so wrong, unnatural. My father did not even take his underpants off on his wedding night. I do not want his pants removed, even if he is wet.

CN [Irritated] If we do that your father's skin will break down.

SON [Now angry] There are plenty of trousers for him for staff to use, and anyway, wet pants in the night are not so injurious to the skin as the day time.

At times unplanned spur-of-the-moment staff meetings would be organised on the direction of a Charge Nurses or the Director of Nursing to disseminate important instructions. I was present at many of these meetings. In one such instance, the Director of Nursing wished to inform the Greek personal care staff that they should learn to write English. She wanted them to document the care they were giving to the residents. The Director of Nursing asked the Australian Greek-born registered nurse present to interpret and to explain to them the importance of their learning English, and how she was expecting them to attend English classes out of work hours and without pay.

I experienced the discomfort and anger of the Greek registered nurse as she attempted to communicate this expectation to the Greek personal carers and tried to convince them that it was good for them to learn English. The Greek personal carers appeared extremely distressed and restless. Once the Greek nurse had finished delivering the official message, the staff commenced a heated *sizitisi* that progressed to *shxolia* about the issue.

Questions of exploitation, coercion, unfairness and unjustified demands were brought into the discussion. The carers also questioned how they could be expected to do things they were not trained to do. How could they be expected to learn English at their age, and in their own time and without pay? Didn't management realise that didn't have the time or the money? If it was so important, why had no-one asked them or invited them to learn English when they were young and when they could have learned? How could they learn now, at this stage of their life? It was a revealing moment that brought to light the immigrant experiences of these people, the exploitation and injustices they felt they had suffered in the past and which they were experiencing and feeling again - and in a Greek nursing home!

Such events would start intense and heated discussions, discussions that revealed many issues and concerns as well as conflicts and tensions among staff and between staff and management. During these times of discussion *(sizitisi)* and critical debate, participants would interpret events from their own frames of reference, and

would debate the issues that concerned them whilever they felt their full impact. I would be involved in these debates and, often, I had to gently arbitrate in order to resolve points of contention or to help in the progression of the discussion. This I had to do with extreme care so that I was not seen to be taking sides. I was genuinely attempting to assist them in finding ways to change or at least become aware of what was happening to them or around them and whose interests it served. These issues always related to work situations and conditions, management's treatment of staff, staff relationships that clearly illustrated the existence of intracultural diversity and ethnic/cultural borders between groups and individuals in the nursing home, families, Greek community and residents' needs and behaviours.

This complex multicultural nursing home context, a social space where different groups were brought together, with different histories and common and individual experiences of ethnic, cultural, gender and class domination and oppression, and where unpredicted and spontaneous events and practices occurred, required me to be a flexible, contextualised and connected multisituated research participant, observer and subject.

I often used modified incremental strategic pedagogical interventions to advocate for certain changes to cultural practice that had been revealed to be disadvantageous to residents and/or staff. My habitus helped me to have insights into and an understanding of the different points of view that interplayed in the generation of the nursing home practices and processes. While my objective subjectivity/ intersubjectivity could be regarded as my weakness, it could equally be viewed as my strength in this ethnic project. I could easily recall and relive experiences of all field roles and thus found myself viewing events, practices and perspectives through different field positional lenses. I was able to critically reflect on such perspectives from the points of view of almost everyone within the nursing home that is, women, ethnic people, the non-English speaking unskilled migrant, the professional nurse and the nurse manager).

Nursing home life was embracing and magnetic detachment and distance was impossible. From moment to moment I could go from participant-as-observer to observer-as-participant, but only seldom, if ever, could I claim to be a completely detached observer. Indeed, several times when I tried to be such an observer I became the object of observation of my research informants/participants. In these instances I directly experienced, rather than only conceptualised, what Bourdieu (1990) calls 'the objectification of objectification'. Thus I became very aware of how the researcher influences and disrupts the field and how the field influences and embraces the researcher.

> For example, on one occasion I attempted to sit very quietly and unobtrusively in a corner where I thought I could not be seen easily by residents or staff during lunch. I wanted to observe and record the lunchtime practices and interactions of residents and staff. Not more than a few minutes had passed before I became fully aware that all residents and staff were watching me with curiosity and amusement. I found it an incredible experience to become aware that I had become the object of their observation as I was observing them. I was forced to objectify myself, and view myself as an object, as I was objectifying them and, with this awareness that they were now observing me, I turned back to observe my objectification of the field itself, the object of my research. The research field changed in front of my eyes. The researcher participant's influence in the field became extremely clear to me for this brief moment. It was clear to me that a researcher cannot be detached, disconnected and objectivist in the field without distorting social practices in the field. The researcher and the research field are interconnected and influence each other as they exist and act in the same time and place and epistemological frame.

Staff and residents had incorporated me and my presence and behaviour into their experiences and practices, as I had incorporated their presence and behaviour into my experiences and research practices. We were intertwined in the field within a complicated and non-transparent aged care and aged health care practice context, mediated by the different and diverse peoples' habitus within and by the larger society's cultural, socio-economic and political forces without.

Now, individual staff members would call me to join them for Greek coffee. If I was involved with a resident or something else and could not go at that particular time, they would show their disappointment. Every day I was at the home I would have two tea/coffee breaks and two meal breaks on a shift, with staff as they took their breaks. On some days I would have extra breaks with individual registered nurses and domestic staff. These breaks had become the regular time when formal group discussions were undertaken. We always had lively debates about problems and conflicts that staff had identified in previous discussions.

During these times I would also raise for discussion and reflection any additional problems or issues that had emerged in different individual interviews and from my field notes. I would also gently challenge underpinning assumptions that appeared to be taken for granted and ask them to consider the underpinning assumptions of practices that were considered 'normal'.

During this phase of my research due to some unexpected events that occurred, I was informed that the top management of the nursing home was questioning my research role[2] . Thus, when my

2 Management questioned the degree of my involvement with the staff and nursing home activities in the research process. I understood later they perceived research in some different way. I was informed that the Chief Executive Officer was asking members of staff whether they thought I was doing anything wrong or burdensome, or that would raise questions of ethics. I was also informed that he was looking for reasons that he could use to question the ethics of my research with the University ethics committee, so that he could justifiably ask me to leave the fieldwork. This information was verified when I asked to see the Chief Executive Officer to discuss the research process with him. He intimated to me his suspicions and concerns about my role. He also pointed out to me that he was informed that I was intending to go and speak about my findings to the Board of Directors. This was true as I had already discussed this with one of the Board members. It had never occurred to me that the Chief Executive Officer would want me to ask his permission prior to such a presentation. I had assumed that all management were insiders with had the same interests, as the Board of Directors hired and fired for the position of the Executive Chief Officer.

I also believe that the nursing home management (not the Board of Directors) started to feel uncomfortable and suspicious about my presence in the home after an article was published in 'Neos Kosmos (a Greek language newspaper) containing some comments I had made about nursing homes and nursing home staffing in general. My comments referred in particular to the lack of senior Greek registered nurses the Greek ethnospecific nursing homes, and argued that it was most important to have staff in those homes who had been prepared in transcultural nursing. These

fieldwork was at an end I was relieved that I had finished gathering data and that I was now free of the possibility of being incorrectly implicated in events I had nothing to do with.

Phase IV - Risk-taking in giving feedback to management and in critical reflection

By the beginning of 1997, my fieldwork had become more intense, continuous and selectively focused. Issues, problems and sources of conflict and tensions identified by staff at all levels were now being used to formulate more focused and direct questions to bring to the group discussions and to individual interviews, particularly the interviews involving the DON and the General Care Services Manager.

Questions were formulated that reflected the problems, issues and concerns staff had identified and discussed with me as elements of the home culture and as sources of conflict and tensions. They related to:

(i) human interactions and power relations

(ii) the care of residents

(iii) professionals' expectations of carers as opposed to carers' expectations of professionals

(iv) working conditions,

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comments I have been making publicly since 1979. At the same time that my comments were published, several anonymous complaints were also published about the care of residents within the nursing home. Later on I found out that a complaint was also made to the relevant government department. The complaint contained information that would not be known to an outsider.

I expressed my disappointment to the Chief Executive Officer in regards to their mistrust. At the same time, offered, as I had previously done to discuss the research findings with him. He did not respond, and he warned me not to discuss my findings with the home's Board of Directors without his knowledge. This I never intended to do. Members of the Board of Directors indicated an interest to hear my findings. Subsequently to this encounter, I was extremely nervous and felt the coercive pressure of surveillance and scrutiny like a knife resting on my throat.

(vi) time management

(vii) food and residents' exercise

(viii) educational opportunities and requirements for advancement

(ix) employment procedures and practices. I believe that most of the issues that the staff were concerned about were made known to the relevant management personnel by this oblique method of referred questions. This, of course, as mentioned earlier, had affected my relationship with management and had caused managements' loss of trust towards me. It also indicates how closed systems can feel threatened in exposing themselves to 'outsiders'.

I arranged to interview the Director of Nursing and the General Care Services Manager for the fourth time and, on this occasion, I took the opportunity to discuss with them specific issues that staff on the floor were concerned about or perceived as being unfair and exploitative. It was most important for me here to ensure that individual staff members could not be identified, only their concerns in general. At this interview both the DON and the GCSM also challenged my perceptions and understandings, and we went on to discuss ways by which some practices could be improved.

I raised these questions and issues only indirectly in an attempt to introduce to them those concerns which I thought, by their knowing, would help them in their future decision making. I used this strategy because, by this time, I considered direct discussion with management to be beyond the level of reasonable risk for staff and myself. I thought that such a direct approach might do more harm than good.

Other managerial staff had also been interviewed a number of times; but now the interviews were more strategic. They were strategic in the sense that problems identified by staff and residents and could materially be substantiated were now turned into questions and brought to the interviews. These interviews were intended to inform nurse managerial staff indirectly how staff and residents were experiencing the nursing home culture.

In addition, the questions were posed in a manner designed to instigate a reflective process in the interview, to stimulate reflection by presenting in question form some of the issues that concerned staff (e.g. they way they felt they were being treated, employment practices and so on). By responding to these questions, management revealed aspects of their social reality that helped explain some nursing home practices and also verified the congruency or incongruence of understanding between different members of staff. For example, a question about whether the president of the Board of Directors thought it appropriate to employ non-Greek or non-English speaking personal carers because they were deemed to have more skills than Greek-speaking staff revealed that different interpretations of policy existed among managerial staff. Indeed, Greek management did not seem to consider that Greek-speaking staff should be members of nursing home staff selection committees, nor did they examine how such policies were or could be made ethnospecifically relevant in application. They had left such decisions to nurse managers.

To present the president of the Board of Directors with a different perspective of the home's managerial structure and to stimulate reflection, I asked whether he thought that Greek staff had the same power to make decisions as ESBID staff, considering the asymmetric distribution of power within the institution because of the types of staff positions the different groups held. The president's body jerked as if in sharp awareness of the issues relating to this question; it was as if he had never really thought of the nursing home structure in this way. He responded thoughtfully, and he affirmed, 'It is an interesting question. Yes it is true that there is differential power and that it can be exercised differentially'. I also asked him to inform me of the selection criteria used to employ staff in the nursing home. This was one of the questions that I asked various people during interviews. My purpose was to cross-check the information I was gathering, both to verify accuracy and to gain access to perspectives in relation to different positions within the institutional hierarchy.

While during the course of my fieldwork I had spoken with many relatives of residents informally and during this phase I also

formally interviewed a number of them. These relatives visited the nursing home regularly and for many hours at a time and we had formed firm relationships of familiarity. I considered such relatives to be well informed about staff and nursing home practices.

During this phase I also arranged to meet Greek-born staff outside the nursing home. These meeting were planned for the purpose of discussing, debating and reflecting on the final account of the research findings. These meetings did not take place, however, because of time limitations and difficulties associated with gathering staff together in groups outside the nursing home.

Preparing for field work closure

As the time was approaching for me to complete my fieldwork, I began informing members of staff, residents and relatives of my finishing date. Many staff and residents expressed regret and asked me to go back and work with them or keep visiting them. They expressed how they had perceived me in my role, and their perceptions corresponded with my own. I believe that one member of staff expressed how many other staff had perceived my research role when she said to me, in her statement ['We were like raw fig and you helped us to ripe, day by day, with your presence, your behaviour and teaching-like a figs that day by day becomes more ripen. We are sad you are leaving us']. For nurse managers, I had been more involved in the research process than what they had expected. Their expectations of a researcher were those which conformed with the detachment and distance from the field characteristic of more positivistic research approaches.

The day arrived when I had to leave. Residents and staff surprised me by holding an afternoon party for my farewell. They presented me with a beautiful bunch of flowers, and a resident and staff representative each made a speech to thank me for having been there, for being interested in them, for entering their hearts, and for being their friend. Finally, staff and residents reminded me that I had to write the 'truth' about the nursing home.

Reflecting on my fieldwork experiences and their effects on me

I felt warmly connected and sympathetic with all groups of people at the nursing home, including the managerial staff, of whom most were registered nurses and women.

Generally speaking, I also felt great joy and satisfaction in having experienced a Greek environment as someone who spoke and understood Greek, and in having experienced a feeling of belonging with most of the people who worked and lived in the nursing home.

I felt I understood the situations of all groups of staff who worked in the home. And most of all, I believed I could understand the problems and complexities associated with having linguistically and culturally different people as members of staff in a Greek ethnospecific environment. I felt, too, that I could understand the difficulties and problems arising from having a trained and untrained workforce working in a highly complex aged care and aged health care institution and under the unfavourable economic conditions produced by economic rationalist policies and practices. I understood management's dilemmas and difficulties as well as those of the 'floor staff'. I felt many deep emotions with regard to the residents' life in the home, but also left the field with a sense that at least residents were humanised in a Greek historically embedded cultural and linguistic sense.

Witnessing, as I had, events unfolding in the home, many times my sympathies and compassion as well as anger or rage would shift from group to group or from individual to individual as, informed by past experience, I realised they could have done this instead of that. These feelings, while at times powerful, I always tried to control or mask. The energy and effort required for me to do so often left me exhausted. Some events that I witnessed depressed and/or angered me so much that, at times, they made me feel hopeless. Thus, even though I am generally optimistic, my despair overwhelmed me at times and I felt its weight. At these times I would cut short my fieldwork and give myself space to reflect upon my feelings and to consider events critically and calmly. This gave me enormous

insight and motivation to raise critical questions and pose them to relevant people at the nursing home on my subsequent fieldwork visits.

I experienced many kinds of emotions and feelings, I had forgotten. These emotions and feelings made me recollect many of my past experiences, which reminded me in turn of the situations the people who worked and lived in the home were now experiencing, and this caused me unbearable pain and suffering. I believe this pain and suffering was intensified because I could see ways of changing things for the benefit of all involved but was incapable of doing so as a researcher. I could only gently suggest and raise awareness.

I had experienced a very complex, diverse environment. I had felt the joy and elation of being with the aged people who reminded me of my parents (as the carers did also) and those old times back in Greece. Equally, at times I felt a deep pain and despair for their predicament, and, at other times, a cold iron hand gripped my heart and I would feel like I was suffocating because I could see that my sisters and brother in Australia, and myself would soon enough be in the situation that the residents and relatives were in now.

Many times I had to leave the field with severe headaches. I experienced many exhausting and emotionally draining days in the field. As indicated above, towards the end of my fieldwork, I also experienced pressure and the coercive weight of power over me from the most privileged in the nursing home. Several people from management attempted indirectly to silence me and to interfere with the process of my research. This was because I was not, nor did I claim to be a detached, disconnected researcher. This would have amounted to self-deception and to a kind of dishonesty would have contributed to the distortion of my findings. Feelings are essential in a number of ways, as Hochschild (1983:31) writes: '[W]e need feelings in order to reflect on the external or "objective" world. Taking feelings into account as clues and then correcting for them may be our best shot at "objectivity". Like hearing or seeing, feelings provide a useful set of clues in figuring out what is "real".'

CHAPTER FIVE

A DESCRIPTIVE VIEW OF THE GREEK NURSING HOME

Introduction

I begin by establishing the geographical location, as well as the exterior and interior detail, of the Greek Nursing Home, to convey a sense of 'the cultural context' in which the home is located, and the distinctively 'Greek' cultural environment that is encountered upon walking through the doors. I argue that the distinctively Greek character of the home's cultural environment is crucial to providing residents' with the sensory stimuli necessary for promoting in them a sense of well-being and 'quality of life'. When Greek-born elderly are deprived of such stimuli they are at great risk of suffering the adverse effects of what is known in the aged care literature as 'sensory deprivation' and loneliness (Garratt, 1999). This chapter seeks to demonstrate the distinctively Greek 'sensory stimuli' inherent in the home under study.

Regrettably, for reasons of confidentiality, it is not possible to include a photographic account of the home since this would render it immediately recognisable. Some other important details about the nursing home were omitted for the purpose of avoiding its recognition.

Geographical location of the Greek nursing home

The Greek nursing home is situated in an outer Melbourne suburb comprised of residential, manufacturing and business districts. The business district, is vibrant, cosmopolitan and multicultural in nature.

The home is located within what might best be called a middle-class residential area. This area is characterised by a high concentration of Greek-born people. In 1996, the Greek-aged in

this area constituted 5% of the total population of aged persons 65 years and over (Tsingas 1998). Most of the residential homes in the area are built of brick and are surrounded by established gardens.

The character of the area surrounding the home is enhanced by the presence of a variety of Australian native trees and shrubs. Despite the presence of residential and other buildings, the sky-line is not cluttered with structures characteristic of inner city living; so there is a sense of 'openness' and freedom about the area - as if one is 'in the country'.

There is a small shopping centre near the home which residents and staff can access easily. There are also two Greek Orthodox churches in the area, although they are too far away from the home to be accessible by foot. Residents wishing to attend church services, therefore, need to have transport arranged. In the case of ambulant residents, car transport can be arranged; in the case of wheel chair-dependent residents, special buses can be arranged.

External environment of the Greek nursing home

The home is made of brick, and has been built longitudinally across the section - extending from the main street running in front of the home, to the middle of the land site. Access to the nursing homes' car park and entrance is gained sideways from the main street.

The front of the home is separated from the main street by a garden of native and deciduous trees, as well as flowers. The aroma and sight of the flowering garden during spring vividly stimulates the senses. In addition to this, there is a large area above and alongside of the front verandah of the home in which potted plants are grown. Often - particularly during spring, summer and autumn - staff, residents and their families are seen sitting on the verandah while they are having their Greek coffee and/or a meal - fully engaged in conversation, enjoying the view, and searching the street with their gaze for signs of human activity. This sight is reminiscent of scenes in Greece, where, both

in the past and currently, it was/is very common to see people sitting on their home verandahs or yards (*αυλυ*) surrounded by well-kept gardens, relaxing, observing the outside street activity.

In addition to the variety of native flora and other recreational facilities a large vine-arbor (*κληματαρια*) grows interwoven along the front side of the nursing home. This vine-arbor not only provides ample shade from the summer sun, and edible grapes, but also tender leaves that can be (and are) often used in the home's cooking. Specifically, they are used to make the very common Greek dish *dolmades* (vine leaves stuffed with rice and/or mince). The meaning and significance of the *κληματαρια* warrants some explanation here. *Κληματαρια* are commonly seen adorning the court yards of Greek residential homes in Greece (they are also a characteristic feature of the residential properties inhabited by Greek-born Australians living in Melbourne). Supported by poles, the *Κληματαρια* usually forms a bed-like overhead cover (*κρεβατινα*) that provides shade from the burning summer sun. In Greek culture, the *Κληματαρια* is a powerful symbol representing home, family life, sharing, warmth, comfort and hospitality. Its shade and fruit also literally 'attracts company' (*παρεα*). Thus, the mere sight of the plant evokes familiar cultural meanings and emotions to Greeks. This is illustrated by the following comments of an informant:

> As we drove through the entrance of the [Greek nursing] home, my husband and I were so surprised to see a building that resembled more a modern hotel than a nursing home. My husband was so happy and enthusiastic about what we were seeing that I felt the heavy weight that was burdening my heart lift a little. And as we saw the vine-arbor (*Κληματαρια*) interwoven along the whole side of the front of the home, we thought this is a 'Greek Nursing Home'! We said, 'We will even be able to seat with company in summer and share eating grapes'.

Side walk-ways to and from the home have well organised gardens; incorporating spacious areas in which people can sit and relax. There is a built-in barbecue, tables and seats scattered through the external surroundings of the home which residents, families and staff can easily access. The barbecue facilities are often

used on special days - for example, celebrating residents' 'name days' and birthdays, and days of national and/or religious significance. Occasionally, relatives like to organise a day barbecue to celebrate important family events with all residents and staff.

Strategically placed and carefully constructed patches of flowering shrubs add to the overall grace of the home as it nestles among other larger colourful and vivid green shrubs and trees.

The home's garden provides flowers which the staff often collect to decorate the resident's dining tables. Flowers and shrubs from the garden are also used in 'emergency' situations, for example, to enable residents and staff to expresses their condolences and final 'good byes' to a resident who may have died. Often, as part of an organised funeral procession, the coffin of a deceased resident pass briefly via the nursing home to enable residents and staff to say good bye and place flowers on the coffin. If, for some reason, staff in the nursing home have made no preparations, staff can still improvise by collecting flowers and quickly forming a bouquet to be placed on the deceased resident's coffin to accompany her/his body as it is transported to its final resting place.

Internal environment of the Greek nursing home

The home accommodates thirty residents. Its internal structure comprises residents rooms (located in two wings an east and west wing), and five different sized public rooms or 'spheres', which are commonly used by residents and staff alike; these 'public' rooms include the *foyer*, the dining room (*τραπεζαρια*), the activities room (*μεγαλη σαλα*), and the television room (*μικρη σαλα*). In addition to these rooms, there is the kitchen and food serving areas, a staff room, a utilities room, a cleaners' room, and some offices. Significantly, there is no specific room according privacy which residents and their relatives could use.

(a) What is seen

In several respects, the interior architecture of the home resembles a 1980s hospital ward. Residents' rooms have large windows overlooking the gardens. All doors to these rooms open

outwardly into two wide and spacious central corridors. These corridors separate the residents' rooms from the central structure of the home where all utility rooms are located. Wheel chairs, trolleys, and people walking two or three abreast can easily move through these corridors. The corridors are all fitted with wooden rails against which residents can support themselves, if required, when walking. Few residents use this support, however, as most of them are wheel chair bound.

(i) The foyer of the nursing home

The entrance to the home is a large open foyer. This room is the centre of the nursing home, and is the most public place. The foyer separates the east and west central wings of the home; two other (and obvious) entrances from this room lead to the dining room (*τραπεζαρια*) and television room (*μικρη σαλα*). The two corridors leading to all home's rooms (including the residents rooms) also begin and end in this room.

On each of the respective western and eastern sides of the room, there is a wooden partition - both approximately one meter in height. Behind the partition on the west wing side of the room sits a young female receptionist. She operates the telephone 'switch board', and using either the Greek and/or English language, attentively welcomes people who enter the home. Behind the partition on the east wing side of the room (which stands directly opposite the telephone switch board) is the nursing station. Someone (usually a registered nurse) is often seen sitting at this nursing station.

The ceiling of the foyer is high; this creates a feeling of 'open space' - similar to that experienced in a Greek town or village square (*platia*). Indeed, the foyer of the home can be compared metaphorically to a *plait*. In Greek towns and villages people would gather in the *plait* (plaza) at certain times of the day, to relax and share drinks and coffee with others, to have a chat, and to generally pass their time. In these locations, other community and celebratory activities would also take place.

In the *plait* of the home, residents also 'sit about' (mostly in their wheel chairs, arm chairs and recliner chairs) to chat and to pass time. At times, the home's *plait* is teaming with life since it is the place where most residents, visitors and staff interact. Almost all conversation is in Greek. Visitors often 'drop in' unexpectedly; known by almost all the residents, they are greeted warmly and asked about their health. Often, if staff are not in sight or available, residents ask any visitors to do certain tasks for them; visitors respond without hesitation.

As well as being spacious, and central to the home, the foyer is decorated with items that are distinctively Greek in nature adding to the 'Greek feel' of the home.

(ii) The dining room (τραπεζαρια)

The south wall of the foyer has a large double wooden door that leads into the *τραπεζαρια* (dining room). The room is long, but wide enough to easily accommodate tables, residents with wheelchairs, staff, and relatives. The room is bright and bathed with light.

There are a number of tables purposefully 'scattered' along the room. The tables are covered with a thick plastic multicoloured material. This material does not stain, and is easily wiped clean with a cloth. Prior to 1997, it was common for a small vase of flowers to be placed on the tables. Occasionally, salt and pepper shakers maybe placed on the tables.

On the north wall of the dining room hangs a large piece of paper displaying photographs of a variety of articles, for example, glasses *(γυαλια)*, a chair *(καρεκλα)*, a bed *(κρεβατι)*. These pictures are all labeled with their Greek names and in English. Next to these pictures are smaller pictures depicting a variety of art works and flowers. Like the residents' bedrooms, this room is dominated by religious icons, which I shall discuss later in this chapter.

At the east wall of the dining room there is a long bench. On this bench is placed a communal radio-tape recorder. There is also space for other articles or objects. At the south wall of the dining

room there is a double door with glass that opens onto a side garden. At the west end of the dining room is the kitchen and food serving area, considered below.

(iii) Kitchen (Κουζηνα) and food serving area

Immediately through the door of the kitchen stands the kitchen sink and a dish washer. Kitchen utensils and cutlery are located under the kitchen benches. Baskets containing bread, cakes and biscuits rest on a trolley covered with tea towels. These food items are for distribution to the residents during meals times, specifically to have with their Greek coffee.

To the right side of the kitchen door is located a serving window, next to which stands a microwave oven. This oven is usually used for preparing quick snacks for residents, or for warming residents' meals.

Morning and afternoon coffee, and evening supper, are prepared in the kitchen. The residents' main meals are, however, prepared in a different building for collection by domestic staff and transferred to the kitchen for distribution.

Food stuff such as milk, natural yogurt, olives, Greek coffee, and dishes prepared by relatives, and which residents might request, are kept in a refrigerator. For example, a resident who loved a variety of boiled grass (*χορτα*) had his 'χορτα' made available from the refrigerator at least three times a week. His children ensured that he had a constant supply of this food. Domestic staff would warm his *xorta* in the microwave oven and add it to his plate as they served him his meals.

The kitchen is, however, out-of-bounds to the residents and other staff. These boundaries sometimes cause tension between personal carers and domestic staff who prefer to have control over 'their' kitchen space.

(iv) Television room (μικρη σαλα)

On the north side wall of the foyer is the entrance to the television room or *μικρη σαλα*. This room is named by Greek staff as the 'small drawing room' or *μικρο σαλονι*. Other staff called the room the 'TV room'.

The room has a large open entrance-way measuring almost the full width of the room. Because of the size of this entrance-way, it is possible to fully survey the inside the *μικρη σαλα* from the distance of the foyer, that is, without actually entering the room. There is a large glass window at the rear of the room; from this window it is possible to gain a full view of the home's garden and car park. Heavy curtains adorn this window and, when pulled back, bright light of the day fills the *μικρη σαλα*.

The only objects contained in this room are: a television set with video equipment situated on a table with shelves and glass doors. A stack of Greek videos are visible through the glass doors of the video table. A bunch of artificial flowers sit on top of the television.

The room is large enough to accommodate about a dozen residents in a semicircle of wheel chairs, with their chairs placed tightly next to each other. At times, the close proximity of the chairs causes tension between residents.

Residents commonly go to the *μικρη σαλα* in the afternoons to watch television; they also go to the room when there are no other activities programmed. After 4 pm, women residents usually gather in the *μικρη σαλα* to talk and to watch television. Men, on the other hand, tend to sit in the foyer where they are sometimes joined by women who did not particularly belong to the *μικρη σαλα* group.

The *μικρη σαλα* is the only space where residents were left alone and thus able to converse as a group with little interruption.

(v) East wing of the home

The east wing of the home commences in the foyer of the nursing home beyond the nurses' station. A short wooden partition distinguishes the area constituting the nurses' station. Behind this partition is a long bench and working area. A number of chairs fit easily in this area; staff have space to gather together during change-of-shift to receive hand over information and/or to move about. Documents are spread over the bench, and the telephone often rings heralding inquiries. A rear wall separates the utility room from the nursing station. On this wall, staff rosters (working hours and days) are posted.

The nurses station is a highly visible and public space. Staff, residents, and visitors often are seen behind and in front of the station talking, inquiring, and at times sharing sweets, drinking and/or Greek coffee. While a wooden boundary separates the space of the nurses station from the foyer, often visitors and relatives are seen behind it conversing with staff. This was not unnoticed by Australian-born staff, some of whom viewed it as an encroachment. One Director of Nursing, for example, commented: 'They (the Greeks) have no boundaries; they come into the office, they use the resident toilets, and they tell you it does not matter'.

Behind the nurses' station is the 'clean' utility room. Narcotic drugs, a trolley containing the residents' prescribed medications, records, thermometers, blood pressure machine, and other medical instruments including a free standing and readily accessible oxygen cylinder, with suction equipment, are all stored in this room. The room is also fitted with a basin, a wall-held liquid soap dispenser, disinfectant, and towel holders ready for use. This room can be locked, and staff keep their wallets and other personal items in this room.

Behind the 'clean' utility room a row of utility rooms follow with the east wing ending as the wall of a room horizontal to the east wing the *μεγαλη σαλα*.

(vi) Activities room (Μεγαλη σαλα)

The activities room or *μεγαλη σαλα* is situated in the front of the home, and lies horizontal to the home's longitudinal structure. It has large windows and glass doors - all of which lead to the home's front verandah. From the verandah, the front garden area of the home together with the main street on which the home is built stands in full view.

The *μεγαλη σαλα* contains a television set and video recorder (both situated on a wall-attachment), and a radio. The radio sits on a bench-top at the side of the room and often plays - whether or not there are people in the room. A small casino gambling wheel is also situated in the room, standing visible to all in a corner. The walls of the *μεγαλη σαλα* are decorated with art work, drawings, poetry, words of wisdom, and parables written by the residents; these works are inscribed with the residents' first names.

The room has tables that can be joined together to became one long table, reaching from one end of the room to the other. Residents in wheel chairs are able to sit around this table and participate in a variety of daily activities. This room is constantly occupied by the residents and daily residents activities are undertaken in this room from 9 am till 4pm. Other general events of a celebratory nature often take place in this room. Sometimes staff and relatives join together to provide entertainment (for example, mock weddings) for the residents. Other times, entertainment occurs on the spur of the moment. For example, even during the busy morning or afternoon periods of the home's daily activities, it is not unusual for residents and staff alike to suddenly start dancing and singing in response to tantalising Greek music playing on either the radio or television. Afternoon tea parties are also held, with ample sweets, cakes and drinks being provided for all. In sum, both planned and unplanned activities take place in *μεγαλη σαλα*. The room is usually full of wheel chair-bound residents, from nine o'clock in the morning until midday, and then again from one o'clock in the afternoon until about 4pm.

(vii) West wing of the home

Like the east wing of the home, the west wing also commences in the foyer of the nursing home. The switch board is located at the head of this wing. Behind the switch board a row of utility rooms follow ending in a wide horizontal corridor.

This corridor contains a number of chairs and a public telephone. The position of the telephone is such that a reasonable degree of privacy for residents or staff making a phone call is assured. People using the telephone are not easily heard or noticed.

(viii) Staff room

At the end of the west wing is the staff room. The staff room and toilets are separated from the central structure by a corridor running horizontal to it.

The size of the room is reasonably large, and can easily accommodate five to ten people at any one time. There is a table with chairs in the centre of the room and, on the left hand side of the room, a sink and a cupboard with draws. Greek coffee, and utensils for making this coffee, are kept in this cupboard. Other types of coffee, sugar, cups, cutlery, dish washing liquid and tea-towels are also kept in the cupboard and draws. Next to the sink is a refrigerator - in which a supply of milk and other drinks and food are kept.

Staff notice boards are located on the walls of staff room. A variety of information is found on these boards. For example, information about occupational health and safety is given in English; information about carers 'duty for care' is also provided in English, and other general notices and information. Occasionally a short (usually laconic) message written in Greek can be found on these notice boards. Above the sink a notice, written in Greek, has been placed to remind staff to 'wash the cups and leave the sink clean'; it reads *(Πλυνεται τα φλυζανια σας και αφηνετε το νεροχυτη κατθαρο)*

(ix) Other rooms

At the west end of the home, behind the resident rooms, and to the left of the centre structure, there are several offices. These offices are occupied respectively by: the Director of Nursing, the social worker, and other personnel involved in activities outside the home - including a Greek-born founding member of the nursing home who is involved in activities that promote community relations. There is also a large bright room used by the co-ordinator of fund raising and volunteers. This room is large enough to hold parties, gatherings and dancing events.

Adjacent to the office area is a large room with physiotherapy equipment and movable walking rails. Although this room is suited for rehabilitation activities, it is rarely used for this purpose. During 1995, a Greek-speaking physiotherapist was employed for several days a week, and offered a variety of exercises to residents. Later, however, his services ceased and he was replaced by a multi skilled masseur.

(x) The residents rooms ('private sphere')

While some residents occupy a single room, the majority of the 30 residents are in shared rooms of either two or four people. The size of the rooms varies according to whether they house one or more beds. The rooms are large enough to enable residents to move about comfortably.

All rooms, except one, have large windows and are bathed with ample light. The room with no windows has four beds. The beds in this room are reserved for - and are mainly occupied by - residents who are semi-conscious, unconscious or non-communicative; residents in this room are totally dependent. All rooms have vinyl floor coverings, and are always clean and tidy. Untidiness is evident only during times when staff were fully engaged with providing care to residents' and preparing them for the day.

All rooms have ceilings fans[1] that can be used to cool residents' down on hot days, and a water heating system for heating them up on cold days. During my field research, however, I realised, that while heat control was very important for the residents, the fan cooling system also caused them some anxiety. They would frequently ask for the fans to be turned off - even on days where the temperature was 40 degrees or more.

Each resident has a locker and a closet allocated for their personal items. They were provided with an over-bed table, and at least one bed-side chair for visitors. Some residents also have a television and/or a radio for their use. There are no wall mirrors. Residents also have a space on the wall either above or opposite their beds in which to house a small shrine. As well as containing Greek saint icons, these shrines carry precious family photographs - for example, of their own and other family member's weddings, children, grandchildren, siblings and friends (both in Australia and in Greece), and other special events (eg graduations, family parties). Upon viewing these photographs with residents, it is possible to gain a fleeting glimpse of the residents' major life events and processes experienced both in Greece and Australia.[2] Family and God thus featured prominently in the residents' rooms. Walking into these rooms, I could not help but think that,

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1 During my field research conducted over the 1997 Christmas period, I became aware of the degree of concern that the elderly residents had about the fans. The weather at this time was hot and dry, with daily temperatures over 40 degrees celcius being recorded. The heat in the home was stifling, and staff resorted to turning on the fans and opening the doors for fresh air to circulate. During this time, however, I was constantly asked by residents to turn off the fans and close the doors. In making these requests of me, residents expressed concern that the draught created by the fans and open doors would give them a cold. They would explain to me: 'We are now old, and our bodies are very vulnerable. We have to be extra careful to avoid illness. Wind that blows directly on us is no good'. Consequently, fans in the residents' rooms were rarely turned on, or, if they were, tended to be set at a very low speed. Alternatively, residents would simply be moved to a cooler room.

2 Photographs of residents taken at the nursing home were also on display. Sometimes, viewing these photographs would be a very emotional experience for residents. For example, in the year I undertook my field work in the home, I took photographs of the residents during the Christmas celebrations I attended. Later, I viewed some of these photographs with a resident who had been at the home about six months. Upon looking at herself in the photograph, she suddenly started sobbing. I asked her why she was crying. She replied: 'Look how I have become. How I was, and how I am now'. As there were no mirrors in the nursing home, this was the first time the resident had seen herself after her illness and admission to the home.

in the final analysis, what mattered most to the Greek residents' were their families and their God.

Residents' rooms constitute the most 'private sphere' of the home, and largely (although not always) represent a 'private space' for residents. Staff, however, still have the prerogative to walk into a resident's room at any time - even though such intrusion is usually heralded by a knock on the door to announce their arrival. Perhaps the most private space for residents is their bed, the bed-side table, and their closets. Nevertheless, even these areas are not free of intrusion by staff. Staff frequently cross the boundaries marked by these items as they attend to the care needs of residents. Despite these intrusions, however, residents' rooms constitute the most private place that residents' and their families can retreat to within the home's domain.

Interior decoration of the home

(i) Greek Orthodox religious presence.

Shrines containing Greek saint icons and an electric candle (*κανδηλι*) are carefully and strategically placed around the home: above or opposite the beds of all residents, in the dining room, adjacent to the kitchen, and in the activities room. The *κανδηλι* can be lit at any time.

Originally, the *κανδηλι* comprised a special glass in which burning oil and a wick was placed. The κανδηλι would be lit at sundown on a Saturday and kept burning throughout the week. For obvious fire safety reasons, this type of κανδηλι is not used in the home. Instead, an electric candle is used.

In the dining room, there is a large picture of a saint's head. This picture is labelled GREECE. In addition to this large picture, and dominating the dining room, are two large religious icons representing the Last Supper; these icons hang respectively on the east and west walls of the room. In Greek Orthodox tradition, Last Supper iconography symbolises family union, togetherness, and desired family harmony. Family union at meal times is most desirable in a Greek household, and everything possible is done to

bring all family members together at the dining table during meal times - although this practice is declining. Significantly, icons representing the Last Supper also hang on the walls of the *μεγαλη σαλα* (activities room) and the staff room.

(ii) Other significant paintings and objects

The 'public spheres' of the foyer, *μεγαλη σαλα*, dining room, and the long large corridors are all decorated with a variety of paintings. These paintings depict Greek places, ancient Greek buildings and art, a well as Australian art. For example, in the foyer there is a picture of the Parthenon (Acropolis) standing symbolically in reverence to ancient Greece; the Parthenon is the honour and pride of today's Greeks. Near this painting is a framed collection of photographs of the residents - taken during certain celebratory events. A modern picture depicting a boat on a stormy sea hangs on the opposite wall. The corridor walls are also decorated with pictures depicting a diversity of scenes, for example: a landscape, a Greek island clearly marked 'Kastelorizo - Greece', and a hand embroidered picture depicting an ancient castle and several chariots driven by ancient Greek horseman.

On the shelves created by the wooden partitions of the nurses' station and switch board are placed a variety of objects: statues of Aphrodite and Apollo, vases representing ancient and modern Greek art. In addition to these items are cards, flowers and modern art works - such as a figurine of two birds kissing tenderly.

Located in the foyer near the nurses' station is a display cabinet made of wood. In this cabinet are displayed: crystals glasses, expensive plates, and other aesthetic articles. Such cabinets are found in most Greek homes usually displaying wedding gifts of the couple.

A blend of ancient and modern Greek artefacts–together with the Greek Orthodox religious icons–all contributed to a distinctively 'Greek' feel about the home.

(b) **What is smelt**

The home, on entry, looks and smells clean. Human frailty and disability inevitably leads to loss of body control, and 'accidents' (incontinence of urine or faeces) can occur, producing unpleasant odours. The home, however, is free of such odours.

During the day (particularly at morning and afternoon tea time), the smell of Greek coffee permeates the atmosphere. This (Greek) coffee has a very distinct and strong smell. Domestic staff prepare and serve Greek coffee to the residents. Residents eagerly wait for their coffee, and if for some reason the domestic staff are a little late, the residents call out loudly to ask what has caused the delay. Staff (including those who are Australian-born) also prepare and drink Greek coffee at morning and afternoon tea time, as well as at meal times.

It is important to note here that Greek coffee symbolises not only relaxation, but marks a way of life. For men it signifies and brings back memories of company, *(παρεα)*, playing of backgammon *(Ταβλι)*, and of conversation *(συζητησι)* in small coffee houses *(καφενεια*) located in town and village squares. For women, Greek coffee brings back memories of the company *(παρεα)* of neighbours and friends, exchanging stories, and 'reading' each other's coffee grained cups to tell their future. While conducting my field work, I observed staff approaching residents on a number of occasions to 'read their coffee cups'. Greek-born staff would also read each other's cups. Australian-born members of staff have learned this practice, and often ask their Greek-born co-workers to read their cups.

Meal times also result in a rich aroma that is distinctively Greek permeating the atmosphere; this aroma also reflects the variety of meals that are prepared for residents in the home. Common Greek style dishes include: meat balls, mixed grill and grilled potatoes, okra and potatoes, olives and fetta cheese, roast pork and potatoes, pasticcio, roast beef with potatoes and mixed vegetables, giouventzi with chicken, gemista, augolemono, Greek salad (offered daily), moussaka, stifatho with beef and potatoes, fakes,

chicken casserole, oven-cooked beans, continental sausages, lasania, a variety of sweets and ice cream, and so on. During meal times, the smell of cooked herbs (such as rosemary, oregano, basil, garlic, and onions) also permeate the home and gently stimulate the residents' appetite.

Residents of the home all love their Greek food, and eagerly look forward to meal times. The food provided is tasty and satisfying. Greek women prepare the food as they would at home, but with some modification. Salt, for example, is not added to the cooking. This omission is for health reasons; as a number of the residents suffer from a high blood pressure and heart problems and are required to restrict their salt intake.

(c) What is heard

Upon entering the home, an unmistakable variety of sound and associated activities is encountered: loud voices calling out - mostly in Greek, but also in English; laughter; exuberant (Greek-born) staff moving about freely, briskly, and communicating loudly with the residents and each other as they go about their tasks; shower water and toilet flushing sounds; wheel chairs pushing open and closing the doors; and above the din, distinctive Greek music playing on a radio and television, sometimes interrupted by the singing voices of staff and or resident or by someone else whistling a Greek tune. Taken together, these sounds are characteristic of the nursing home. Activity and sound vibrates everywhere, and if, for some reason, silence falls for a while, the residents became restless and anxious; to them, silence is a foreign and foreboding 'sound'. Overall, the residents are fully involved and aware of the sounds around them. If an unfamiliar sound intrudes, they quickly asked the staff (or me) to inquire about the sound and inform them accordingly.

Greek radio programs together with some English radio programs are heard throughout the day. In recent years, two Greek radio stations have operated in Victoria on a twenty four hour basis. On Sunday mornings, the Greek radio has a church service program, which the home tunes into; the sound of church *λειτουργια* (liturgy) thus fills the air on Sunday mornings in the home.

Although residents have their own radios, few listen to the *λειτουργια* alone. Instead, residents prefer to gather with other residents in the dining room (where the radio is on) and, as if a group in a church, respectfully listen to the *λειτουργια* together. As one resident commented: 'I know this is not a church, but I feel like I am in church when I am here listening to the *λειτουργια* with the others'.

Greek videos depicting Greek singers, traditional Greek folk dancing, and significant Greek religious ceremonies are often shown to the residents. In addition to this, the activity lady was investigating the feasibility of subscribing to 'Pay TV' so that residents could access two Greek stations directly from Greece. At the time of completing my field work, however, no decision had been made about this matter.

The noise of domestic staff working in the kitchen is also audible. The 'clinking' sounds of crockery and cutlery being moved about, running water, and vigorous conversation are all regularly heard coming out from the kitchen area. At times, residents would ask me to go into the kitchen to find out what was going on, and to come back and inform them.

Not all noises and sounds are 'happy', however. Often, when staff lift or move a disabled resident, a scream or cry of pain is heard. Anxious calls from residents struggling or suffering in their rooms, showers and/or toilets also punctuate the atmosphere. These sounds vividly remind onlookers of the nature of the place, and of the pain and suffering that residents can and do suffer.

The suffering experienced by some residents is palpable. In one case, for example, a resident constantly called out for company. Her suffering was not based in physical pain but on the lack of constant presence and touch of a human being. A companion had been formally assigned (by the family) to sit with her most of the time; when the companion was not available, however, other residents sat close to her and held her hand. But when residents got tired, or when the carer had to go, the resident's distress returned and she would call out loudly: 'Love' (Αγαπη), αγαπη

αγαπη. Often, late in the evening, I would hear her urgent lonely voice through the silence calling out 'αγαπη'. This call always sent a chill down my spine[3]. At times, particularly in the mornings when residents were getting up, and in the evenings when residents were preparing for bed, residents and staff alike would offer urgent encouragement to each other to 'hurry up'. At times, short disputes would erupt among Greek-born staff, as they disagreed about the task that had *not been done*, the tasks that *had* to be done, or task which *had not done as well as they should have been*.

Among the most distinct sounds heard on a daily basis are, however: the voices of the 'activities ladies' and the residents as they all talk together, debate, and carry out entertaining activities; the poignant silence at critical moments when residents are engaged in playing bingo; and the voices of visitors greeting and conversing with their family members and with other visitors and residents.

Activity and Movement

Generally speaking there is a great deal of activity and movement about the nursing home.

Activities vary according to the time of day, and whether there is a holiday, a weekend, or a significant day to celebrate - for example, a name day (which always have a correlate saint day), a national Greek day (held 25 March, and 28 October each year), Christmas, Easter, Decadente Augoustou (15 August), and so on. The sound of music, laughter, joking, singing, talking, vigorous discussions, and the like are all heard on these days when the rich aroma of Greek food and herbs also permeate the nursing home on these days.

3 The residents call encapsulated for me the sense of loneliness or feelings of abandonment that one can feel who has been brought up in close proximity with others and to expect to be in the presence of others at all times. Living alone, in Greek rural culture of the time that relates to these residents was perceived as the most unfortunate thing to happen to an individual. The person was considered to be metaphorically speaking in a desert. Alone, thirsty, burning under the piercing heat of the sun, in anguish and pain, for human contact and understanding.

Dancing, embracing, kissing, singing together and the like, are common sights in the home and indicative of the free expressive behaviour of the people within. Staff or relatives taking residents in wheel chairs to different events and activities add to the movement and sense of activity in the home.

Other sources of activity include community events involving organised visits from schools, scouts, and religious philanthropic organisations. Musicians and dance groups well known for their performance of Greek music and folk dances also visit the home (usually during festive seasons, such as Christmas), and create a festive mood. Food is always available at such events, and a party atmosphere prevails - which residents enjoy immensely.

Action, movement, sound, and light are all perceived as relating to life and living. Prolonged silence, quietness, inactivity, and darkness, on the other hand, are associated with death - and hence to be avoided.

Conclusion

The lived cultural context of the nursing home is difficult to be capture in words; words reduce its holistic nature, and hence do violence to its significance. Nevertheless, I have attempted in this chapter to convey, through words, a sense of the Greek nursing home's unique cultural context. The unique atmosphere and sense of Greek place of the home derives from the physical, architectural, decorative and cultural objects found in the home. Similarly, the combined effects of the use of Greek language, body language, staff comportment and tempo of life in the home creates a familiar, stimulating environment. Here aged residents can avoid isolation, loneliness, and the devastating affects of sensory deprivation that can be brought about by a an unfamiliar or unintelligible environment. They can also discern what is going on, and create new meaning in their lives. Cultural context is essential for the reduction of anxiety, and for promoting a sense of safety, place and identity and humanity.

CHAPTER SIX

RESIDENTS AND CARERS: THEIR RELATIONSHIPS AND INTERACTIONS

Introduction

Currently in Australia, residential nursing homes for the elderly, like most public service institutions, are controversially regarded by government bodies as 'rational commercial enterprises'. This stance is not merely rationalistic (in an economic sense) but reductionist, in that measurements, auditing, benchmarking and the like can be - and are - promoted by government agencies to ensure maximum efficiency and efficacy in order to control funding. This economic rationalist perspective, however, obfuscates actual care practices and human processes in residential care nursing homes in a manner that is, paradoxically, detrimental to the quality of services otherwise provided to the elderly thus accommodated.

In this chapter, I shall describe and analyse the concept of 'Greek family' and actual care practices and human processes in a Greek nursing home - practices and processes which have been obfuscated by an otherwise (mainstream) rationalistic and reductionist approach to the home's management. Particular attention is given to the various cultural considerations that underpin conceptualisations and practices of elderly care in the home. I examine the conflict and contradictions that sometimes arise when lay carers find themselves under pressures that are imposed by institutional processes mediated by government and social considerations. It is argued that institutionalisation, economic rationalisation, and mainstream professional nursing notions of care generate working conditions which limit cross-cultural understandings and transformations as well as potentially beneficial cultural care practices as understood by both residents and carers.

Lay care as practised in the Greek nursing home (mainly by unqualified Greek carers or 'personal carers' [PCs]) is substantially modelled on notions of Greek *family* lay care, that is, care that is

otherwise expected of members constituting a 'Greek family'. In this instance the character of the 'Greek family' upon which it is modelled as was particularly characteristic of families living in rural Greece prior to the mid-1970s and the type of care familiar to those who have come as the majority of residents in the nursing home from rural areas.

The unique character of the (rural) 'Greek family' being referred to here, developed in an environment (notably, a harsh rural environment) where, as a collective social unit, the family had to 'struggle' to survive. Survival, in this instance, depended on each member of the family unit upholding and maintaining specific obligations, duties and responsibilities that were expected of *all* family members. The intricate set of duties (which involve notions of care and caring) of family members toward each other and the elderly - provide the moral context for residents ideas about their own care.

I hope to show that caring for elderly persons who speak a language other than English (in this instance, Greek) and who hold different notions and expectations of care from those prevailing in a mainstream (non-Greek) health care system, generates both challenges and opportunities. Meeting these challenges requires not only a sensitive attitude and competent cultural and cross-cultural communication, knowledge and social skills, however, it also requires adequate and relevant material resources. So as to enable a sensible and equitable approach to addressing the many profound (cross-cultural) issues raised in and by nursing home (residential) care practices. I illustrate this by revealing the elements (for example, traces of a rural Greek family structure) that have remained unaltered since the residents' and carers' immigration to Australian and by describing, the ongoing dynamic processes of symbolic role playing that I observed directly in the Greek residential nursing care home under study. Through these examples, I will also uncover certain paradoxes that have long been embedded in the discourses of Greek families living in Greece - and have survived the transfer and transformations of Greek culture to Australia. The complexity of these paradoxes, together with the interests they serve and the power

relationships which they sustain, will be made visible in the practices of both residents and carers.

Cultural processes manifest in the home

A complex array of Greek cultural processes was manifest in the home. While residents' and carers' life trajectories had been disrupted by their immigration, their understanding of self and their realities illustrated continuity of thought, feelings, and expectations as grounded in Greek culture and their experiences of being Greek in Australia. I begin by exploring the 'cultural universes' from which they have arisen as they unfold in the current Australian context. These include: Greek generic (lay) care; Greek family structure and relationships; Greek family care; care for those other than family; Australian challenges and impacts on the Greek family; Greek past intertwined with the present; 'Look how we have become' (embodiment: reading residents' body as a text); Greek carers and their notions of lay care; Greek-born carers' reflections and sense of responsibility towards the residents; symbolic role-playing and the paradoxes involved; and 'industrial' care practices.

Greek generic (lay) care - born in and embedded in Greek culture

Lay care is embedded in the culture of a people. A perspective of Greek lay cultural care[1] can be gained by examining its conceptual origins in Greek rural families prior to the 1970s and as it relates to public or 'stranger' care. *Thus family care (private* as opposed to *being cared for by strangers* [2] (ξενους) *(public care, including* in part *institutional)* constitute lay cultural care

1 Kleinman (1980 : 49-50) explains that 'Health care systems are composed of generic as well as particular "cultural - laden" components. The internal structures are roughly the same across cultural boundaries, while the context varies with the social, cultural and environmental circumstances of each system'. He outlines in his model three overlapping parts: (i) popular or lay (ii) folk and (iii) professional. He explains that while the 'popular/lay sphere of health care is the largest part of any system, it is the least studied and most poorly understood. It can be thought of as a matrix containing several levels: individual, family, social network, and community beliefs and activities. It is the lay, non-professional, non-specialist, popular culture area in which illness is first defined and health care activities initiated'.

In the United States and Taiwan, roughly 70 to 90 percent of all illness episodes are managed within the popular sector(Hulka et al. 1972; Kleinman 1975a, 1975b; Zola 1972b, 1973). Kleinman (1980:51) explains that the popular (lay) sector has received far less attention than the usually more dramatic and exotic, but less important, folk healing traditions. The popular sector is excluded from most studies dealing with 'indigenous' healing traditions, yet ironically it is for almost all

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Greek family structure and relationships

Greek family structure prior to the 1970s, (and mainly in rural areas)[3] ensured the production of a culture that strongly bonded family members. The Greek family existed for the most part in harsh rural and often poverty-stricken environment. In the struggle (αγωνα[4] επιζησεως) to survive, the Greek family faced many difficulties and demands. Choices were affected and mediated by the constraints and opportunities available in the undeveloped physical environment (no electricity or other facilities) and rigidly structured family and social roles. Within such conditions individuals habitus[5] developed

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societies the most active and widely used indigenous healing tradition. Self-treatment by the individual and family is the first therapeutic intervention resorted to by most people across a wide range of cultures. Care and caring is, of course, essential for human healing in its broadest sense, and care is in the first instance and in many countries given by members of family. See also Leininger, 1984, 1991, 1995 and in this thesis pages 98-99 footnote)

2 Ξενοι (strangers), in this care, refers to people who give care but are not family members. That is, they may be known and liked individuals but they are considered outsiders to the family. Such strangers or people outside the family, may include paid carers and nurses, or anybody else for that matter. Strangers usually are not trusted before they prove their worth.

3 Orso (1979): (xv) states that, 'Greek life is very complex, and life in the rural Greek villages differs greatly from that in the large urban areas. Except for a veneer of technology, life in the villages has not changed drastically for over two thousand years in regard to folklore, particularly folk religion, and folk customs. (see also Lawson 1964; Kyriakides 1968)'.

4 Αγωνας (Struggle): Καθε εντονη προσπαθεια για την αντιμετωπιση δυσχερειων, την επικροτηση επι αντιπολων η την επιτυχια καποιου σκοπου σε Πολα τα κλιματα, σε Πολα τα πλατυ, αγωνας για το ψωμι και αλατι (Κ. Καρυωτακις) Ελληνικο Λεξικο 1993 Τεροπουλος –Φητρακης Εκδοσεις Αρμονια Α.Ξ.

5 Bourdieu (1990, p. 53, English translation by R. Nice). 'The conditioning associated with a particular class of conditions of existence produces habitus, systems of durable transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organize practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operations necessary in order to attain them. Objectively 'regulated' and 'regular' without being in any way the product of obedience to rules, they can be collectively orchestrated without being the product of the organizing action of a conductor'.

According to Swartz's explanation of Bourdieu's sociology (1997, p. 102-103) 'habitus is a "structured structure" that derives from the class-specific experiences of socialisation in family and peer groups. Habitus results from early socialization experiences in which external structures are internalised. As a result, internal dispositions of broad parameters and boundaries of what is possible or unlikely for a particular group in a stratified social world develop through socialization. Thus, on the one hand, habitus sets structured limits for action. On the other hand, habitus generates perceptions, aspirations, and practices that correspond to the structuring properties of earlier socialization. According to Bourdieu (1990, p. 56, English translation R. Nice habitus is "embodied history, internalised as a second nature and so forgotten as history - is the active presence of the whole past of which it is the product. As such it is what gives practices their relative autonomy with respect to external determinations of the immediate present. This autonomy is that of the past, enacted and acting, which, functioning as accumulated capital, produces history on the basis of history and so ensures the permanence in change that makes the individual agent a world within the world. The habitus is a spontaneity

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and mediated their daily practices and the structuring of social structures. Habitus entails early socialization, in relation to class, gender, ethnicity, nationality and race, that takes place in a particular situation, and physical, social, economic, cultural and political conditions which produce constraints and opportunities that can be internalized and forgotten as embodied history. Habitus like a deep structured cultural grammar, engenders and regulates action through internalised individual dispositions. These dispositions incorporate the particular fundamental social conditions that determine materially, socially, and culturally what are probable, possible, or impossible for a given social group (Swartz 1997). Habitus, however, while it is structured is also structuring structures and is amenable to individual improvisations and creativity that mobilise individual agency and/or will.

Often, family members lived and shared life in restricted physical spaces. These living arrangements permitted in-depth knowledge of each other and created a need for constant physical presence (παρουσια[6]) of family members considered essential in a caring and

without consciousness or will, opposed as such to the mechanical necessity of things without history in mechanistic theories as it is to the reflexive freedom of subjects 'without inertia' in rationalist theories. The habitus which, at every moment, structures new experiences in accordance with the structures produced by past experiences, which are modified by the new experiences within the limits defined by their power of section, brings about a unique integration, dominated by the earliest experiences of the experiences statistically common to members of the same class. Early experiences have particular weight because the habitus tends to ensure its own constancy and its defense against change through the selection it makes within new information by rejecting information capable of calling into question its accumulated information, if exposed to it accidentally or by force, and especially by avoiding exposure to such information'.

It seems that habitus results from early socialization that takes place in particular situations and physical, social, economic, cultural and political conditions which produce constraints and opportunities but are lived, contemplated, manipulated improvised and adapted or rejected by individual action and practices that require individual agency or will. Such habitus, however, develops within a family, group and/or class and or society at a particular time and place and as such has broad parameters, and is homologous with diversity. This socialisation, then, produces the habitus cognitively, through embodiment, and psychologically creates individual dispositions which in turn structure structures - dispositions that produce principles which unconsciously operate as strategies that have been learned earlier and are generative and adaptive. This situation does not preclude conscious strategy generation and practice, but emphasises the habitual behaviour of human beings which they have learned in their struggle for survival in particular conditions in time and space.

6 Παρουσια (presence): Here presence is used in its full Greek sense. Presence in body is

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loving family. Physical *presence* of members was vital for feelings of family integrity and wholeness. The fact that people lived in small, cramped spaces meant that they usually grew up with the view that living in close physical proximity with others creates a comforting intimacy that is the expression of familial care, love and integrity.

The ideal nature of Greek family relationships created a foundational interdependence between family members. Despite family conflicts and noisy discussions, disagreements and, at times, brawls (καυγαδες) love, commitment and obligations to care for each other remain deeply embedded in the psyche of each family member to the extent that serious family separations were rare. Family members had the assurance that when they had needs that required the help of other family members, they would respond as expected.

For both residents and carers this cultural ideology and the rural environment in which it developed formed a cultural universe that embedded family members in enduring relations which were intensely intertwined over the whole lifespan. People grew up expecting to live and die in the same place, to marry and mix with people from their locality who shared their values, beliefs and ideals. Familiarity and intimacy were fundamental to the evaluation of family life. The bonds involved sentiments that sustained the paramount value of family love, care and responsibility.

Elderly residents, some carers (and I) had been inculcated with these family values (although it must be recognised that in actual practice family relations and interactions did not always reflect this ideological construction). This taken for granted family cultural construction masked struggles, tensions and conflicts that existed among family and other community members. Nevertheless, although there are changes in families in the Australian context, the ideological structure (Greek family idea) underpinning many

extremely important, and simply being near in view and in the same space as each other is crucial. Parousia of a person denotes the concern, interest, respect and love elements of care that are viewed as essential in health, illness and caring situations. Deep emotional nurturance is gained by presence in talking, acting, or in silence.

families remains a powerful influence on many Greeks living in Australia.

The cultural construction of a moral universe - the ideal of family life

The ideal Greek family structure (which is both child-centred and patriarchal in nature) attempts to reflect 'God's family'. The father is the protector, provider and guardian of the family and has ultimate authority. He also has responsibility for the economic welfare of the family. He must be obeyed and given respect. Although opinions of family members are sought by parents, the father is the arbitrator if consensus cannot be attained.

The mother is meant to be a reflection of virgin mother (Mary), respected for her holiness, purity, meekness, sapience (ταπεινοφροσυνη) and strength of character in hardship and suffering, and for the love, care and nurture that she 'by nature' gives to her children. The mother is responsible for the physical, character and moral development of the child, and has the ultimate responsibility for holding the family (οικογενεια) together. The mother is to be loved and revered. Children are expected to respect and obey their parents and share life events with them. Parents are expected to provide and care for all the needs of their children. Single children are the responsibility of the parents, no matter how old they are, and should live with their parents.

The Greek family always struggled (αγωνιζωταναι) to achieve in reality the cultural ideological construction of the family, although its ideal form supported the interests and life chances of some members more than others. Nevertheless, children were inculcated in all aspects of their lives (from church to school and in everyday interactions) in the ways of the ideal family.

Within the family, power, freedom, rights and obligations were apportioned to individuals on the basis of age and sex. Specifically, the father was the head of the family and provider (constructed as the breadwinner - whether this was so in reality or not), then the oldest son, and so on. Female children also had rights, duties and obligations. For example, the oldest daughter had the greatest

responsibility towards all other siblings for their care, nurturance and protection/health promotion. In order of precedence the older siblings also had more rights, albeit within constraints. The oldest son took priority over the oldest daughter, and so on. For instance, if someone invited the father to a wedding but he (or his wife) could not attend, he would then send his eldest son with the eldest daughter to the wedding. Or, if parents wanted to educate all their children but did not have enough money for all, the oldest son and or a son would have priority before any of the daughters. It was also a common expectation that women had to be married first - and according to age - before men.

Women's power[7] was mostly recognised in private circumstances and as a mother. In public spaces the men needed to appear as more powerful. Single women's power was enormous but, like Eve's, considered dangerous in that it could harm the family. Single women had the power to shame their family by their acts, particularly through their sexual behaviour. Women were reminded at home and in public that they needed to be 'good'. Children were exposed to and inculcated by a 'gender-differentiated' culture from birth. The subordination of women's interests and desires was deemed natural and in accordance with God's will.

Unless they were homosexual, single men's sexual behaviour was not considered shameful. Men were basically free to explore and satisfy their sexual urges. Manly sexual prowess added to the man's manhood (ανδρισμο) as long as it was not reckless. Nevertheless, men were judged and given status, esteem or honour (τιμη[8]) according to their character and manhood (Ανδρισμο και Λεβεδια[9]).

7 Women in Greek society may seem to an outsider as powerless and subordinate to men. Such a perception would be a very erroneous one since women in Greece can be extremely powerful and often dominate the men in the home space. The home is the castle of the woman, not the man. In public, however, women and men agree to observe and perpetuate common expectations of women's subordination and woman's powerlessness in private and public.

8 Τιμη ('timi' honour) refers to a man who has a truthful character, is brave, and is not frightened to face difficulties or even death if it is required. It refers also to a man that can be trusted, has manhood and has gained the respect of the community through his deeds, deeds which are contextualised and culturally relevant.

9 Ανδρισμο και Λεβεδια (manhood), connotes strength, hansomness and courage with no fear of death or of taking risks as necessary.

Women were prized and would gain status and prestige if they were considered to be fast and hard working (Προκομμενες[10]) and modest, (καλες νοικοκιρες, και ταπεινες[11]) housewives. Women were generally the invisible, silent and unpaid foundation and support system of families and society in general.

Men and women, however, were not considered to be complete human beings as long as they were unmarried and, in particular if they lived alone. Their full humanity could only be revealed in the way they interacted in the family and in this context within the larger community. Family (Οικογενεια[12]) itself was perceived to be the source of human life and spirit.

Each person started their own family to actualise their humanity, cultural gender roles and social worth. This meant that each family member had to develop their physical (home) environment and have children and nurture their development (including their unshaken bonds, relationships and obligations). Parents were expected to do everything for their children and, if need be, to sacrifice their interests for those of their children. Within this broad cultural framework cultural expectations in relation to roles were developed. Parents' and children's roles were developed and nurtured according to an age hierarchy. Absolute commitment to the

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10 Προκομμενη (Prokommeni): According to Mead (1955:69-70), diligent says something about her attractiveness. Diligence is an internal attitude; it rests on self-discipline and free incentive, it includes interest and enjoyment. It does not mean a valuation of work for its sake; it is the personal quality of diligence, not work itself, which is good. In the way that is used here, it is used in its pure form as an indication of a good woman who is worth something in a world that devalues her. This worth is essential to maintain women's self-esteem, since working conditions and social pressures have roped them from freedom and individual esteem. In order to counteract such feelings and so that they can accept themselves as worthy human beings, the symbolic behaviour of a 'prokommeni' creates a space for them that walls off external influence and gives them the courage and confidence to go on in action, even though while they know their work itself is not how they would have liked it to be.

11 Ταπεινη (Tapeini): Humble and unassuming.

12 Οκογενεια (Oikogeneia): This is a combination of two words 'oikos' (house) and 'geneia' (birth like) that can be interpreted as birth and or a combination of woman and birth, offspring, race (oikos & geneia). 'Oikogeneia' thus captures the meaning of home, woman, birth and growth, and the aspirations, values and expectations and traditions (including religion) associated with it. It is the foundational social unit of Greek society and the birthplace of economic and material life. (See also Dubisch 1986:102-120.)

family was paramount. The family however, was an open social system that permitted, via a variety of means, known although unrelated individuals into its circle. Each family, according to its accumulated economic, social and cultural capital, would develop relationships of power that would bring it in direct contact with different levels of society. Through these relationships different families had the ability to fulfil their interest in a competitive social field structured by social networks of power.

Respect was given to those who earned it by being 'good' parents, brothers and sisters or trusted friends, who followed the cultural practices and expectations of Greek society. This meant that human needs in the family environment were expected to be satisfied according to cultural rules. These rules produced certain distinctions, and these distinctions were often at the expense of some members. Therefore, while the family context was one that provided for the needs of all members, it did not necessarily fulfil them equally. So family members, often challenged or resisted such rules, inevitably producing tensions.

Greek family care (περιποιησις)[13]

Family care is essential to family responsibility. Care associated with provision of resources (economic) is usually the man's responsibility but actual care delivery is the woman's duty and responsibility. Within the family women are the carers in health and illness; they promote and maintain the health of family members from birth to death. In relation to family care, the mother and sisters would provide for the environment and personal hygiene, food, clothing, comfort and rest, and would seek local, folk, lay, and/or medical treatments. They would provide culturally psychological, emotional and spiritual care, including such cultural care practices as religious rites and sacraments, presence (παρουσια παρεα) and instillation of hope and courage. In the events of illness and injury in closely-knit communities, members and neighbours would come to sit with the family (παρουσια παρεα), share hospitality and instill hope and

13 Περιποιησις (care) Peri means 'about' and Ποιησις comes from the word poiw which means 'to create'. The word peripoisis, however, refers to care - care given in a creative and artistic way. It is extremely intense, with deep interest towards the other persons - particularly a family members - deeply connected and based on love. (See Kanitsaki (1993.)

courage by talking. They would help with home chores, share common experiences, and lament their misfortunes that were brought about by fate (τυχυ η μοιρα).[14] Such situations, provided opportunity for those involved to express all kinds of feelings, to be listened to and to receive supportive care.

The aged lived with their children expected to be and were cared for by them. The concept of a nursing home and nursing homes as such were not known in Greece when these Australian Greek residents lived in Greece. There was no question or even a doubt that adult children would not take care of their elderly parents or relatives. Only people who were destitute, in poverty, with no family, abandoned (εγκαταλημενη)[15] would end up in 'Old Houses' (Γεροκομια)[16]. These were houses for the destitute aged in society. Such Old Houses had a very poor reputation in Greece, and no aged person who had a family would expect to go to such an institution. People were frightened of such places, evidence of their worst nightmares, that is, being abandoned by family and community and forgotten by society.

Care for those other than family (ξενους)

Care for those other than family-or strangers-may involve (i) volunteer *unpaid* care, and (ii) *paid* care. This kind of care is care that is offered by the community and/or care that is provided in

14 Τυχη, μοιρα (chance, destiny, fortune): The use of such words should not to be taken as a form of fatalism. Rather this word is a reflection of the Greek peoples' constant struggle to survive and when all struggle is been made and risks taken, alternatives explored and improvisations employed (in, other words, once all human will and agency has been vigorously exhausted then the words 'tyxi' and/or 'moira' used as an indication of coming to a point where one concedes one's limitations. Limitations of being human, after all, and not God. By accepting these limitations, by placing oneself in a space which is undifferentiated, broad and uncontrollable by human nature, one also creates a new opportunity: a chance for further action through contemplation and reflection.

15 Εγκαταλημενη (engatalimeni): This is a word that denotes a human state that involves the desertion and denial of a human being by those one expects to receive love. It has deep emotional connotations and evokes feelings of intense humiliation, shame, guilt and embarrassment, to mention a few.

16 Γεροκομοια (gerokomia): Houses where old people who had no one and /or had been abandoned by their family and society (εγκαταλιμενοι) were taken for shelter. They were usually poor and were considered forgotten by society.

institutions by unqualified carers (who used to be called 'practical nurses') and by qualified nurses in Greece.

Public institutions were not trusted, were severely criticised, and generally avoided. When a family member or relative had to go to a hospital for medical treatment in most cases relatives went to care for the person on a 24 hours a day basis. The institution, doctors and carers were under constant surveillance by families and friends. Care for strangers in neighbourhoods and communities was motivated by the existence of personal relationships that engendered empathy and sorrow (λυπη[17] και ανθρωπισμο[18]) towards the other. There was no systematic organisation of care services in rural areas prior to the 1970s.

Community members would help neighbours and others, but freely and without pay. Folk[19] healers often would attend to injuries (broken bones, birth of a child, and so on) and other problems. People did not expect to be cared for by ξενους ('foreigners'). If someone cared for them, however, and without pay, this was perceived by the recipients and community as an extremely virtuous act, and earned prestige both to the caring person and her/his family.

People in old houses, (γεροκομια) and hospitals were cared for by carers who often had no training or limited training. These carers often were from poor backgrounds and worked for money. Public carers (women) who worked for payment had a very bad reputation and often they were perceived by the public as being at the same level as sex workers. Voluntary care delivery in a community or neighbourhood was seen as sacred and exceptional. Paid public care was seen as low, dirty work delivered by low class, poor women who were viewed as having low morals.

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17 Λυπη Οικτος (lipi/oiktos): Feeling pity or deep sorrow towards another human being for their suffering, pain and poverty (thus empathising with them and offering help or care).

18 Ανθροπισμο (anthropismos): A sense of humanity that engenders positive emotions and feelings towards another human being and the desire to help if in need.

19 Folk: Not formally educated health care providers, but well known to the community as practical healers (like bone setters, midwives, or experts in relation to local diagnosed conditions - like matiasma which only they could only treat).

Australian challenges and impacts on the Greek family

The Greek-born residents' and carers' living in Australia, had their Greek notions of family and old age, as well as their care expectations, challenged for the first time in their lives. Mainstream Australian culture was brought into their homes by their children and the media. Greek family and cultural notions and practical ways of life were constantly confronted and juxtaposed with the prevailing Australian notions of family and Australian social constructions of the aged. This juxtaposition occurred (and is occurring) as comparisons were/are made between Greek and Australian ways of experiencing society and life.

This confrontation of Greek versus Australian experiences and ways of life, values, beliefs, ideas, expectations and aspirations became a reality inside the home of every Greek family in Australia. Their young children and/or Australian-born children were experiencing the reality of two cultures. Australian culture at school, located within the larger Australian community, and then Greek culture at home. Juxtapositions between the two cultures were inevitable and, as a consequence, responses to these experiences and their comparisons within the home brought new challenges that resulted in tensions and conflicts. Children were struggling to develop their-self-esteem and identity, demanding freedoms and rights which they had not felt or known before.

Parents felt they were losing the family they knew and were aspiring to create and maintain. Among these dynamic situational tensions within the family, pain and suffering, hurt and bitterness was felt by all. Many parents seemed to have come to understand and accept their Australian social world and within that, their destiny. Many others, however, while they may have had such understandings, their pain, hurt and sense of failure in family relationships seemed to linger on.

This constant presence and reality of living within and between two cultures has given rise to two incompatible social and human psychological contexts. The constant co-existence of these two

cultures and, often, their collision in everyday practices within the family and between the old and the young, has shaken the foundations of Greek life ways and the security and certainty that the old Greek culture provided for the old.

The demands of a new life in Australia for many immigrants who spoke no English were heavy and the experience was painful. Often, when seeking social, health and other services, parents had to adopt child-like roles while their children assumed parental roles to communicate and mediate between service provider and their parents. Similarly, because parents had difficulty speaking English, their children had to interpret Australian life and events to their parents as they themselves were trying to make sense of their world. Because of this, parents were often placed in powerless positions and their children were burdened with responsibilities that should have been the parents' while they themselves needed the guidance and support of their parents. For many parents dependence on their children still remains. For many young Greek-born and Australian Greek-born their general experience as children of immigrants has created a constant source of unrest, anxiety and often conflict that they have to deal with in their daily life, including when the time comes for them to care for their old parents or grandparents.

Past and present, cultural universes: 'Residents and carers'- thinking, judging, doing and relating in the nursing home

This section presents discussions I had with residents and carers, as well as some observations I made in the field. Discussions revealed the upbringing and past experiences of the particular residents and carers, as well as the material and other conditions to which they had been subjected living in Greece and in Australia. These discussions also revealed that their past, as interpreted and perceived, mediated their present behaviour and practices in the nursing home. Their behaviours and practices, however, were also mediated by the nursing home conditions that they were experiencing. Nursing home conditions however, were in turn mediated by mainstream professional, managerial, administrative and government discourses.

Some residents' experiences of family life in Australia left them feeling failures in their life. Some desperately sought to recapture the warmth of a family in the nursing home.

One resident, in a group discussion with 20 other residents, expressed his thoughts, experiences and sentiments - by comparing expectations with actual family changes that took place in Australia. All other residents present endorsed his views.

RES 5 Now there is no time for the old. Now there is opportunities for the woman like the man etc.). I want to say that the children are a big joy, to keep them with you. Here you cannot. It is a wonderful country - one of the best. We are lucky to be here, but we miss the most important thing: the warmth of the family, the sharing.

We came with good purposes - to give a chance to our children, but which we had lost. **It is too late for us. When we wanted them to share our lives they were not there. They are not here!**

Children, siblings, all they are here, **but no-one wants us.**

Another resident interrupted and explained that she came wounded, psychologically and spiritually, to Australia. Despite this she managed economically, but she could not create a family the way she envisaged it should be:

RES 6 I came to Australia wounded (πληγωμενη). I worked and I got old here. I did not remain without water to drink (χωρις νερο να πιο δεν εμινα). I have nice children here. Two children that I bore. We separated and they do what they want. They do not listen to their mother. ...

While all residents in the room were agreeing verbally, one man took charge of their animated conversation and explained:

RES 5 The old and the young have different ideas. The young brought their parents to Australia to care for their children. They exploited them. The old thought, 'This is permanent. We will live with our children'. The children did not look after the old.

The way of life the old knew was different. For the old here it is like a jail.

OK Happiness does not depend on money?

RES 5 This is what I am saying to you. That the plenty [affluence] did not do good to us. It harmed us. Here we had two boys and a girl whom we lost [meaning they did not live with them]. But we came with the purpose of making Australia our country, not to go back. Our children mixed with other children in school but they did not stop as we did to say "we want to learn Greek". We were born in the Middle East (Αραπια),[20] but we kept the language and Greek culture.

Unfortunately for us the family that we were hoping to become did not eventuate. We were working hard. We bought and paid off a house, but we, on the other hand, **lost the family, the warmth of family, the connection** (συνδεσμο). Now that they are older they are becoming interested to find out more about Greece.

This is good. It is a little late for us to enjoy what we had in our minds. This is a general problem with immigrant Greeks. Economically we managed but psychologically (ψυχολογικα) **we have become wounded, dried up and deserted** (μας εχη ρυμαξη). The children, our brothers and sisters, we separated. We have grandchildren and great grandchildren away from us. We have not seen them!

The demands of this country, from all of us, that is why we lost. For us it is too late. Our children are not near us.

Greek family life in Australia has been inextricably influenced by Australian culture and society. Despite some changes, many parents who have been socialised in the Greek cultural context remain psychologically intertwined and in a symbiotic relationship with their children. Even though they are rationally aware of the temporal world they live in, they remain locked and bonded to

20 Αραπια: 'Black country', means here Middle East countries.

aspects of Greek family culture. Unavoidably, they are held prisoners to the culture they grew up with, experiencing feelings that arise from broken dreams and unfulfiled expectations in a different world. Their experiences in Australia and the changes they feel their family has undergone and their institutionalisation made them feel lost/abandoned, and at times to experience the nursing home like a prison.

'Look how we have become' ? (κοιτα πως κανταντησαμε) (Embodiment: reading residents' body as a text)

During field observations, I adopted an oblique approach to discover how residents felt and/or how they interpreted their nursing home placement. The following discussion with a group of carers (all PCs) revealed a sense of shame, loss and abandonment among residents.

CARER 5 The residents do not speak among themselves about being here.

OK Yes, I noticed that. Why do you think they do not speak?

CARER 5 Look, the first thing is they are ashamed (ντρεπονται) that they are here. And they feel very reduced. For example, they ask themselves, 'How many children did I have?'. They say, 'Two or three. But look, I am here!'.

CARER 6 For example, we lifted Mrs so-and- so. We hardly touched her and she said, 'Ah, ah, ah, ah!'. Then she said, 'It is not your fault, it is the doctor's'. [The doctor had insisted she should be placed in the nursing home].

OK You mean because of her body being frail?

CARER 6 No, no. Miserable and wretched (δυστυχης) because she is here.

CARER 7 [emphatically and with sadness] Yes, that is right!

CARER 4 For these people who have grown up differently it is a disaster to be in here, in a nursing home.

OK In another words they communicate without words?

CARER 6 & 7 [In unison - emphatically] That is right!

CARER 3 Have you heard any Greek that has a family problem to discuss this with whoever?

I found that residents felt they had to defend their children to me. They gave me reasons without my asking for them about why their children could not care for them. An appeal to Greek family values explains why they did this. Notably, if the residents expressed disapproval, they risked exposing their children to community criticism. By offering reasons for their children's behaviour, the residents were thus attempting to protect their children from external criticism.

A woman resident whose children visited her on a daily basis spoke about how good her children were. At the same time, however, she could not understand why they could not take her home. She also told me how her children were tormented by her appearance, as though it mirrored her suffering.

Similarly, another resident defended her children, explaining to me that she was better off in the nursing home. This was because she had been at home alone all day while her children went to work. In the nursing home she said 'I have now company [παρεα]'. She added, however, with passion and in tears, 'Everyday when my child walks in my room, it is like I see God entering my room. My children are my life. My life. My sight'.

Several residents, in momentary despair, would quickly make comments like, 'I feel like I am in prison here' or 'I wish I could go home for one week. Only one week, and then die'. It seemed that the residents could not experience meaning outside a family context. A family-like context, however, was generated by the interactions and relationships that both carers and residents had established by family role-playing. It seemed that such role-playing made residents' lives bearable and, at many times, enjoyable.

Most residents avoided comments that could indicate the depth of feeling they had in relation to the fact that they were not being cared for by their children. There were many signs of their despair, however, evident in staff members' comments, and residents' body language. Being with the residents and staff, sitting with them, eating with them, talking and sharing, at times, their deafening silence allowed me to read their bodies. Their bodies were inscribed with their lived experiences and their cultural and social expressions of self-esteem and identity.

As rational human beings they behaved like Greek 'good family' members defending their children. Their bodies, however, told a different story, which, as a Greek, I read day after day in my fieldwork. Walking, standing, gestures, expressions and gazes are indexes of embodied experiences, feelings, sentiments and thoughts.[21]

Body and facial expressions can be read like a text by anyone who has lived and experienced as a deeply embedded and connected person in Greek culture and history. Joy, happiness, suffering, pain, bitterness and despair can be discerned in silent people. It is on their bodies that their joys become visible, similarly their hopes, dreams, and expectations as well as their burdens, losses and disappointments. Their bodies loudly lament the loss of their youth as strangers in a foreign land (ξενιτια). Sitting now on wheelchairs, an array of bodies, some trembling and weak and others with paralysed limbs. Some distorted from the injuries of disease with some parts shaking without control. Husky, squeaky and weak voices. Faces painted with a thousand kinds of detailed and exquisite sadness. Masks, parading a huge and penetrating human drama. This drama vividly expressed the futility of their former aspirations.

Residents' and carers' bodies were speaking constantly and loudly to each other. Their souls were dancing in a cultural universe that constructed their reality - 'it was the way it was'. I, having only

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21 See Hall (1976) and Calhoun et al (1993).

limited courage to ask them questions that could open their wounds and/or bring them shame, many times refrained from doing so. Questions like 'Why are your children not looking after you?' I never asked. I feared for their unbearable pain and I did not want to be one who reminded them of how they 'had ended up' as they had; as they often told me, 'Look how have we become' (Κητα πως καταντησαμε).

Instead of asking them such questions I left it up to them to speak or remain silent. I read their bodies and faces. I tried to capture their suffering and pain - for what they were dreaming and had lost, for what their were expecting and yet what could not be. But most of all, for their overwhelming pain and suffering for being separated from their children and uprooted from their homes. Their Greek land and their Australian homes - doubly uprooted (δυο φορες ξεριζωμενη).

Greek carers and their notions of lay care

From the many and varied discussions I had with Greek carers it was evident to me that these carers generally shared the residents' views generally.

Greek carers perceptions in relation to the Greek ideological representation of family and care were revealed by the way they juxtapose themselves in relation to Australians generally and some Australian Greek-born carers.

RN They are cold human beings, the Australians. They do not understand the Greeks.

CARER 4 They may be smiling, but inside them they do not have that [moving her hands about] - that warmth which we have!

I don't think even many Australian-born Greek young girls (κοριτσακια) bother much; some girls here, they say 'I am not going to be bothered' (σκασιλα μου).

CARER 5 I love the elderly. I see all the elderly like my grandfather and grandmother and I do whatever I can to help them. We consider the old our parents.

And as I would like my children to look after me (if they can), that is how I want to help them.

OK What is it that the Greeks want? What is it that Greeks give to residents that Australians cannot give?

CARER 3 Love (αγαπη) and understanding. (κατανοηση). These two things. The Australians... they do not have much love for the elderly. They say, 'Leave her/him. They are old. She is 80 years old, so old. Why will I look after my old mother?' They take it like that, that is how their life is. They have grown up like that, with that thought.

Carers described what cultural care practices they considered meaningful and relevant for the aged. They paid significant attention to the manner in which care was provided. Expressions of love and tenderness were vital. Similarly, acceptance of who the aged were and the way residents understood life seemed to be essential in the carers' care delivery approach. Carers expressed their notions of care by comparing their behaviour with that of the Australian staff. They perceived themselves as upholders of Greek values and, like the residents, they opposed these to Australian values. The construction of a 'minority' identity as an immigrant often entails the development of a critique of the host culture's values and behaviours that makes them morally inferior and robs them of symbolic capital. Their comparative critique is also an attempt to re-gain and legitimate their symbolic capital that has been inferiorised and made invisible on account of their 'minority' identity 'ethnic' status.

CARER 5 The way we behave with them. You will go and say, 'Good morning, Mrs so-and-so. How are you today? Did you sleep well? Do you want me to do something for you? Do you want something? - instead of waiting for them to call us.

We have a different manner. We will embrace them, kiss them, speak to them, sit with them - sometimes to say one word, to understand! We know their pain [here, the carer does not mean physical pain, but is referring to social suffering]. We know about their children, as they [the elderly] say,

'That is how life is'. And we try to give them something - that which they need and which their children, who are working, cannot. All Greeks have to work; there is no-one who can afford not to work.

Carers described how they perceived dignity. Dignity was viewed from a social and personal perspective. Carers believe that providing for the Greek cultural orientations, and in a manner acceptable to the residents, maintained residents' personal and social dignity and quality of their life. (Dignity also related to how a person dressed and to one's appearance in relation to their age, sex and social position). For example, a priest's wife's hair would be long and combed in a particular way, her dress and general appearance would convey modesty, wisdom and sacredness, not only to sustain her's and her husband's respect and prestige, but to avoid social disgrace and contempt.

CARER 1 Take Australians... They do not have the same culture. We the Greeks are very careful about our **ethics in dignity.** A stranger (non-Greek) nurse cannot understand that dignity - the Greek dignity. The old and we who are younger - we understand because we have the same culture. We take them to the church, and for those who cannot go to the church, the priest comes here. We hold prayers for them here. We give them Communion. We take them to activities, and the activities woman does a very good job. They do Christian activities (εργα). They will see and hear the Christian church. They will hear a little singing in church (Ψαλμο). All these play a big role.

OK What difference do you see in dignity of the Greek versus an Australian - as you conceive it?

CARER 1 The Australians have learned to be free. They do not sit [meaning 'reflect'] to say, 'Mother Mary, my skirt must come down! It is too short!' Or that my dress top and back is too low. I see many old Australian women who are dressed with make-up on and they wear any colour. We do not do that. Because we think, according to age and how we have grown-up, the norms, folklore ηθη και εθημα – you must dress this way. For example, Mrs so-and-so [an old Greek woman] to try and put lipstick on,

to put on make-up and a red dress would be ridiculous and a disgrace. The Australians, however, do not see this as being wrong. For them, the more make-up, the more lipstick, the more light colours the better. They do not see such things as an insult, like the residents do. While we, the Greeks, we don't have that. We want our dark colours when we are of age, and we want our jokes (αστεια); someone may not like our jokes, but appearances must be right - there is a difference.

Dignity and respect seem to be intertwined concepts that were firmly embedded in Greek cultural life and in the elderlies' sense of self-value and worth. Below is how a resident expressed the loss of her dignity and also the lack of respect that she was accorded, particularly since she was the daughter of a priest. Cutting her hair in the nursing home affected her sense of worth and dignity, as she laments below:

RES 6 I always had long hair. I never cut it. Did you know that my father was a priest?

OK. Yes, I know. You have lovely hair, though.

RES 6 I always had long hair, never had it cut. Then, it was beautiful [with sadness].

OK Why did you cut your hair?

RES 6 Well, they told me that I could not have it long [almost in tears she added] because it took too long to comb it! They said, 'Since your arm and hand is paralysed and you cannot do it, we have to cut it'. Look how have I become [showing me her short hair and her paralysed arm]. Well, when you get like this you are nothing! It is better to be dead, but it is not the Lord's time.

OK. Who told you you had to have your hair cut?

RES 6 The Nursing Director.

Greek-born carers' reflections and sense of responsibility towards the residents

The discussion with two carers (below) partially makes visible their thoughts, perceptions and understandings of residents' experiences and position in the web of power relationships and interactions within the nursing home. Their reflections show their commitment and feelings of responsibility towards the aged residents. Carers recognise that they are in a powerful position relative to the residents. They feel that this situation arises because residents not only depend on them but rely on them (on their will) for the satisfaction of their needs. They explain that residents' reliance on carers generates power differentials that could be abused or beneficially used by them. On this basis, the carers' thoughts (below) reveal their sense of moral responsibility towards the residents. As will be indicated later, however, when some carers are under pressure, by reverting to role-play they can, in practice, justify their use of role-power in a variety of ways to overcome these pressures.

CARER 6 The ethical aspect! That is the most basic thing for us and for the aged here. This is because it is a nursing home, and here the aged are so dependent on us and rely on us. Here, these human beings [ανθρωποι] are very dependent on us - in other words, they **rely** on us. You see, they depend on us and they feel different. They **rely on us to act** and we have to do it. They want, for example, to go to the toilet. Well, they rely on us that we must do it. But we know that it depends on us, and if they go to the toilet, **we have the power,** not them.

Our role is not to show that we have power over them - so that their morale does not go down. So we should say, 'I will help you to go to the toilet', **not** 'I will take you to the toilet'. This is the difference. In many instances we have to run. We have not time but we must not use power over them.

Many times we have to help them not only bodily [σωματικα], as they say, 'by our hands', but psychologically 'til the difficult times pass. I understand because when it is a case of cancer, for example, the aged may start to cry and to say some words [λογια], 'Why did this happened to me? Why

am I in this situation? I cannot, I cannot take it any more', and so on. Many times we become God, as they say, and we take the place of God and we try to excuse the actions of God. At that moment you cannot swear at God. We must not **take away the hope** of the aged by saying that this is what God wants, therefore do not expect anything. Because we know this already, we know it is hopeless. We know that there are worst things to come for them. Better things will not come for them. We must take them out of that sentiment [συναισθημα] so that they can turn to do something else to see if they can feel better. Many times, and at the time they eat, it comes to them - that situation, the despair. And the other residents are around and you, we, must isolate that individual so that s(he) does not affect the others around them. And all that is not only cleaning and tasks; we use our sentiments/feelings [αισθηματα] more than our body.

CARER 7 They need tenderness/love [στοργυ, αγαπη]. It may be because they have gone from their home. Perhaps they are abandoned [εγκαταλημενοι].

The carers clearly articulate cultural notions of hopelessness, and how the despair of others is to be feared and avoided. She also indicates how carers strategies are mediated by their dispositions (habitus) in difficult and disturbing situations and without the benefit of professional knowledge in an attempt to sustain residents' hope and courage. Clearly, the carers are attempting to clarify the complex nature of the care required in the nursing home and the time and patience that is required to listen, to understand and to use culturally relevant experiences and knowledge to sustain residents' sense of well-being. This, they explain, requires more than just the use of their bodies in tasks. It requires them to be involved and to practise as a whole person, which taxes them physically, emotionally and spiritually.

Symbolic role-playing and the paradoxes involved

Residents and some Greek-born personal carers (to be referred to here on in as PCs) were not accustomed to institutionalisation beyond the social institution of the family. Some of the Greek PCs and residents had worked in Australian factories and had had

experiences of industrial assembly-line type work. Others had worked at home as piece-work labourers where speed, repetition and absolute attention to one task were required.

Working in a nursing home as a PC, however, with 30 frail and dependent residents, required complex skills different from those they had learned from past experiences. Having 30 residents to care for in a nursing home and working with other health care providers generates a different environment from that of caring for one or two aged people at home. As PCs, they adopted the skills they had learned in caring for their families. Adopting familiar family roles to organise their work within an institutional arrangement was for them 'natural'. Their 'natural' behaviours and practices illustrated carers habitus that helped them generate and improvise their actions according to the situations they were facing rather than following cultural rules (Bourdieu, 1980). Such roles helped them to familiarise, at their level, the institutionalised nursing home environment, and effectively work and cope with such a physically taxing and emotionally demanding environment.

Greek carers' and residents' relations, interactions and care practices were mediated and sustained by the adoption of Greek family role-play. This role-playing often facilitated family care delivery most acceptable to residents. At times, however, such role-playing also permitted both carers and residents to quickly reverse roles in situations where their interests were competing because of professional and/or institutional constraints. Such roles and their reversals revealed both Greek caring processes as well as the power relationships these roles formed.

Although exhibiting individual variations in attitudes and behaviour, carers from Greek speaking backgrounds shared some very fundamental understandings of the Greek family and family relations. Greek carers, no matter what their age or birth-place, stated that they perceived and related to the elderly as if they were their grandparents or parents. While the carers identified with the elderly residents as their parents or grandparents, the meaning and intensity of the relationships varied and often with respect to individual experiences in the family context. Residents perceived

carers as their children or siblings. Carers constantly expressed their respect for the old and their needs. For example, parents and grandparents expect respect, obedience and children's physical presence, particularly when in need. Children, on the other hand, vulnerable and without the necessary experience, wisdom and maturity of mind, needed to be *protected,* guided in the right way of life, to have all their needs, and often whims satisfied but within accepted cultural boundaries which parents determined.

Knowledge, skills and experiences which carers gained in their homes and workplaces (Australian and/or Greek) are unconsciously used as the basis for understanding the conditions and practices in the nursing home. Background assumptions are used also to symbolically generate Greek family structure. Structural roles mediate relationships and interactions between residents and carers. However, while carers were fully aware of Greek expectations in relation to aged care, their responses varied.

Parent /child-child /parent role

Discussion with PCs revealed some of the Greek family roles and expectations and their implicit beneficial and healing care values :

CARER 6 I think that we, the carers, we become sometimes like mothers. Because of their age weakness. Because you have a human being (ανθρωπο) in the bath in a weak, vulnerable position, it is like the **mother who has her little child** in the bath [emphatically].

The Greeks, they see me **like a daughter** or like a neighbour or like their own person. Because they sees us **like a family** and they feel free to say whatever they want.

OK You have a bond with them?

CARER 6 Yes, I see them as my grandmother and grandfather because we associate with other things, too. Because I lived back in Greece and I say, 'Oh, well, you went through my town' or 'You went through this and your town was this, and I saw this, and about this, did you go there'... and where I went, you know.

OK Sharing common experiences?

CARER 6 Sharing. Exactly. And so this brings us closer again, and makes them feel that they are not just a disabled person or whatever, in a corner [meaning abandoned] **because they have no families with them, to feel that they are loved.**

OK When for the first time you see the aged nude in front of you, how do you feel and become accustomed to this?

CARER 5 For me, it is not a great difficulty, because from the beginning when I started, my mind was on my **grandfather and grandmother.** Inside my mind I had my grandmother and my grandfather. Grandfathers and grandmothers, when you have in your mind that they are grandfather and grandmother, you do not feel any embarrassment. Because one aged person is a 'grandfather' and a 'grandmother'. They need your help, and you must wash them. It is not bashful or shameful (ντροπη) to wash the grandfathers' private parts or the grandmothers!

The above discussion not only reveals carers' and residents' bonds, but also the cultural, conceptual, embodied apparatuses which they use to cope with situations that otherwise might engender in them emotional discomfort and anxiety. A further example that illustrates the family role-play in a caring situation is given below. Role-play of child/mother and mother/child between resident and carer is adopted in relation to the caring process and progresses from moment to moment, changing their psychological situation. While observing a Greek-born carer showering an elderly woman, the following interaction between them took place. This kind of interaction was common between residents and carers in the nursing home:

> The resident was sitting on a shower chair, nude, being showered. She explained that she was cold and was feeling unwell. The carer, reassured her that she was working as fast as she could to finish her shower. The carer while soaping her body all over, at frequent intervals asked the resident with a tender voice tone, 'Are you all right, my baby? (μορο μου?)' (like a mother reassuring a small child).

The resident repeated, in a weak, trembling voice, 'I am cold!' (Again, the carer, while speeding up her actions, reassured her). 'I am nearly finished, my love (αγαπη μου)'. The carer swiftly finished, and quickly and warmly dressed the resident. She combed her hair.

Kneeling on the floor so as to be at the resident's level, the carer then took the face of the resident between both of her palms and kissed her on both cheeks. She said 'You look good,' and asked her tenderly, 'Are you all right **my baby**? (μορο μου) Do you feel all right, my love? (αγαπη μου)'.

The resident smiled tenderly, looking straight in her eyes, and with confidence responded, 'Yes, my **child**, thank you (ναι παιδι μου). **Have my blessing my child** (εχε την ευχη μου παιδι μου)'. The resident, now dressed and out of the vulnerable situation, reinstates her role status as an old parent. She blessed her child (the carer) for having done a good job and a good deed.

As the carer was pushing the wheelchair out of the shower she said to the resident, 'God be with you to protect you and to give you a good day (Ο Θεος να σε προστατευη και να εχης μια καλη μερα)' as a mother would say to her child going out of the home for the day. At the same time embracing the residents' shoulders and pressing the side of her face against hers. The resident kissed her and responded, 'Have my blessing my child (εχε την ευχη μου παιδι μου)'. Again the resident reinstates her status as an adult parent, now giving a valuable gift (her blessing) to her well behaved child.

The carer, with an expression and body language showing pleasure, submissively pushed the chair towards the dining room while the resident gave her instructions of where she wanted to sit.

The above interaction revealed cultural care practices based on the mother/child relationship. The carer and resident played both roles at the exact point of time required in the process of the shower. Their chronological age would not permit such roles, but the situation of dependence and vulnerability engendered cultural dispositions which helped both to cope with a situation that could have made the resident feel vulnerable and powerless and the carer embarrassed. Bonds were reinforced and loss of dignity, from their perspective, was avoided.

Having the blessing of the elderly was felt by the carer (as Greek children learn to feel) as good as receiving a blessing from God, as the blessing of an old person (ευχες) is considered to be beneficial to the receiver. The aged can give a blessing or a curse, and this gives some power to the aged over those who share their beliefs. Blessings from the old are considered very important by the carers; they were also perceived to validate their provision of 'good care'.

As soon as the care process (ritual) was completed, however, both parties assumed their original roles. The resident returned to being the parent and the carer the child or sibling within the symbolic family.

Residents' and carers' connections and bonds, and the cultural care practices which sustain such bonds, are manifest in other ways. Such bonds are fundamental for sustaining the quality of life and well-being of residents. These bonds appear to be difficult or impossible to develop without both participants speaking the same language and sharing similar cultural background and experiences. The discussion below illustrates this. It makes apparent cultural care knowledge, behaviours and practices, which remain invisible or may be misinterpreted within larger Australian health care contexts.

OK How do you like it in here Stavroula?

RES 7 I feel very well - I, for me, anyhow, the way they treat me. I love all the girls, very good they are. You also have some-for example, personal carers (PC's). For example, the doctor told me to go for my eyes and a personal carer tells me, 'I will go with you Σταυρουλακι [little] Stavroula', [endearing, but babyish talk a name for someone you like or love).

She said, 'Monday I do not work. I will come with you Σταυρουλα'. And she came with me to the doctor. She behaved towards me so well! Even if she was my daughter, she would not have done the same. If I was in an Australian nursing home [this woman had been in a mainstream nursing home] this, it would not have existed. This kind of bond. This has big meaning /significance [σημασια]. I feel like they are **my children**, true. I do not feel like I am thrown away/abandoned [παραπεταμενη] here.

Not at all. I feel very well. I do not think that they would do this only for me but they will be the same to the rest. I see other residents - Ηρακλια; for example, who she shares a room with me - I see all the girls caress her, embrace her. Will speak to her. All like me. What they do to me, they do to her. They do not show preferences - this is a good thing. Namely, they do not have love for me and not have love for the other.

Everything is good. For example, on the toilet that they sit me, if I tell them I am not right they fix me. They play with me. They care here. There is no comparison with the Australian nursing home. Here, the nurses [meaning the carers] they have their laughs, and so on. They joke, they tease me and I think they are mine, my people/family like [δικοι μου ανθροποι]. This bond which I feel here I could not feel at other places. I love the girls, but perhaps because of the language. But the Australians here are very good.

The establishment of the ethnospecific Greek nursing home permitted the bringing together of residents and carers who shared a common language and similar habitus that included shared history and cultural horizons. This situation created an opportunity to make visible the tacit and often difficult to explain Greek cultural care practices which are relevant, appropriate and conducive to the well-being of the aged in nursing homes, and which add to their quality of life.

Satisfying, beneficial and healing cultural care practices are holistic in nature and not reducible to items or tasks. Their holistic, beneficial, and healing nature involves the simultaneous synergic interplay of many caring cultural elements that are put into practice in a particular manner, as was illustrated in the following discussion with residents:

OK Are the meals the same as in the Australian home?

RES 7 Here, they have much more! They have pasticcio and moussaka and lazania. There they do not have them, nor do they have olives. But there they do not have the same tenderness/love [στοργη] as we

have here. Bodily and psychologically [Ψυχικος] my health is good here. I am very good here, because you have something to do always - exercises, handcraft, company [παρεα].

My sister-in-law told me, 'you understand here the meaning of Christmas and Easter with all the other Greeks'. We greet each other. Today we wished to each other a good month, like we would do with our own people [σαν δικοι μας]. The Greek songs, TV, the environment - they make me feel better. While at the Australian nursing home, we were eating, we were resting a little - five o'clock we had the meal. Here, at 6pm we go to bed but before that we have all the company. We must go to bed at 6pm. This is because they have 30 people to care for. When are they going to put them to bed?

I like the women [κοπελες] They [the activities women] do different things. They search to find ways to (κοιταζουν) entertain us. They try everything [κανουν το παν] **They do whatever, according to our mood.** Tomorrow is Saturday and they read us theology. I like that very much. And the news-paper they read it today. She brought the priest and he gave us communion, to all of us. He did first a prayer. Three months ago he came and did a religious sacrament [παρακλησις] it was beautiful!

OK That way you feel Greek?...

RES 7 [Emphatically] Here you feel it! This is a good thing. There is a need for nursing homes like this.

RES 8 From care [περιποιησι] I am personally completely satisfied and I would not change this institution to go anywhere else. Our jokes - I have my warmth [ζεστασια means psychological satisfaction] and the Greeks are excellent. The staff that provides care to us I am completely satisfied. I have not one complaint.

OK This is very significant.

RES 8 They are very caring and with much understanding [περιποιητικες, και με (κατανοηση].

OK If you were in a mainstream nursing home, would you have the same warmth and understanding?

RES 8 No. No.

OK Well, what is this warmth? Is it language or ...?

RES 8 It is the language. It is the customs, traditions, norms and morality [ηθη και εθιμα]. It is the way of life, beliefs, values, ideas, the way we see the world [η νοοτροπια]. The **foreigner** is different! They, the carers, they give us rest and comfort **with the manner by which they treat us** [ξεκουραζει ο τροπος με τον οποιον μας φερωνται]. It is a big thing to have staff who **speak your language and who have the same ethnicity and the same manners** [νοοτροπια]. The same culture and you can **be in the centre of meaning**. Within the meaning, you can be yourself. Yourself!

RES 6 Since we have become like this, they provide for our needs. What else do we want?

In such an intimate, connected, meaningful linguistic and cultural universe, residents and carers feel free to request their preferences and express their feelings, sentiments, moods and frustrations as they would in a Greek family and closely-knit community. They feel accepted and relatively empowered being among their 'own' people and in their own cultural space, and they experience a 'sense of place', (Bottomley, 1992) even though they are not in their own home.

Struggling for the satisfaction of interests and needs under pressure and in situations of tension and conflict

In the nursing home environment both residents and carers, when under pressure and in situations of tension and conflict, were able quickly to adopt and enact family role-play. The variations of family role-play permitted the creation of a temporal space for carers and residents within which they could resist, improvise, and struggle for their needs and interests. In such situations, some paradoxes of

Greek culture are made visible, as well as the power relationships which they sustain and which affects care processes and practices.

Role-play among residents and carers was symbolic. For this reason, both carers and residents found it easier to distance themselves from each other when their interests were competing. This freed them to assume and impose symbolic roles on each other, as it suited their interest of the moment.

When carers experienced dissonance and tensions it was not because they lived in a different cultural universe from the residents, even though their horizons were more extended. It rather was because residents' expectations of the carers were those they had of their children and family. Also it was because, institutionally and professionally, residents - and at times families' - cultural care requests were sometimes perceived as being demands rather than requests for detailed, culturally complex and refined care processes. Cultural care processes requested by residents required more staff time. Cultural practices which required different approaches to care delivery also required time that could not be compared with that allocated for 'universal' mainstream practices. In addition, managerial expectations of PC care practices and (professional) behaviour placed them under enormous pressure.

The PC's cultural and linguistic skills were central to the success of the nursing home. They behaved like lay Greek carers (since they were not trained to be professionals) and used practices that were vital for the wellbeing of residents. From my perspective as a nurse, given the opportunity, carers had the capacity for dramatic improvement, under suitable learning conditions. Because of their limited knowledge of formal English, however, and lack of institutional policies which required an ethnospecific approach, genuine opportunities for them to learn were difficult to obtain. Lack of formal English knowledge it also effectively prevented them from actively participating in the production of institutional policies which affected their practices and opportunities provided.

Tensions often arose because cultural care practices had to be located within institutional rules, regulations and government policies, that

were mediated by professionals habitus and managerial practices that often were in opposition to carers and residents habitus, thus compounding the invisibility of cares and residents interests and needs.

Financial considerations, inadequate staff time and the lack of appropriately trained staff to care for 30 dependent residents created a need for staff to be fast and efficient. Staff time was regulated by managers to maximise outputs within the shortest time possible. Similarly, the mere presence of one qualified registered nurse per shift had direct implications for the care of the residents. This issue is dealt with in Chapters 7 and 8.

It was difficult for RN's to evaluate the effects of PC care on residents. As most RNs spoke no Greek, it was hard for them to understand the relationships and interactions between residents and PCs and to assess the PC's practices or guide and teach them in a culturally relevant way. Because of this, full responsibility for the assessment of care given to residents, and for guiding and teaching PCs fell upon one Greek speaking RN. This generated situations where PCs could neither respond to residents' constant requests and preferences, nor to professional staff members' expectations.

Then residents and PCs unconsciously used roles which benefited them in moments of vulnerability, when under pressure. In tension and/or conflict situations the power relations were shifting to serve their relative interests of the moment. They used symbolic roles that, on deeper analysis, encapsulated invisible but useful paradoxes involving sets of cultural assumptions that construct webs of power relationships in Greek culture as they relate to: (i) family structure and family member roles and relationships of parents and children, (ii) notions of aged with a healthy body versus old age and a disabled body, and (iii) notions of family care based on love and trust versus public care given by paid strangers who did not love and could not be trusted.

Parent / child / benevolent protector

During my fieldwork I observed all carers and worked quite closely with them. I observed their practices in different situations and

under varying pressures. For example, during 1995 and the beginning of 1996, the PCs and residents appeared to be happier than during 1997. The atmosphere of the home was more relaxed and the morale of carers high. Care delivery was then less institutionalised.

Changes in carer practices and the atmosphere of the nursing home coincided with changes that were brought in by the Australian Federal government. Reforms in industrial relations and aged care policies in 1997 seemed to directly impact on the nursing home policies and timetables. In addition, the resignation of several key members of staff and role changes of two other senior members of staff affected nursing home care practices and its atmosphere.

At this time, cleaning activities were contracted out and the time available for such activities was reduced. Similarly, staff time tables were changed and some carers' working hours were reduced. This coincided, with additional work demands that were made on them by additional tasks. Similarly, more demands were made on them as a number of residents' health status had deteriorated, and new residents admitted were more dependent and frail.

PCs were also informed that they would need to have more education, and in the future, new staff members employed would need to have more training. At the same time, two new members, at the PC level of staff, were employed who were selected because they were considered to have more skills in spite of the fact that they spoke no Greek and little English.

All of these changes effectively devalued Greek cultural capital (in the form of Greek language and culture, reasons that justified the development of ethnospecific homes) and produced an atmosphere of insecurity for both carers and residents. Carers were concerned about the heavy work load and the effects this was having on their health. They feared losing their jobs and being replaced by more educated workers. Residents were also concerned about the carers' workload; they did not want to lose them, as they foresaw being cared for by people who did not speak Greek or understand their culture. Such insecurities and pressures affected the behaviour of both carers and residents alike.

The paradoxes generated by role-playing and role - imposition reveals the power of Greek culture and how, in practice, sustains hidden power relationships. For example, while aged people particularly parents and grandparents are to be respected and obeyed, in situations where their body becomes frail and they become dependent, they can be placed in the role of child within a family. As the bodies of the aged, their senses and appearance changed, it appeared that some carers perceived residents as being childlike. Some residents' disabilities made them slow to respond or unable to speak and impeded their mental responses. In Greek society often one hears that a person who ages becomes 'like a child' and should not be taken seriously (συνεριζεται)[22]. Often, this refers to old people who become dependent upon their children or relatives and expect them to fulfil their needs by behaving in ways considered less than adult. It is as though changes in bodily function and appearance directly influence the mind and the character of the person.

At lunchtimes I would always go with the residents and carers to help. Often, I observed that the domestics who were preparing the food and serving it to the residents did not ask them to choose between the two meals that they were offering. The domestics simply served them. According to professional and Residential Care Standards instituted nationally, residents had to be given a choice of meals. Domestics were informed of this requirement a number of times, and were expected by the professional nurses to ascertain which of the two meals provided the residents preferred.

When I asked the reasons why they did not follow this requirement, the domestic staff informed me that they had to have the dining room empty by a certain time. This was necessary so that the cleaners could come and clean the room. They felt that they did not have enough time to complete all their activities within the designated

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22 Συνεριζομαι: This has a variety of meanings, such as, not competing, (only children compete when they see no reason), understanding where they are coming from, not taking something into account, dismissing. Whatever the behaviour is, silly or other wise, it is because they do not know better or they do not mean it. Thus the rational person is obliged to understand them and forgive them and respond appropriately, that is, not engage.

period. Asking residents for a choice took time. Some residents could take at least two or three minutes before they made a choice.

On closer examination it was also revealed that domestic staff felt they could not genuinely ask residents to choose between two meals. This was because one of the meals being offered was less in quantity. This created the impression amongst domestic staff that the larger meal was meant to be the main meal. They felt that if residents were given a choice, they would all chose the lesser meal which would run out before all meals had been allocated. This, they were concered, would lead to complaints by those residents who missed out on receiving one of the smaller meals.

While ideally the aged in the Greek family are expected to be respected and obeyed, and children are expected to have all their wishes or whims granted, neither of these expectations were fulfiled. Work conditions mediated the domestic staff's behaviour; often they would do things they conceived as being 'more feasible' under the circumstances (for example, restricting salt intake, restricting certain foods), ultimately justifying their actions by appealing to knowledge gained through their historically embedded experiences, upbringing, and via the mass circulation media (both Greek and Australian) and by other means.

A combination of institutional factors, mediated by the individual domestic's disposition, (habitus) generated cultural practices that served the interests of individuals who found themselves in relatively more powerful positions in the nursing home field. Thus domestics, from where they stood, used cultural assumptions and little scientific knowledge to construct residents' childlike behaviour (by stating how residents should behave and look), and in the same way justified their behaviour when it was challenged.

OK Why don't you ask them what food the aged want?

DOM We know what they want.

OK How do you know what they want, if the residents do not even know what you offer?

DOM Well, we have tried to ask them before, to choose what they want to eat, and they take hours to answer. And then, when we serve different food from what they had requested , and at the same table to other residents, they change their mind and want what the other residents have been served. You see, the poor things they have lost it (οι καυμενοι τα εχουν χασει)[23]. They do not know what they want, like children. They want this, they want that.

At the same time a resident called me and informed me:

RES 9 I am going to insult her [the domestic].

OK Why will you insult her?

RES 9 I will ask her for more food.

Here, the domestic is expected to offer the resident more food without being asked as in a Greek home. For a person to ask for more food is an insult to the host/housewife, since they are expected to offer food and ensure the person does not finish a meal being hungry. It is also embarrassing for a person to ask for more food since they are not supposed to do so. In order to lessen this resident's embarrassment, I said to her:

OK Do not worry. I will go and ask her. [I went to the domestic and asked her]: 'Can you please serve a bit more food for Mrs ...?'

DOM Uh, she had enough. She does not need to have more, she is overweight.

OK Yes, I am aware of that. But she is hungry, and she wants more.

DOM Ah, don't listen to them. They do not know what they say. They can eat till they burst and still ask you for more. They do not understand. They have lost their mind (μυαλο). You must not listen, take seriously what they say (μιν τον συνεριζεσαι).

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23 Καυμενοι (Kaoimeni): Refers to people who suffer and are wounded immensely for a variety of reasons. They are to be pitied. Often 'Kaoimeni' refers to someone who is unlucky.

OK How do you know that she does not know what she says?

DOM Uh, old human beings now! What do you expect (γεροι ανθρωποι τωρα τι περημενης)?.

OK What do I expect? I would expect you to do what they request. They know what they want. They are adults. Why are you concerned about their weight? The residents do not think they are overweight.

Here the domestic indicates that the instructions of professional nurses are taken into account. Carers, however, without the necessary nursing knowledge were unable to make relevant clinical judgments and in application generalised professional nurses instructions. Because of this they were also unable to challenge on professional grounds instructions that were culturally incongruent and potentially harmful to residents' **well-being** and **quality of life.**

DOM Well, we have been told not to give them too much for their own good (για το καλο τους) because they become too heavy and the girls will have to lift them, and they break their backs.

OK I noticed also that you do not have any salt and pepper on the table. Why?

DOM They are not allowed to have salt. They do not know when to stop pouring salt into their plates.

OK But why are they not allowed to have salt?

DOM Because they have blood pressure and their heart.

OK Who told you that?

DOM The registered nurses.

OK But you know, not every one has high blood pressure or problems with their heart. Also, they have minds and they can decide themselves what they want. They know they have high blood pressure and problems with their heart!

DOM Well that is what I was told, [while walking away attending to her work, appearing unconvinced] and

they pour, anyway, the salt. They do not know when to stop.

At a later time I used salt for my own lunch. I was surprised to find that I was 'pouring' the salt on my food. This, I realised, was because the salt in use was very fine and low-strength salt. The above example illustrates how internal Greek cultural paradoxes and/or contradictions create a space from which persons in relatively powerful positions can justify their interests in their cultural practices. The above case is not a case of an aged resident senility but an illustration of carer cultural improvisations used in the logic of practice.

The following discussion was held with a mixed group of Greek background and Australian background carers. While the information below holds a variety of meanings, it constitutes a further illustration of ideas of the aged as irrational.

RN Here the aged do not wish to get up at night even if they are wet. They prefer to stay in bed till the morning when they get up. Here the aged Greek prefer to stay in bed even incontinent, and prefer to have a sleeper bed pan.

OK Why do you think they do this?

CARER 4 It is because they have no brains. They do not feel what they do and whether they like it or do not like it.

OK But they have brains.

DOM They have brains, but they see us and ask us to take them to the toilet a hundred times. You tell them, 'I can not do it. It must be the proper person [carer]' and they still insist. Therefore they have no brains because, if they had brains ... !

It is illustrated in the above discussion that carers' cultural notions and limited scientific knowledge informed their decisions and practices. However, their lack of nursing and medical knowledge and their subordinate position in the nursing home hierarchy, made them unable to question professional opinions and instructions, or

challenge them in any serious way. My purpose in referring to the discussion is mainly to expose the cultural paradoxes that underlie PC's behaviour and practices. Such practices support the interests of those who have relatively more power in the given situation.

In instances where the carers are faced with such paradoxes their care role reverts to that of parent and the resident becomes a wayward child. At the same time as this role reversal occurs, respect for the old aged and for their wisdom and experience is still believed to be maintained, in reality the situation is misrecognised. Within such an emotionally charged environment these unexpected and frequent discontinuities allowed a 'see-saw' power-play between residents and carers. In such a permissive cultural field between residents and carers, no-one seethes or remains silent; rather, they express and communicate their feelings and distress.

Care by strangers (ξενους) as opposed to family members

While an imaginary family relationship context, based on Greek culture, has been created within the nursing home, this can be disrupted. Qualitatively, family care and care by strangers differ significantly in the experience and minds of Greek people. These domains of care are based on assumptions that symbolically promote different relationships and affect care delivery processes accordingly. The imaginary family relationship between carers and residents can easily be changed by both players, according to circumstances to a public care context that promotes stranger relationship. This change takes place in times of pressure and is used by both residents and carers to place psychological pressure on each other. Again role play, in such situations helps to mask the interests of the respective participants.

CARER 6 I do, I tell them. They all want attention at the same time, and they are all dependent on us. You tell me if you have two hands and you only have got so much time per person how much time you spend with them?

OK Why, if they do not need it?

CARER 6 Λουλα [resident] is all over and she demands. They, other residents, feel jealous and they say why

call at the same time (This situation is not uncommon). Σοφια! Σοφια! I must turn, from the four or five residents who call to see who has the real first need that I must go, and then I will go to others. **This does not mean that I love more that person!** I told them this! [loudly and with emphasis].

CARER 7 &8 They say, 'Why are you going to that person first, and you do not come to me?' **They are like children, jealous. You love them all, but when all the children call you together you must see what?** Every one has become self-centred, every one sees her/his pain and looks after themselves.

OK In other words, they have no feelings for the others (συναθροποισμο) or empathy?

CARER 7 No! Because they are deserted here, in the nursing home, that is the motivation. Sometimes they say, '**Since my family deserted me, why should these people look after me? If I do not scream, if I do not make my presence felt, what will happen to me? They insist, insist** (επιμονα, επιμονα)!

OK How do you feel by being called like that and also, at times, being sworn at as well?

CARER 7 & 8 [Both carers with emphasis] You understand? You understand why they treat you like that? Because you are the only human being (ανθροπος που ερχεσαι σε επαφη μαζη τους) that comes into contact with them like that.

Periodic detachment that occurred through ascribing and adopting carer roles that reflected relationships of strangers versus family members permitted both residents and carers for short moments of time to psychologically let go of ideal cultural family associations. The residents' situational distancing of carers and carers' distancing of residents enabled them to cope with internal tensions, insecurities and cultural dissonance. Temporal detachment created a space that allowed carers to cope with residents' constant requests and 'demands' that they knew they could not respond to adequately. Residents also, by temporarily detaching themselves from familial

relationships with carers could then treat carers as (αδελφες) strangers from whom they could demand care (because they were paid). While emotions and frustration would be freely expressed, some residents would also forcefully resist their objectification, by insulting the carers.

The following incident illustrates how residents would resist their objectification if carers were behaving towards them in this way, (that is, not the way a family member would behave with a parent's requests).

As I was walking down the corridor at the nursing home with a Greek-speaking registered nurse, a resident sitting on a wheelchair but with fully functioning arms asked the nurse:

RES 10 Push me down to the foyer (Σπροξε με εκει κατο στιν σαλα).

GSRN You can push yourself. It will do you good. (Εσυ μπορεις να σπροξης μονη σου την καρεκλα θα σου κανη καλο)

The registered nurse did not play the family role of a dutiful child and thus the resident felt free to abuse the nurse by distancing herself and placing the nurse at a 'stranger' paid carer role.

RES 10 [Furiously, she barked at the nurse] Lazy dog (Βρε κοπροσκυλο)! [Then she turned her head away searching with her gaze to find someone else to ask].

OK Can she push herself?

RN Yes she can-and well- but she does not want to do it.

OK Do you know why?

GSRN Because everybody else is on a wheelchair and is pushed around by the carers

OK Have you explained to her why she is different?

GSRN Yes, but she does not care. She wants us to do everything.

Some residents unfortunately were not willing to participate in physical activities even when it would have helped to maintain or improve their physical abilities. This, however, is not surprising. The residents' moral universe and social experiences endorsed the view that it was right and correct to have their wishes fulfiled by their children - and instantly, and particularly when old, tired and sick. The 'sick role' forms part of this relationship of obligation.

In a family environment in Greece (it is for children to do normal chores for their healthy parents out of respect for them - such as to serve their food, bring them water, make their coffee, respond to their general requests during their time of rest. The old believe now that they are tired and disabled. They deserve to rest after a lifetime of serving the needs of their own parents, marriage partners, their own children and grandchildren. Their expectation is that their wishes should be fulfiled. These chores were expected to be done by their children. The children, by doing this, showed they understood the harsh life they had to cope with to survive.

As I followed PCs while they were attending to the needs of residents, I observed behaviours which at times deeply moved me. I observed instances of lay cultural care (as described by residents earlier in this chapter) which, according to Leininger, and Kanitsaki, would be considered helpful, enabling, and healing. But I also observed elements of care practices that were produced under institutional constraints and tensions and that consequently were provided with the fastest possible speed PCs could manage and with time economy that demanded bare minimal task performance. This I call **'industrial care'**. Elements of such care practices can be viewed as toxic rather than healing, empowering and/or enabling. Indeed, from the residents' perspective, such carers could be viewed as uncaring and, from a nursing perspective, could be judged unprofessional and harsh.

Industrial care practices

'Industrial care' is care delivery that resembles factory assembly line work. That is, care practices are production-driven, task - and

outcome -oriented, fragmented, reductionist, objectifying and inevitably dehumanising. Institutional forces (such as time availability) and often invisible managerial expectations, the residents' 'many needs' (as stated by carers) and expectations, and carers' lack of health care education generated a working environment where industrial care seemed to be the most efficient method that carers could use to cope with heavy demands.

Nursing home conditions generated a situation where a degree of institutionalisation was unavoidable in order to ensure maximum performance outcomes from carers. Carers seemed to be trapped in a situation where practice of industrial care was inevitable. This appeared to be borne out by the fact that managerial awareness and acceptance of how institutional constraints impacted on the quality of life for both residents and carers was difficult to discern. Certainly, there was no material evidence that management was taking measures to relieve some of the burdens generated by institutional conditions. For example, there were no efforts to increase relevant staff employment, or increase carers' hours of work per day. On the contrary, management was reducing some carers' daily working hours (see Chapter eight).

Industrial care practices intersected with the carers' past experiences in various Australian industrial assembly lines, and with their own notions of what it meant to be a fast or diligent Greek woman (προκομμενη)· For example, teams of carers often competed and subsequently prided themselves when their own team finished its tasks first. This accords with pervasive cultural norms where women's work (a form of women's capital) that is undertaken efficiently and with speed is highly valued. Greek women had to be strong to survive in harsh and often poor environments where those who were slow were perceived as lazy and incompetent, and softness was seen as a weakness in character.

Someone who has not lived within and or experienced the Greek culture might judge such care practices as being cold and harsh. However, the warmth, love and bonds that such practices concealed - and which carers and residents shared - could easily be missed if viewed without cultural insight and understanding.

As carers themselves were becoming more institutionalised and as pressures were mounting they adopted industrial care practices to cope with demands. By adopting symbolic roles that justified the delivery of industrial care they could relieve their anxieties and frustrations - as well as the effects of cultural dissonance. Such role-playing, however, emphasised the power of carers over residents.

In my fieldwork, I followed most of the carers and some registered nurses as they worked. I was well aware of the demands made on the institution by government policies as set out in the Classification Certification,[24] Accreditation Funding[25] and User Charges Standards[26]. Also, as a nurse I knew that holistic and individualistic care could not be separated out to tasks, without being fragmented, from personal and other professional care without serious consequences to care practices.

The person as a whole human being does not experience him/herself in a fragmented fashion. Individual fragmentation, however, is frequently imposed upon individuals who need the services of others. Nevertheless, a person acts, and experiences life and events as a whole socially interactive human being in every situation.

Greek lay care often had to be curtailed by PCs as institutional conditions governed carers behaviour (eg lack of time) and because of its 'invisible' nature in the eyes of professionals. This lay care involved such activities as keeping company (presence, παρεα), sitting with and listening to residents expressing their concerns and needs, exercising paralysed limbs, taking residents for a walk, paying attention to details, joking and playing and using humour with residents, responding to residents requests and passing time with each other. A caring work tempo could not always be sustained, under conditions which fostered practice of 'industrial care'. Carers felt the need to be task-oriented and were driven by time constraints.

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25 Accreditation Funding see Chapter eight

26 User Charges Standards see Chapter eight

Some coped better than others, but all exhibited stress, strain or anxiety. Some examples will be given below to illustrate occasional tense interactions between carers and residents under pressure. Different individual carers would handle stressful situations and situations involving conflict using different coping strategies. One might interact with a resident in an 'obedient' child- like role, another like a benevolent or authoritarian 'oppressive parent', and yet another like a stranger carer.

The tempo of industrial care practices

('No matter how hard we push ourselves we have not enough time')

Sometimes some carers performed tasks hurriedly and the quality of care was compromised. For example, residents washed in bed (sponged) would be quickly undressed, often by dragging their clothes over their faces. Bodies would be moved quickly, often when frail and painful limbs required gentle and slow movement to avoid suffering and harm.

Residents' faces would be washed first, then the rest of their body in quick sweeping motions. The carer's would miss large areas of the body although they paid special attention to the armpits and to the area under the residents breasts. Carers would then, quickly, with one long sweep over the body, arrive at the genital area which would be carefully cleaned. This example represents a fragment of lay, culturally congruent care that was retained amid the haste of work. It was also observed that, when residents had to be turned over from side to side to be washed and/or for their back to be massaged to relieve pressure, they were sometimes flipped over like a pancake. Often the head, unsupported by a pillow or a hand underneath it, would be hanging uncomfortably over the bed, or the face would be squashed against the pillow. This, of course, was potentially dangerous as a resident who could not voice distress could be suffocated. The bedclothes on which the residents lay were often left loose and bunched up under them as they moved, forming ridges on their skin that could foster the formation of pressure sores - and, of course, discomfort.

In the case of washing, carers' attention seemed to be directed solely to the task at hand - that is, to wash the body quickly and precisely.

The body was, at such times, entirely objectified. Such procedures would last from 5 to 10 minutes at most. I also found that one particular carer, who did not speak Greek or English could complete the bed bath/sponge of a small, thin resident within three minutes. One might consider this simply an impossibility. However, the procedure was quicker because the carer could not communicate with the resident. In this case, the resident was confused and obviously distressed, constantly asking the carer, 'What are you doing? put my clothes on, put my clothes on'. The carer meanwhile continued to work quickly and in silence.

Carers often remarked that they were forcing themselves to work faster to cope with the amount of work. They could not work any faster, they explained. 'We do all we can but our body is so tired and aching from exhaustion that we will drop down'. They felt they could not satisfy the 'many needs' of the residents. They seemed to think that they had to streamline their activities in order to cope and to attend to as many requests (at times firm demands) as possible. These requests included such things as, fetching a variety of things the residents needed, moving and turning them on their beds, clean residents who were incontinent, or who had not been taken to the toilet in time and had soiled themselves, and so on.

During the morning shift when most of the residents had to be showered or sponged in bed, each carer would have up to two residents sitting on toilets while waiting for their turn to be washed. At the same time carers often would be washing or showering a third resident. The residents who were sitting on the toilet would start to call continuously for someone to go to and help them to get off the hard toilet seats, so the carers were under enormous pressure to finish what they were doing as quickly as possible.

One day, I was observing one of the carers taking a resident to the shower. The carer took her first to the toilet and as she was pushing the shower/commode chair over the toilet, the resident started screaming. The carer did not stop but kept pushing the chair till I interfered and said 'just a moment. Let us see what the problem is'. I kneeled on the floor to investigate. I realised that the loose flesh of the resident's buttocks was protruding below the chair. Because of

this, as the chair was pushed over, the residents flesh was getting caught between the toilet seat and the chair. I communicated this to the carer and suggested that a more appropriate way had to be found. As I was talking, however, and before I had a chance to do anything, the carer pushed the chair over the toilet. The resident screamed, and then stopped. The carer said, 'I know what the problem is but what else can I do? Since we have no other chairs and the other carers are busy, how am I to lift her over the toilet?' At the time I felt a surge of anger and a sense of dismay. However, I tried hard to control my feelings and said to the carer, 'this is very dangerous for the resident, painful and cruel'. As a nurse, I then proceeded to explain ways to avoid these types of practices.

At a later time in my fieldwork I was most surprised, when observing a different carer, to see that she did the same as the other while also being aware of the problem. These carers were two of the 'best' carers in the nursing home, and well-liked by residents. On this occasion I said to the carer, 'This is terrible! Have you reported that the commode chair is too low or the toilet too high and need to be adjusted, to the floor registered nurse?' She indicated that they had, but no action was taken.

It seemed to me that lack of carer education in relation to their responsibilities and care skills played a significant role in their practices generally. In the above example, it seemed that the carers were unaware that such acts could actually injure the resident. They knew that they caused pain, but they had learned to cope in the situation by dismissing the expressions of pain as momentary. The resident also seemed to forget the incident as soon as the pain had subsided. No one could possibly prevent harm to the resident's skin and muscle, let alone the pain and suffering caused, without knowing how it had been brought about. To know this, however, carers needed to be supervised by registered nurses and preferably by those who spoke Greek. The nursing home, however, had only two Greek-speaking registered nurses, making this impossible.

Similarly, I observed that some carers would sometimes miss, or normalise, early signs of residents' physical changes. Even very obvious injuries and early physical signs of impending problems

went unnoticed. However, on those occasions when some carers did relay important information, about the residents' conditions to the registered nurse on the floor, the nurse seemed not to respond immediately.

Child /mother role in cultural dissonance

On one particular occasion I followed one team of two carers for their full shift. During this time I observed that the two carers worked in unison, working with and helping each other. They had to provide the toileting, hygiene and dressing care for 15 dependent residents within a time frame of five hours. Several times the Director of Nursing explained to carers that they did not have to have all residents finished by lunchtime. One of the carers was rostered on until one o'clock and the other until 2.30 pm. They were most anxious to finish toileting, washing and dressing all residents by lunchtime. The other carers and the residents all wanted the same thing. That is, they wanted the residents to be out of bed and prepared for the day, on their respective chairs and in their respective places in the dining room, before twelve o'clock. On this day, however, one of the residents could not be prepared by the carers by lunchtime. The resident (a woman), was most disturbed and depressed about this situation. The carers explained in detail to her, while one of them had her in a full embrace, why they could not have her ready by lunchtime. They washed her face and hands, however, made her comfortable and prepared her for her lunch in bed.

The resident explained that she understood, but felt neglected. She was attended to after lunch, dressed and taken out of bed to be with the other residents. She told me, however, that she felt ill for the rest of the day. The resident kept saying, 'I always used to get up at the crack of the dawn (χαραζε η αυγυ). I never stay in bed, only when I am for death. Staying in bed makes you sick (σε αρρωστενει)'.

The carer involved with the care of this resident shared her feelings. The carer, anxiously, declared it was a sin (κριμα) to leave the resident in bed so late into the day:

CARER 4 It is a sin [Ειναι κριμα] to leave them so late in bed. Everyone wants to be up and ready by lunchtime. It is not good for them to stay in bed. They like to get up and be prepared before anyone sees them.

I want to help all residents and do the best for them but it does not matter what I do. I cannot help ... this. We have been delayed today. We had several people, that is, as we finished washing them, they dirty themselves again all over. We could not leave them like that.

Resident and carer here felt that the residents' dignity and integrity was injured. Getting up early and preparing herself in a socially acceptable manner related to her sense of social presentation of self, which also is intertwined with a persons sense of dignity.

This example, is one among others that indicates how carers who are culturally sensitive and informed feel psychological dissonance and guilt for not doing what they believe has to be done for residents so that their quality of life is not diminished. It seems that these carers wish to give care they believe is culturally specific and appropriate; however, residents' needs are such that, often, time is not available for carers to deliver that appropriate care.

Authoritarian parent/child and stranger role adoption and imposition

The following observation speaks to the variations of role-play and the asymmetrical power relationships which such roles engendered under pressure.

The resident was showered dressed and sat on a wheel-chair. She was taken to her room. One of the personal carers, in a benevolent, authoritarian tone of voice (like a parent), stood in front of the resident and, with body language that meant 'business', emphatically instructed the resident:

CARER 7 Now [σε περιποιηθικαμε], we have done everything for you- all you asked and wanted. Now we have done everything for you, make sure you do not call us again since you know we are so busy and we

have so little time. We have to attend to other residents.

As I walked into the room the personal carer looked alarmed, embarrassed, and stopped talking. The resident was sitting on the wheelchair with her head down, looking at the floor; submissive, like a child receiving parental instructions about how to be 'good'.

I was most surprised to hear this particular carer talking in this manner to the resident. I had thought her to be one of the most sensitive carers and indeed, according to the residents, she was. In this instance, however, I recognised that carers and residents were unconsciously adopting family role-playing to cope with mutually understood pressure.

Another type of interaction-between a different carer and resident-indicated clearly that carers could also distance themselves and treat residents like strangers (ξενοι). In such instances, the power interactions were apparent. Once a resident was having a shower and, according to the personal carer, she was taking too long. Loudly, angrily, and in frustration, she shouted to the resident:

CARER 8 Come, finish [Αντε τελειωνε πια και εσυ]!

The resident quickly stopped what she was doing and obeyed the carer's orders. I observed the same personal carer, at a later time, taking another resident to the toilet. She left the resident sitting on the toilet for about two minutes, then ordered her, with authority:

CARER 8 Get up [Σηκο]!

As I was standing there, I said:

OK How do you know she has finished? She has been sitting on the toilet for such a short time.

CARER 8 [Abruptly] **I know!**

The resident then was helped (pulled) up by the carer, had her bottom wiped quickly, and then was taken to sit with other residents. The resident said nothing, as if the incident had never happened.

While different practices operated, the care that prevailed, however, was more akin to beneficial family cultural lay care model. When carers, however, could not deliver such care or residents could not receive it for a variety of reasons, carers and residents would quickly assume different roles that allowed them to express behaviours and practices which reflected relationships of parent/child, child/parent, family carer-receiver of care and stranger carer-receiver of care. By flitting from role to role regularly and according to the situation, both residents and carers generated an environment with a certain flexibility that enabled them to struggle for their interests. This also permitted them to express their anxieties and frustrations, and to share warmth, love and understanding. Similarly, such a changeable relational environment also permitted residents and carers to temporarily trade insults, objectify and to dominate and oppress each other.

Conclusion

PCs, under stress and pressure, could not adopt any other method of delivering care but task-oriented 'industrial care'. Institutional planning, rules and practices are guided by the country's economic, legal, industrial, and professional mainstream discourses which, by their nature, define and determine which of the residents' needs are legitimately fulfilled. Under such conditions it is the Greek carers' dispositions (or habitus) and language skills which mediate between institutional structure and the cultures involved (professional mainstream and Greek) and which foster culturally-congruent, meaningful lay care delivery to residents. Culturally-congruent lay care becomes a reality in the home because residents and carers share common experience and understandings and because they use a common language, co-extensive to culture, together allow vigorous interactions, even negative at times, and deep, meaningful relationships to develop between carers, residents and their families.

Carers,' residents' and families' dispositions produce a 'Greek' cultural context within which significant and meaningful relationships and bonds develop which sustain a sense of place for both carers and residents alike. Both residents and carers struggle against a number of forces to maintain their cultural practices and universe within an institutional power field (see Chapters seven and eight).

Achieving and maintaining a meaningful cultural universe in an ethnospecific institution demands energy and commitment from those who work within it. This is because such institutions are situated within, are dependent upon, controlled and shaped by, the larger mainstream political and social processes. Additionally, these processes permeate internal institutional policies, regulations and rules, and find their 'natural' supporters in the managerial (professional) staff who are drawn from 'mainstream' society.

Thus, in relation to the many tensions and competing interests within this environment, great demands are made on all members of staff; but in relative terms, far more are made on domestic staff and PCs, who can fully communicate with and understand the culture of the residents but who are positioned at the bottom of the institutional structure. This situation reflects the many difficulties which ethnospecific institutions are faced with, as they become the domain within which larger long-term social inequalities[27] become visible.

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27 Larger social long-term inequalities based on 'ethnic' (non-English speaking background migrant) differences occur because of the inadequacy of government policies and the lack of will on the part of power holders to transform adequately Australian institutions so that all peoples' life chances are enhanced. For example, in nursing education, while it is true that many ethnic groups, including Greeks, would select medicine, law and so on before nursing, so do Anglo-Saxon-Celtic background Australians. What seem to be the issues of concern are the selection criteria of different courses and, for those who enter the courses teaching processes and practical expectations which they find difficult and which seek to assimilate them to mainstream expectations. This creates for them enormous pressures; and even if they survive these pressures they stand to lose much of their culturally useful knowledge and skills. or may come to judge them inferior and so avoid using them. In this case, reduces their particular usefulness to ethnic migrants would be reduced. Equally, government policies and professional requirements have created a difficult environment for overseas qualified nurses (particularly southern and Eastern European) to register in Australia; and thus many of these nurses cannot practice as registered as Division 1 nurses.

Variations in interactions and relationships, and the prevalent generic (lay) cultural care (as opposed to 'industrial' care) delivery were mediated by mainstream professional expectations as well as by the working conditions that were produced because of asymmetrical power relationships in the nursing home (see Chapters seven and eight of this thesis).

Although constituting disadvantaged groups in relation to the larger society and the internal management of the nursing home, residents and carers were also empowered by the Greek space they occupied in the larger scheme of things.

They had a Greek space which, by its nature, permitted both residents and carers to legitimately struggle to ensure that a sharing, meaningful and enabling cultural universe survived where most of their interests were served. A sense of belonging, a sense of place, a sense of legitimacy to be who they were and a sense of security was provided in the Greek nursing home which could not be provided in mainstream institutions. This is clearly indicated in discussions I had with residents earlier in this chapter. The Greek nursing home provided a cultural universe at the cares' and residents' level that made residents feel free to exercise or express their right to make requests and/or demands. Similarly, it provided a cultural universe that allowed them to converse meaningfully as intelligent human beings and adults and as equals among themselves. It also enabled them to converse in ways where they could use effectively their dispositions and their role-playing to struggle to compete and fulfil their respective needs and interests.

CHAPTER SEVEN

THE NURSING HOME FIELD OF POWER[1]: STRUCTURE AND AUTHORITY

> Fields are conceptual constructions based upon the relational mode of reasoning. "To think in terms of field is to *think relationally*", (Bourdieu & Wacquant 1992:96, Swartz 1997:119). They illustrate Bourdieu's relational logic by encouraging the researcher to seek out underlying and invisible relations that shape action rather than properties given in commonsense categories (Swartz 1997:119)

Introduction

In this chapter I examine the 'force field' wherein the distribution of mainstream capital and how its privileging reflects a hierarchical set of power relations within the larger society and among competing individuals and groups within the nursing home. The 'naturalisation' of the hierarchy and mechanisms of authority within the home are examined in terms of the cultural hegemony of British-Australian social and cultural norms, and the dominance of English-language institutionalisation over the ideas of ethnospecific care. This discussion will illustrate the unexamined 'common sense'[2] and hegemonic practices that reveal structural inequalities and distinctions that directly influence the construction of an independent nursing home field, albeit homologous to the larger society, and mediate its conditions.

I shall demonstrate the ways that the hierarchical structure within the home echo and reinforce the structural inequalities and distinctions of Australian society that maintain a pattern whereby

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[1] 'By field of power, I mean the relations of force that obtain between the various social positions which guarantee their occupants a quantum of social force, or of capital, such that they are able to enter into the struggle over monopoly of power, of which struggles over the definition of the legitimate form of power are a crucial dimension ...' (Bourdieu and Wacquant, 1992:229-230)

[2] Common sense: see introductory chapter footnote 5.

immigrant groups from non-English-speaking countries are positioned as 'other'. Drawing on Bourdieu's analytical constructs of *field, habitus* and *capital*, as discussed in Chapter Four, and Gramsci's (1971) theoretical work, I shall discuss the ways in which notions of British-Australian 'normality' and 'commonsense' constitute the Greek residents' and staffs' values and behaviours as alien, inappropriate or obstructive to the smooth-running of the home.

Finally, I argue that the field struggle between British-Australian and Greek staff, residents and relatives to define social reality in the nursing home (that is, which of the two groups' cultural capital is legitimate and/or 'normalised') illustrates both groups' resistance to each others' 'commonsense' expectations and practices. Ultimately, however, the structure of the nursing home privileges British-Australian capital and its holders, as it does in the larger society. At the same time, however, the resistance by Greek staff, residents and relatives to conforming or complying with the normality of the British-Australian staff's 'commonsense' and with institutional regulations affirms the stratification whereby ethnic differences are conceptualised as inferior.

In discussing the nursing home governance and practices of the nursing home which was the site of this study, I omit material that might reveal its identity.

Nursing home structure and field of power-distribution of mainstream and Greek capital

> [E]very power which manages to impose meanings and to impose them as legitimate by concealing the power relations which are the basis of its force adds its own specifically symbolic force to those power relations'. To put this in the context of the theory from which it derives, and which it develops powerfully in new directions, we can say that not only are 'the ruling ideas, in every age, the ideas of the ruling class', but that the ruling ideas themselves reinforce the rule of that class and that they succeed in doing so by establishing themselves as 'legitimate', that is, by concealing their basis in the (economic and political) power of the ruling class (Bottomore 1976:xv).

> "Each social class and class fraction has a characteristic habitus that generates specific sets of practices and produces distinctive lifestyles (Swartz 1997:144). "[S]ocial inequality is rooted in objective structures of unequal distribution of types of capital" (Swartz 1997:145). "Agents bring the properties of their location in a hierarchically structured social order into each and every situation and interaction" (Bourdieu 1984:244, in Swartz 1997:145). "Class boundary institutionalization depends on the relative symbolic power of particular groups to impose as legitimate their vision of the social divisions in society" (Swartz 1997:148).
>
> The specific efficacy of subversive action consists in the power to bring to consciousness, and so modify, the categories of thought which help to orient individual and collective practices and in particular the categories through which distributions are perceived and appreciated (Bourdieu 1990: 141).

The Greek nursing home was created through the efforts of a group of Greek Australian people who could be viewed as middle or upper class (doctors, lawyers, pharmacists, businessman, etc.) 'ethnic' Australians and, in the main, men. It was established with the economic support (economic capital) of the Greek community and the Australian Commonwealth and relevant State government. It has been operational for nine years and is governed by a 12-member Board of Directors (BD), of whom four are women. One women, holds a position on the Committee of Management (Annual Report of 'X' 1996-97[3]).

Members of the BD were of Greek background, and the majority were born overseas of Greek parents. However, they had been *educated within the Australian educational system,* as most had arrived in Australia as young children. Senior Nurse Managers were Australian-born of English-speaking British Irish descent (ESBID). The Board of Directors (BD), Chief Executive Officer (CEO), and General Manager Care Services (MI) (who was also a Division 1 registered nurse) were responsible for a number of other facilities in addition to the home.

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[3] For reasons of confidentiality and disguising the identity of the home, full citation details cannot be given here.

In terms of Bourdieu's 'habitus', the production of nursing home conditions and practices was mediated through people from different cultural and language backgrounds and with individual experiences, histories and life trajectories working together in a Greek ethnospecific nursing home or Greek space. However, this 'Greek space' existed within the larger Australian society that is dominated by the Australian mainstream cultural symbolic order. While the nursing home field was autonomous it was homologous to the larger society's institutional fields. Members of staff who occupied the spaces of the hierarchically ordered positions in the nursing home generated through their dispositional (habitus) practices, social distinctions translated from the larger society.

Wider social distinctions made on the basis of gender, ethnicity, class, the mainstream (dominant) English language and culture and the subordinate Greek language and culture, were at work in the nursing home field. Such distinctions were revealed in the practices of oppositional groups struggling to dominate the nursing home: that is, the Australian (ESBID), the Greek and the Australian Greek-born groups. The impact of these distinctions was influenced by the power network relationships that were formed in relation to:

(i) the occupation and reproduction of hierarchical nursing home positions by individuals who possessed legitimised mainstream capital, that is, British-Australian culture (e.g. behaviours, tastes, preferences, lifestyles, communication styles, presentation of self, and so on), language and educational credentials (which also made visible gender distinctions at the CEO and BD levels);

(ii) the privileged access of these individuals to mainstream economic, cultural, social, and symbolic capital such as: professional discourses[4]; English language; information and

[4] Power/knowledge: Foucault (1977:27-28) explains that the notion that knowledge can only be produced in the absence of power relations is fallacious and that, instead, '[w]e should admit rather that power produces knowledge (and not simply by encouraging it because it serves power or by applying it because it is useful); that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations. These 'power-knowledge relations' are to be analysed, therefore, not on the basis of a subject of knowledge who is or is not free in relation to the power system, but, on the contrary, the subject who knows, the object to be known and the modalities of knowledge must be regarded as so many

knowledge; network relationships, power formations and Government (Federal and State); and other discourses on policies and regulations;

(iii) access to discipline discourses (e.g. nursing, administrative etc); and

(iv) staff directly associated with mainstream society's general symbolic power of 'normality' that defines the 'other'.

The nursing home's authority structure (and field of positions) paralleled dominant cultural/symbolic order[5] and power. This reproduction of the dominant cultural/symbolic order in the nursing home's hierarchical field of power illustrates the relational nature of culture to social structure and how these are mediated through individual *habitus* that generates human action and practices. When agents were talking, acting and practising in all field positions in the nursing home, they were expressing their dispositions and the corresponding social symbolic bounded spaces they occupied (mainstream and ethnic, male and female, professional and unqualified, upper and lower class) homologous to the stratified larger society. Thus, agents' dispositional practices made

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effects of these fundamental implications of power-knowledge and their historical transformations. In short, it is not the activity of the subject of knowledge that produces a corpus of knowledge, useful or resistant to power, but power-knowledge, the processes and struggles that traverse it and of which it is made up, that determines the forms and possible domains of knowledge.

[5] Calhoun, LiPuma, and Postone, (1993:18-21) explains Bourdieu's concept of culture. 'The cultural/symbolic order runs parallel to the social structure in the sense that it is an independent domain that is derived from, though not reducible to, its role in expressing, reproducing, and legitimizing social structural relations within fields. Because culture is "relational", there exists a "space of symbolic stances" which is independent of, yet homologous to, "the space of social positions". When agents classify talking (as when a speech pattern is said to be bourgeois), [in this case the Greek speech pattern], they take a position in social space through position taking in symbolic space [in this case, ethnic space]." In Bourdieu's theory, the symbolic system cannot be reduced to, or viewed as simply reflective of, the social structure, because the symbolic orders are specific to given fields'. In this case, the symbolic orders are specific to the nursing home field. Symbolic oppositions were expressed in the nursing home and were mobilised on a daily basis to influence nursing home practices and power relationships. 'The symbolic order "owes its structure" to the social conditions of its production and circulation, and its particular "force" to the fact that the power relations which it expresses are manifest "in the misrecognizable form of relations of meaning ..." (Calhoun, LiPuma & Postone, 1993: 20). Within this home there was no doubt that the cultural/symbolic order was used, perhaps unconsciously, to valorise and elevate certain behaviours and practices (and, of course, English language), while demoting Greek language, behaviours and practices. It was also evident that this situation attracted oppositional resistance from Greek staff. Bourdeu's theory can help explain the different habitus at work in the nursing home which, while they were in opposition, the symbolic order and cultural capital that different groups claimed or aspired to were used accordingly as instruments of power to constrain and/or create opportunities for members of staff. Conflict and tensions based on different aspirations, expectations, desires and needs, including struggles as to whose culture (practices, behaviours, knowledge) was to prevail in such a complex context, were alive and constant within this environment. Thus the functionalist symbolic order was only potential and could only be purely functional in fields were people had lost their agency.

visible the forces of power in the nursing home field and their effects on staff relations, interactions and practices.

Structure of institutional field of power in relation to institutional positions staff occupied

Tables 3 and 4 below depict: (i) the objective nursing home field power structure (positions and their occupants according to ethnicity), and (ii) residents and staff characteristics. The tables also reflect the field structure and field of power in relation to the positions agents occupied. Relations of rank were differentiated on the basis of legitimated capital (cultural, social, and symbolic) agents possessed in relation to professional and non-professional credentials, and English versus Greek language and culture.

	P/C	DO	SEN	RN	M II	M I	CEO	BD
British/Irish descent Australian	-	-	1	3	1	1	-	-
Greek born	7	6	-	1M	-	-	1	#
Australian Greek-born	3	-		1	-		-	-
Other non-English speaking countries	2	-	1	2	-	-	-	-

All the above staff are female except one RN who is male

PC	=	Personal carers (Unqualified staff)
DO	=	Domiciliary staff (Unqualified staff)
SEN	=	State Enrolled Nurse (One year nursing education, now known as Division 2 registered nurses)
RN	=	Registered Nurses (Three years nursing education, now known as Division 1 registered nurses)
M II	=	Director of Nursing (DON) (a Division 1 Registered Nurse)
M I	=	General Manager Care Services (GMCS) (a Division 1 Registered Nurse)
CEO	=	Chief Executive Officer (Management)
BD	=	Board of Directors
#	=	Hold positions, but unable to enumerate.

TABLE 3: Staff and the respective institutional field positions they held in the nursing home.

The value of the capital each individual possessed was determined, however, by: (i) Australian English speaking British Irish descent (ESBID) senior nurse managers who selected members of staff, and (ii) the broader social field of availability that, in turn, was influenced by larger institutional and social practices which are discussed below.

Greek-speaking Division 1 registered nurses (GSRN's), while arguably possessing the most valued resources (that is, capital, both mainstream and ethnospecific, essential for an ethnospecific nursing home) occupied subordinate institutional positions.

The inequitable distribution of Greek capital as possessed by Greek-speaking staff in the nursing home field structure of power ensured that not only were asymmetrical power relations maintained but also that the Greek elements remained subsumed, unacknowledged and without authority, under the control and direction of Australian ESBID middle - ranking and senior nursing staff.

This situation is not surprising. Similar practices historically had produced the same employment patterns for immigrants in the larger society. For nurse managers, as members not only of mainstream society but also of the nursing profession, their dispositions (habitus) ensured the reproduction of the dominant mainstream health institutional system in the nursing home.

Numbers of female and male residents in the nursing home

Female	Male
21	9

Residents' birth places

Greece	Turkey	Cyprus	Albania	Egypt	Armenia	Australia
21	3	2	1	1	1	1

(27 residents were born in rural areas; 3 were born in cities).

Age range of residents in the nursing home

Age	50-59	60 - 69	70 -79	80-89	90-99
No	1	1	10	14	4

Residents' range of years living in Australia

Years	10-20	21-30	31-40	41-50	51-60	61-70	71-80	Not Known
No	3	5	9	7	2	0	1	3

Age range of Greek-born staff in the nursing home

Age	30-39	40-49	50-59
No	3	7	4

Range of years living in Australia of Greek-born staff

Years	10-20	21-30	31-40
No	4	5	5

All Greek-born staff were born in mainland Greece or the islands of Greece. Three were urban born, all others were from rural areas.

TABLE 4: Resident and staff (Greek-born) profile

The practices of the Board of Directors, the Chief Executive Officer and senior nurse managers are informed and guided by Commonwealth and State government legislation and policies that regulated the delivery of aged care generally. These directors and senior staff members also have to take into account general legislation that frames and affects the practices of health professionals generally. In addition they had to give consideration to industrial policies, regulations and standards of practice which aimed to regulate nursing practitioners employment and practices and which extended even to the individual nurse practitioners themselves. Also, professional nurses were encouraged to undertake further education to prepare them to occupy different career positions that have been constructed within the discipline of nursing

and had been legitimated by industrial law. These positions are categorised and graded according to relevant levels of professional expertise and responsibilities.

Public nursing homes, generally, depend on Commonwealth Government funding for their viability. Up to 1997 nursing homes had to observe government regulations and guidelines that included explicit nursing care processes in order to receive funding and thus survive. Since the 1997 aged care legislative changes, nursing homes must conform with the Commonwealth Government's Health and Family Services Planning Approval Classification[6] Certification[7] and Accreditation[8] funding standards. These discourses legitimise the

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[6] Classification: The Residential Care Manual 1997:5-1 Classification Appraisal explains that '[f]nding for the care recipients is varied, based on their relative care needs. Through the Resident Classification Scale all care recipients are categorised into a care category and, accordingly, a level of subsidy. The appraisal used for the Resident Classification Scale does not consider all of a care recipient's care needs but those that have been identified as contributing the most to the total cost of care'. It is of great interest that the policy states that '[t]he scale is completed by the approved provider or someone acting on the approved providers behalf'. The Resident Classification Scale contains questions about a care recipient's clinical needs, ability to do various daily tasks, major areas of personal care need, required communication or sensory assistance and need for social or emotional support. Technically speaking such a policy could allow for any person to assume such responsibility. Such a policy, while it sets the relevant parameters and domains as set out in the Resident Classification Scale, fails to ensure that those who complete the scale are educationally prepared health professionals with the relevant expertise to enable them to assess the complex human needs of elderly people and, in the case of ethnic aged fails to ensure that people who speak the language and have the necessary cultural experience and knowledge assess such needs. While one may argue that any nursing home proprietor should ensure that a skillful person completes the Scale, it does not mean that the relevant health needs of the elderly can be identified without meaningful communication and cross-cultural including gerontic education and experiences. (For legislative base see *Aged Care Act* 1997, Part 2.4 Classification of Care Recipients and the Classification Principles 1997-.

[7] Certification: The Residential Care Manual (1997:14-1) refers to '[s]ervices which are assessed as meeting certain building and care standards may charge accommodation bonds and receive concessional resident supplements'. The process of assessing these standards is called 'certification'. The aim of certification is to provide an incentive for and an income stream to support capital investment in improving buildings. Building and care standards are also part of the assessment criteria of the new Aged Care Standards and Accreditation Agency in accrediting services. The physical standard of a facility is measured against a 'benchmark' set by an assessment instrument and using the methodology which has been developed for that purpose. (For legislative base see Aged Care Act 1997 [Part 2.6, Divisions 37 to 39] and the Certification Principles).

[8] Accreditation: The Residential Care Manual (1997:13-1) [s]tates that '[a]ll services must obtain accreditation by January 2001 to continue to receive Commonwealth Government funding. An Accreditation Framework that sets four primary standards has been established against which the nursing homes/facilities are assessed'. Of particular importance to ethnospecific homes the Greek nursing home is education and staff development that would involve staff who do not speak English adequately but, in the case of the Greek nursing home spoke Greek and were the carriers of Greek culture, to enter or complete an educational or staff development course. Such members of staff are essential for communication and cultural lay care provision, but to be educated and, in such a way that are not assimilated to dominant culture, but in order to be able to care for a group of vulnerable people (in meaningful social, cultural, emotional, spiritual and physical terms) with multiple and complex diseases, illness and needs. Government policies and educational facilities, make little and unsystematic allowance for such educational programs and resources, nor do they allow for the funding or flexibility to provide for the educational and staff development needs of ethnospecific nursing homes (in this case a Greek nursing home). Barriers to access are enormous and managers of such homes face enormous difficulties in this regard. Such homes may be forced to lose their most valuable staff from the point of view of culture and language, and substitute them with others who do not necessarily speak the language or have the cultural knowledge pertinent to the residents that uniquely generate the ethnospecific

priorities of mainstream capital in relation to the setting up of power relationships which permeate and legitimise the use of regulating and controlling mechanisms, processes and practices in nursing homes.

The above Government discourses, with their necessary rules and performance criteria, set the limits of 'truth' and the network of power relations within different state apparatuses and residential care facilities. Mediated through managers' dispositions, they translate into nursing home regulations and processes that help to produce the nursing home conditions which staff, residents and relatives experience and struggle with.

Government discourses (mainstream cultural capital) translate into tools and processes by which the nursing home (*viz.* the professional nurses managing it) determines and classifies residents' health care needs and guide the planning and implementation of care processes and the monitoring and evaluation of outcomes. Consequently, government-appointed review and/or monitoring committees are charged with the responsibility to review/evaluate nursing homes performance in general. In turn feedback from monitoring committees to the nursing homes represents an entwined disciplinary mechanism which may prescribe further managerial disciplinary measures to ensure carers' residents' and/or relatives' actions conform with Residential Care Standard criteria of the mainstream.

Cultural imperialism (in the form of legitimate normality that has the force of cultural, social and symbolic capital or power) therefore is encouraged by mainstream forces outside the nursing home. These hegemonic forces were also embodied by the praxis of registered nurses whose own positions were externally defined and validated.

Government legislative discourses have emerged from both hegemonic bureaucratic and professional medical and nursing

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nature of a home. This without any doubt would result in an improvement of bureaucratic care, but resident care would suffer seriously and, consequently, the residents' well-being and quality of life. (For legislative base see *Aged Care Act 1997*, particularly Part 4.1, and. also, principles formulated under the *Aged Care Act 1997*, particularly the Quality of Care Principles).

discourses which in turn have contributed to the constitution of their professional/disciplinary habitus. Thus registered nurses hold cultural capital that permits them to become vehicles of power as well as the 'knots' that hold in place the network of power mechanisms in the nursing home institutional field. In order to achieve the aims of the nursing home, staff necessarily operate in the network of power/knowledge (Foucault 1977, 1972) relations that encapsulate the resistance of differing and competing elements. Struggles, confrontations and conflicts thus emerge over which - and whose - cultural capital is legitimate and will dominate in the nursing home field.

While the Board of Directors was ultimately accountable, the Chief Executive Officer, General Care Manager Care Services and the Director of Nursing developed and instituted disciplinary techniques (monitoring and auditing systems) and oversaw their implementation within the nursing home. They were responsible for the interpretation and implementation of the Commonwealth government's Residents' Classification, Certification and Accreditation standards 1988 and 1997. They produced and disseminated nursing home policies and regulations and determined the number and quality of staff, and at what level they were employed. Discipline within the nursing home operated through the development and implementation of elaborate documentation for residents' assessment and classification, care plans, care delivery and evaluation.

The Director of Nursing allocated the nursing home budget and was responsible for its administration. She also was responsible for employing/selecting members of staff for the nursing home. However, she had to consult with the Chief Executive Officer before any staff member was dismissed. I was unable to obtain any formal guidelines for a staff selection committee, and there was no evidence of any formal Greek involvement in the selection of staff. It was, however, generally understood that staff who spoke Greek, all other things being equal, should be given priority in employment. This issue will be discussed below, as it relates to the mainstream distribution of capital that helps to construct social fields with

relative power which, in turn, compete for the accumulation of capital.

The nursing home's mainstream space location: competing for capital with relative fields of social power

The nursing home, as an ethnospecific institution appeared to experience difficulties similar to those experienced by other public nursing homes. In addition, however, its ethnospecificity acted to diminish its competitive edge and thus rendered it less than desirable in relation to attracting and maintaining capital (staff). This indicated its marginal position in relation other public (mainstream) aged health care services (and reflected the Greek community's socially marginal position).

The government's disciplinary discourses provide guidelines according to which residents' health care needs and classifications are determined. Consequently, and depending on their conformity with these guidelines, nursing homes receive their funding. Meeting these requirements in an effective way necessarily requires the employment of formally educated registered nurses. In addition to this, the ethnospecificity of the nursing home which was the site of this study needed Greek-speaking staff (particularly registered nurses) to provide accurate and culturally specific assessment and classification of residents' health care needs. This required nursing knowledge and skills that included transcultural nursing as well as linguistic and cultural competence. (It was most troubling in this respect to hear both senior nurse managers at the nursing home say that not speaking Greek was 'not a problem' for them).

Professionals are also needed to plan, implement and/or supervise the implementation of relevant care. Unqualified Personal Carers (to be referred to here on in as PCs) and Division 2 Registered Nurses (formerly State Enrolled Nurses, to be referred to here on in as SENs) do not possess the level of knowledge and skills required to undertake such processes. The aged care industry, however, has been deregulated. This deregulation, in an age dominated by economic rationalism, encourages competition. However, it also demands that employers save money (or seek to increase their profits) which, in

turn, encourages the employment of unqualified or lesser trained staff since such staff are cheaper to employ. In recent years the employment of unqualified or lesser trained staff has been increasingly common in Victorian nursing homes. Australia-wide it is estimated that at least 50-60% workers employed in nursing homes are unqualified (Nay & Closs 1999; see also Nursing Workforce Survey 1999; NSW Nurses' Association 1998; Nursing Workforce Survey 1996).

The government has produced policies and regulations to demonstrate its commitment and accountability with regard to age care, while funding to the area in real terms has been reduced. Government policies do not take into consideration social and health field factors which might mitigate against aged care services and nursing homes' effective functioning, let alone the extra difficulties which ethnospecific nursing homes might confront because of their relative marginality in the field. From the point of view of Bourdieu's field analysis (Swartz 1997; Bourdieu & Passeron 1970) the Greek nursing home and community hold subordinate positions in relation to both the field of health services and the mainstream social field of power.

Discussions I had within the nursing home indicated that the Greek nursing home was perceived by all staff to be marginal and subordinate to mainstream nursing homes. Through these discussions I also gained the impression that the nursing home was under pressure because of surveillance by bureaucrats related to its ethnospecificity and mainstream fears of 'ethnic ghetto' formations. In this regard, the General Manager Care Services believed that she was an asset to the nursing home, because in her interactions with government and other community authorities she was perceived to be of the mainstream and therefore more 'legitimate'.

Other observations from these discussions related to staff recruitment and turnover. Attracting and keeping Division 1 registered nurses (to be referred to here on in as RNs) in the aged health care sector is generally difficult (Nay 1999). Attracting RNs was even more difficult for the Greek nursing home, especially in the case of Greek-speaking RNs.

These kinds of problems are not difficult to understand. In the field of health care, not all fields hold the same capital value - and thus the same power - in relation to competitive advantage for competition and thus the same power. As far as nursing and medicine is concerned, for example, aged care is the least preferred field in which to work (Brooker 1998: 46; Radford 1987:4-9) This is because of a perception that, in aged care, there is no capital value for personal accumulation. Most RNs would give priority to working in accident and emergency nursing, coronary and intensive care nursing, paediatrics, medical and surgical nursing, and so on, before they would elect to work in aged care (Nay 1999, 1997; Davis 1998; Stevens, 1997).

RNs feel that they have more prestige and status (symbolic capital) - and they certainly get more money (economic capital) - working in acute care than working in aged care. The social value of specific areas of nursing is encoded in the salary differentials. Long-standing notions of ageism, embedded in the culture of the community, may play a part in the choices nurses make (Stevens 1997). The devaluing of aged care is further reinforced by government in its healthcare sector funding priorities such that in relation to other health care fields, the aged care sector holds the lowest value. This situation is also evidenced in the variable rates of pay that government allocates to RNs in different sectors. RNs employed in the aged care field receive 15% (News 1998: 6) less pay than RNs working in the general health field.

In order to succeed, the ethnic nursing home needs to institute specific practices to counteract the dominance of mainstream 'normality' and its own (ethnic) disadvantage. It is vital to recognise that mainstream 'normal' solutions and practices, unexamined and unchanged, might well perpetuate disadvantage. The discussion below illustrates some of the problems the nursing home faced because of its ethnospecificity.

MII I would like to see staff with a high level of qualifications, but we can't attract them.

OK Sad, isn't it? Is it a common thing across all nursing homes?

MII It's common in aged care, **but it's worse for us.** It's worse for us because I think it takes a special sort of person who can work in the environment that we have here. I've had people apply for a position here, and I tell them straight up that it is an ethnospecific nursing home and they need to be aware that Greek is the main language spoken. **Personally I don't speak Greek and I don't have a big problem with that.** I do use interpreters [staff]. At least they [potential applicants] know if they are going to persevere with the application, that that's one of the things that they'll find. **You either find it a challenge, or it's not worth the effort.** The other problem with aged care is that we are almost 20% behind on wages compared with the acute care sector and the private acute care sector.

OK So if you worked in an acute care you would get more money?

MII Yes.

The Director of Nursing (MII) indicates below that the Chief Executive Officer did not, at least publicly, recognise that extra efforts might have to be made to compensate for the disadvantage deriving from the ethnic status of the home in order to attract the 'right' staff, let alone Greek-speaking staff. The hegemonic influence of mainstream 'normality' thus was reflected in the values of the CEO.

MII Now, the **CEO has said that nurses aren't going to get any more money; they are well paid now.** I've said, 'Well, you are not going to attract the right people.' I think he said it in a half-joking manner, but I don't like those sort of jokes. And as I've said in many of the formal meetings I've had, if you are not going to pay the rate, you will not get the quality, and you will continually put up with attracting people who either don't feel they can work in another area, or who just want the hours that suit them. And you don't generally get the level of commitment.

OK Has he understood that?

MII I think he is starting to.

OK Oh, that's good.

MII It makes you feel extremely devalued. It makes you feel that, yes, you are **second rate**, and that is what has been done to aged care.

OK So they are talking about rhetoric, really - rhetoric about valuing old age.

MII That's right. We are valued, as long as it doesn't cost any more!

Senior nurse managers' employment practices and their effects

The nursing home is clearly located within a larger Australian social space. It struggles for survival in a relative social field of power determined by and classified according to the distribution of capital that locates it at the margins. It competes for and struggles to attract resources (capital), and for its survival in relation to other social and health fields of power within the larger society.

The employment of bilingual and bicultural staff is considered essential for the effective delivery of care in an ethnospecific facility. Government inquiries and ethnic community requests have made it abundantly clear over the years that mainstream institutions need to employ bilingual and bicultural staff in order to be able to effectively service the multicultural and multilingual population of Australia (*Working with people from non-English speaking background 1991*, 1992; *Responding to a multicultural society: Issues and strategies for nurse education* 1991; *Ethnic Aged Report* 1987; Galbally 1979; Martin 1977) In the Greek nursing home it was expressly stated by management that they were desirous of employing Greek-speaking staff, and they were showing their distress at not being able to attract them. They believed that the unavailability of Greek-speaking RNs was due to a lack of numbers available. However, while such beliefs were based on reality in 1980s the same was not true in the 1990s. As indicted in Chapter Two, there were 259 Greek-speaking RNs in

Victoria in 1997. As events unfolded in the field, however, it was not clear that what managers publicly stated was also their priority or what they actually aimed to achieve - that is, the employment of Greek-speaking RNs.

There was no systematic recruitment and retention program offering incentives to attract and maintain Greek-speaking RNs that had being instituted. On the contrary, there was evidence in the home's employment practices which pointed to a systematic devaluing of Greek capital (language, cultural knowledge and skills) which adversely affected the way in by which Greek-speaking RNs were employed.

Indeed, employment practices as they related to the Greek-speaking RNs differed considerably from those used for Australian ESBID and other non-English-speaking (NES) RNs. All Greek-speaking RNs were initially employed, for at least six months, as either SENs and/or as PCs, while none of the Australian ESBID RNs was employed on the same terms. It is suggested here that such practices were accepted by the BD and CEO and that they were seen as professionally appropriate.

Their stance can be explained in a number of ways. In the first instance it may be explained by their lack of knowledge of nursing which rendered them unable to raise relevant and critical questions on the issue; they were relying entirely on nurse managers to make the appropriate decisions. Their position in this regard might also indicate the hegemonic effects of their education on their notions of management and administration. Further, it also may have indicated their lack of awareness of, or their indifference to, the kind of cultural skills and knowledge that managers require to successfully manage and administer an ethnospecific nursing home without reproducing oppressive hegemonic cultural practices. Finally, it could be said that such employment practices provided cheap but valuable and competent labour, and this may have been too attractive for them to reject. In this instance, the employment of Greek-speaking RNs as SENs and PCs ensured the presence of linguistically, culturally and competent nurse practitioners who could be employed cheaply and who could support nurse managers'

functions, but from an invisible position. In this situation the managers, even without Greek language, cultural knowledge and skills, could remain in a dominant position and in control, and their linguistic and cultural competence would remain unquestioned.

The nurse managers meanwhile, justified their employment practices on the grounds of experience. They argued that the Greek-speaking RNs required more experience before they could be given *Grade four*[9] positions. At the time of my field work there were two Greek-speaking RNs employed in the nursing home. Both of them, however, had been employed initially as *SENs*. There was also a Greek-speaking RN employed as a *PC* and she was still in that position when I left the field two years later. There were also several Greek-speaking nurse students employed as PCs, but they informed me that when they finished their nursing courses they had no intention of coming back to work in the nursing home that did not recognise the value of the Greek-speaking RNs.

The Greek-speaking RNs were young and, were considered to be inexperienced for a grade four position. The fact was, however, that, of the three qualified, two at the nursing home, had had several years' nursing experience and only one was a new graduate. It is true that one of the experienced nurses had not practised for a period of time before her employment but this was not a rare phenomenon and there were other English-speaking RNs in the nursing home

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[9] Level four registered nurse, according to the carrier structure for nurses adopted after a long campaign by the Victorian branch of the Australian Nursing Federation: the structure classifies nursing duties and responsibilities into different levels as these levels are related to experience and postgraduate educational credentials. This career structure was incorporated into the Victorian nurses' award. With deregulation, however, the situation again has become ambiguous and it is left to employers to negotiate with their employees the conditions of nurse employment. A level four appointment is considered to be an appropriate level of appointment for a nurse who is responsible for the management of a floor/ward. A person employed at this level is expected to have educational qualifications and experiences required. This however, in reality may not be possible. Indeed, this was the case with level four nurses appointed in the nursing home. Only one of the Division 1 nurse had a postgraduate diploma, this was not in gerontic nursing however.

There is no statement, however, that sets out that it is mandatory for nurses to possess postgraduate qualifications before they can be appointed at Grade four level. Therefore, Division 1 nurses can be employed at a grade four level with or without postgraduate qualifications such as postgraduate diplomas in management. It is left to the employer in this case to assess whether, the registered nurse has the required knowledge and skills.

who had not practiced nursing for a comparable period of time but who were employed as RNs nevertheless.

The Greek-speaking RNs seemed to have been evaluated on criteria that entirely ignored and subordinated the valuable capital (language and cultural knowledge) they held for Greek residents. Management also seemed to have forgotten why such a nursing home was needed for Greek aged in the first place in preference to mainstream nursing homes. If it was for nursing 'skills' alone, there would have been no necessity for ethnospecific nursing homes to be established.

Nevertheless, even if the Greek-speaking RNs were inexperienced the positions in which they were employed did not provide an opportunity for them to gain the necessary nursing experience to qualify them for a grade four position. On the contrary, their work actually deskilled them, as they were legally precluded from practising nursing skills at the level of an RN. These skills included ordering, checking and giving medications and or/injections, assessing residents' health needs and classifying residents accordingly, planning, managing and evaluating residents' care, managing and co-ordinating floor activities and other health providers' activities, supervising, guiding and teaching carers and other less qualified staff members, and so on. They could, however, on request be very useful to their superiors (even though this was not formally or monetarily recognised) with their nursing and cultural knowledge and their knowledge and use of Greek language.

There were other nursing positions (for example, grades one, two and three) where they could have been employed as RNs, thus recognising and acknowledging their value as human beings who had worked hard to obtain their qualifications and who were extremely valuable resources (capital) to the residents and Greek community. In these positions they would have had genuine opportunity to gain the supposed 'experience' they lacked. The decision to have only one nursing grade (Grade 4) position available per shift in the nursing home was made by management. This restrictive employment practice, while it fulfilled minimal legal requirements, closed off all other options that could have been exercised. It is proposed here that these decisions might have been

influenced by the availability of funds and by the priorities set in the overall scheme of nursing home administration. This situation, however, was to the disadvantage of Greek-speaking RNs and to the nursing home and the Greek community.

While these RNs were employed and paid at these levels (SENs or PCs), they were expected to perform at the level of RNs. They were placed in an ambiguous position professionally and legally and one that created confusion and role conflict. It compounded identity insecurities, and forced them to be in multiple and in-between spaces engendered by perceived status as 'marked' individuals. Consider the comments and experiences of a Greek-speaking RN informant who had occupied such culturally liminal spaces:

> GSRN Because the other registered nurses and the other SENs knew I was registered as [a Division 1] a nurse they would give me a little bit more to do. But their expectations of me were higher, and that was fine by me. I wanted to meet those expectations. So, yes, I think at that stage I didn't really know whether I was Arthur or Martha because I was an SEN (they were paying me as an SEN) and that was what my job description said I have to do. Yet there was that expectation from them [that I would function as a Division 1 RN], and I also had that expectation of myself.
>
> But, if I did something wrong, it was twice as bad. If I did something good, it was half as good. That still carried on even when I got the position of RN. Even to this day I feel that and it's probably the culture, my gender, etc.

It is difficult for those who have not occupied such spaces in our society to imagine or understand this RN's experiences and the situations she was placed in. But this is a common situation that many ethnic background RNs find themselves in mainstream health institutions in regards to bicultural and bilingual expectations of them. Many immigrants, of course, experience this in Australia when their qualifications are not recognised by the relevant professions. These Greek-speaking RNs, however, were the product of mainstream Australian education - and yet in their situation the process of their employment resemble those overseas RNs who are

given permission to register after a 'specified period' of practice under the supervision of RNs in Australia.

Greek-speaking RNs employed as if they were *not* RNs have thus had *violence done to them* (Young 1990) by being demoted and by being demeaned in the eyes of their professional colleagues and the Greek community. While they were employed in the position of a PC or SEN they were nevertheless expected informally to perform at the level of an RN. They were also expected to use their language and cultural knowledge to communicate and relate effectively as RNs with residents, other Greek-speaking staff and relatives, while such expectation did not apply to non-Greek speaking RNs. They were devalued (and with them their capital) and made subordinate even within a Greek ethnospecific space. They were under the control and the mercy of their 'peers' without having any control or authority themselves. Stereotyped as 'ethnic' 'young' 'women', they were exploited while they were devalued and slowly destroyed or completely alienated by systemic injustice (Young 1990). Consider the following discussion:

OK When you say 'culture' and gender', can you be more specific?

GSRN With respect to my peers and my superiors, firstly, in terms of culture, they expected me to do well because I was Greek. And when I first started there, there weren't many Greek-speaking staff. So here I was, experienced in terms of knowledge as a registered nurse, and I had the appreciation of the language and the culture, and so they expected me to establish a rapport with these residents and to do really well in my interpersonal [relations] in addition to my [professional] skills. I had them both, so the expectation was there. And from a gender perspective [they saw me] as a woman, a Greek woman, who should [behave like a Greek woman]. Greek women have all been trained from young - you know - they are supposed to look after the old people. Because I was a Greek woman, they probably thought it had been instilled in me from young.

OK So who do you think was expecting that? Or thinking that?

GSRN My peers, and...

OK Even though they were women?

GSRN Yes, but they weren't Greek. The majority of them were not Greek. In fact, the only Greek ones were girls like me who had either nearly completed their diploma, or who were undertaking it in the second year. We [the Greek girls] were all the same age. So we didn't have that expectation. But [the other women] we are talking about Australian women of forty or fifty!

OK Are you saying that it is age as well, then?

GSRN Oh yes, that's right.

OK Tell me how. What did they expect you to be able to do? Tell me a bit about that, how relationships were developed.

GSRN My relationships with who?

OK With the Aussies.

GSRN Well, it became an issue at one stage, where I had to speak to MI because ... it wasn't really so much the SENs, it was more the RNs because there were no Greeks except for one.

OK Was he an RN at the time?

GSRN Yes. When I was there, he was an RN. Whereas the other RNs saw me when I was on, 'Here's my little interpreter', and 'Here is my little second hand person'. I didn't mind that. I loved the opportunity to be doing some other skills that reinforced what I was trained for.

OK You were doing their work as well?

GSRN A little bit, yes. Interpreting. So I had to speak to the senior nurse manager. This was early days, I wasn't even employed as an RN at this stage. I said 'MI, I want to know that I am employed here because I am a nurse, and not because I am Greek. If you wanted an interpreter, if that was what was needed,

then you need to go out and get one. But that's not what I am, I am a nurse. That's what I want to be. I am really happy that I can help, that I am Greek and that I can have a rapport with these residents because of that ... but I don't want to be taken from one duty, nursing duty, and be put in another duty'. She was good, she spoke to the RNs and explained to them that this is not why a GSRN is here.

OK And how did things change in your situation?

GSRN I think it was soon - close to the time when my employment become an RN, so the RNs didn't feel that they then could ask me to do things, because we were on par. They couldn't delegate and give me directions because then I became their peer. And then obviously I wasn't working with them. That was the major thing. The fact that they no longer had me as working with them [only one RN working on the floor per shift] because I was an RN too.

OK So how did they communicate with the residents?

GSRN Through interpreters. Through any staff that was available.

OK Did they have official interpreters? Or just staff?

GSRN No, they didn't have official because it is a 24-hour job and they are not going to get an interpreter at eight o'clock at night. The receptionist at the nursing home, her title is also interpreter. She is also paid for her interpretive skills.

OK Is she paid extra?

GSRN. Not extra, it's part of it. I don't know how it's worked out.

Senior managers' employment practices in relation to Greek-speaking RNs and the justifications they used to explain them can be proven without difficulty, as already indicated, to be seriously flawed if not prejudicial. It is nevertheless my argument here that the rigid employment policy not only indicated cultural incompetence but also produced institutional conditions that created serious problems in a number of ways. Their rigidity lay in their outlook that there

was only one option in relation to the employment of RNs: that was at grade four level. Thus a situation was set up that while it might have been economically effective, was ineffective and harmful to Greek-speaking RNs. Unfortunately this situation generated conditions that permitted exploitative employment practices. Greek-speaking RNs who felt ambivalent about their competence and who lacked of confidence, for whatever reason, fell victim to such exploitation, as the case below shows.

OK You said you were employed as an SEN How was that explained to you? What reason did they give you?

GSRN No, I don't think I was given a reason. In fact, to be honest, they also offered me a position as a PC. I think the fact that I lacked confidence in terms of my professional, competency, I thought, I can't be thrown into Grade 4 that was what the role was there, an RN, you had to be Grade 4. Or you were an SEN or a PC or whatever. So I thought, 'I understand. Because of my lack of experience...' and I had been out of it for a while that this is what I felt. And they also acknowledged that. So I do not think it was explained. It was more me telling them why, rather than them telling me why. But they agreed with me. Does that make sense?

OK So who was in the selection committee (do not say names)! Were there any Greeks?

GSRN There was only one person. No Greeks.

The issue of inexperience, however, did not apply to all of the Greek-speaking RNs, as indicated above. For example, a Greek-speaking RN with several years of experience was also employed as an SEN, like all other Greek-speaking RNs at the nursing home before they were 'promoted'.

Australian English-speaking from British Irish descent RNs, however, were employed in grade four positions, even though some had been away from nursing for a time and did not have recent or current experience. This is not a rare phenomenon in aged care. Many RNs, when they feel their nursing knowledge is no longer up-to-date or when they are ageing and they feel that working in the

aged care will be easier on them physically, seek employment in the sector. Several such nurses were employed in the nursing home, at grade four level.

Senior nurse management might well have had to make some compromises in the employment of staff. This is because they had considerable difficulty, as indicated earlier in this chapter, in attracting RNs . It seems that the ethnicity of the nursing home was a crucial factor in discouraging potential applicants from seeking employment in the nursing home. Discussion with MII and other staff revealed that nurses generally were less inclined to apply for employment in an ethnospecific nursing home. This is how it was explained to me by an Australian Greek-born RN (GSRN) who just had resigned after five years working in the nursing home.

GSRN Olga, the sad thing is that, in the situation there, beggars can't be choosers. They do not have staff, they have to compromise with less than standard care because they are not going to get anything else. It is not exactly nurses knocking on the door to work here. PCs, SENs, aides, no-one wants to work there. When I resigned and MII was interviewing, she was saying 'now this is ethnospecific'... Phones were hanging up. She wasn't even getting 'oh well, thanks very much but no.' Hanging up on her!

OK That's interesting. So why are they doing it?

GSRN. Because they see it is... The demand is greater.

While management may have recognised this difficulty with Australian English-speaking background nurses and may have been prepared to compromise, they did not act as if they recognised that there was at least equal difficulty in getting Greek- speaking RNs; nor did management apply the same compromising practices in the case of Greek-speaking RNs. This stance of course can be interpreted in many ways, none of which might be viewed complimentary towards managements' practices.

This employment strategy that nurse managers employed unfolded in my presence. An RN who had just finished his nursing degree in a university was invited to apply for a position in the nursing home.

He was Greek-speaking and of Greek background. The following brief encounter took place:

MI	Apply for a position in the nursing home.
OK	And he is a brilliant, excellent nurse. [Addressing the potential applicant, I added]. Please apply. The nursing home needs people like you.
GSRN	Yes, I am considering applying...
MI	Yes, do. But you have to be employed as a Personal Carer. I will not be able to employ you as a registered nurse for six months.
OK	[Emphatically] Why?
MI	Because we cannot supervise him [walks away].

From where I stood, I interpreted the informal instituted employment practices in a number of ways:

(i) Exploitation on economic grounds. Greek background registered nurses might find it harder than other Australian nurses to find a job and thus may be inclined to accept whatever terms of employment are offered to them. Similarly, they may lack confidence because of their long-standing experience of disadvantage as ethnic background students within the general education system (and nursing schools in particular), and thus accept less than optimal job offers.

(ii) That the nurse manager employed Greek nurses at this level so that they would, then leave on their own initiative.

(iii) That the nurse manager employed Greek nurses at this level (it is a common phenomenon that disadvantaged groups that are perceived by authorities as being less able and competent) to test their assimilation to the relative professional culture before offering them the positions to which they were entitled.

(iv) That the nurse manager wished to ensure that she maintained power and control over the nursing home and its culture.

The consequences of employing Greek speaking RNs as SENs and PCs were devastating for them. It was a practice that ensured that other Australian ESBID RNs could present themselves as being benevolent and understanding and thus consolidate their superior position. (This practice, however, also ensured that their authority was seriously undermined among Greek members of staff, residents and families). It also ensured that GSRNs remained relatively powerless, even though, at the same time, their cultural capital (cultural knowledge, language) was used and, indeed, was vital for the humane functioning and ethnospecificity of the home.

OK So when you became a registered nurse there, how did it all change?

GSRN I can't remember specifics, but I remember that it was a really difficult time. It was difficult for the residents to give me that-to see me as the Charge Nurse.

OK So they were still seeing you as a State Enrolled Nurse?

GSRN It was difficult then. These women who were once telling me what to do six months ago, showing me directions, it was very difficult for them to accept direction from me. It's strange, but I think the RNs were best. The RNs were really happy for me and really supportive, gave me that respect (the ones that were still there, whilst I became an RN). Oh, it was so hard, it was really hard. The families of course...

OK They couldn't perceive you in a different role?

GSRN No, they couldn't. Do you know how I finally got accepted? It was a natural attrition, Olga [with emphasis and visible emotion]. It was because those residents died, and we got new residents in. We got new staff in and that was all they knew me as. They only knew me as a Charge Nurse. I mean, some of the residents are still there and that's been over time.

OK That's very interesting, how people can get stuck in a perception.

It is suggested here that Greek cultural capital vital as it is, was considered to have limited use when judged by mainstream professionals in positions of relative power within the nursing home and to be of subordinate value even when held by Australian educated Greek-speaking professionals. Such judgments illustrate the hegemonic forces of professional discourses that makes their specificity universal relevant and dominant.

Greek-speaking RNs born in Australia and employed in such a manner were reminded that they were still 'marked', 'ethnic' women and men and in competition with mainstream capital. As such, Greek-speaking RNs were subject to exploitative practices of the dominant culture's agents.

While Greek-speaking RNs were employed as SENs or PCs on grounds of inexperience, it did not seem (from the discussion below) that RNs of Australian English-speaking and other ethnic backgrounds practised nursing as effectively, as might have been expected due to their presumed greater experience.

OK Ah. So you say that RNs may have the knowledge, but not necessarily use it?

GSRN Yes, it is not even knowledge that you've gained from education. You could have knowledge that you've gained from education and not use it with the residents. Like, you see some RNs and they have got so much experience and they've done a post-graduate Dip. in gerontology [at the time there was no one in the nursing home with such qualifications] and I think, Where does it show? And then you've got somebody with no experience who has done some med. surg. [medical and surgical] nursing whatever, and they really know what it is about. You know, it's that balance.

OK Can I ask you then one thing. Who do you think... How many of them, do you think do exactly what you describe now?

GSRN The PCs,... I think the vast majority really care about the residents, I really do. The vast majority. Unfortunately there is just that small minority that really brings shame to RNs, I don't know.

RNs, I feel that is a job for the majority of them. And there is an old saying: 'From the little things you can tell so much'. From working with them in a team, there were just some things that I think, 'No, you really don't care'. And, yes, not with the RNs, I am not really impressed.

The above discussion illustrates a number of issues. For instance, just because somebody was appointed as an RN at a grade four level, this did not mean that they would perform their role or discharged their responsibilities satisfactorily. Furthermore, such a situation was tolerated even though continuously problematic (ie in this instance, from the time the General Manager Care Services took up the position), and even though assessment of the professional staff was similar to the one above made by the GSRN.

According to MI, she consciously changed the staffing profile of the nursing home from one of English-speaking dominated to one of Greek-speaking dominated. This capital (language and cultural skills), however, was unequally distributed in the nursing hierarchy. Employment practices had set up a situation which could be described in effect as a method of exploiting Greek-speaking staff by segregating their labour at the lower echelons of the nursing home hierarchy. Thus they were located in positions where crucial labour remained invisible, (and cheaply paid), and where they were controlled and without authority.

Nevertheless, this managerial decision of the DON brought about a positive initiative in the nursing home, one that served the interests of and was of relative benefit to both the residents and the Greek community.

The employment of Greek-speaking PCs and domestics ensured that some Greek cultural care practices were maintained in the nursing home. It also ensured that residents did not feel entirely isolated and powerless. Residents without any language or cultural barriers felt

free to communicate, to ask, to complain, to feel safe and to belong; they were thus facilitated to have a 'sense of place' (Bottomley 1992). The PCs even in their relatively powerless institutional position, empowered residents by their presence. By being present and by valuing Greek cultural practices, they were able to lessen the impact of alien care practices derived from formal regulations and professional discourses that had emerged from different socio-cultural and historical contexts.

PCs validated and legitimated residents' needs by acknowledging them - and by breaking the rules at times (for example, by giving an extra biscuit or drink or piece of fruit or other food item to a resident [some residents had been placed on what might be called reduction diets without their consent]. Greek PCs praxis acted to resist mainstream 'normality', whose force was denying Greek cultural practices.

It is proposed here, that, in the case of Greek speaking RNs, because of their youth and ethnic background, they were perceived negatively and thus the value of the capital they had to offer was not only negated but was also made marginal within the nursing home. This prejudice helped to place them in a demeaning, and powerless position to other Australian ESBID and non-Greek speaking RNs that were not subject to. The Greek-speaking RNs were put, like outsiders and undesirables, through a trial process to prove their worth to the judging, legitimate, 'normal' cultural group (dominant Australian ESBID nurses), even though this was an illegal act. By being placed uncritically in such a position, Greek-speaking RNs were occupationally segregated and the negative status of their ethnicity and 'ethnic gender,' a status that they desperately wanted to avoid was reinforced.

Their nursing performance, however, was observed and evaluated by residents to be superior to that of other RNs who had retained their professional status and who were benefiting from their labour. The cultural capital of the Greek RNs was also more valuable in this instance than that of non-Greek speaking RNs and was fully exploited without due recognition or acknowledgment.

It was difficult not to discern, from my observations and the discussions I had with a various staff, that Greek-speaking staff generally were found to be difficult to control and shape, and this made them less desirable than other more conforming staff. This, I was informed, was 'obvious' to all staff. The discussion below captures what Greek speaking staff generally thought, as well as the only Australian ESBID SEN who was working in the home.

SEN They [nurse managers] do not treat Greeks well. These Greek women who come here... They [nurse managers] do not treat them well, so they can't keep them. This is the reason they leave. And if they do not leave they feel the pressure to leave. This is the reality. I am 100% sure that Αδριανη (a GSRN) left because of them. They applied pressure... for her to go. The ... (another RN working as PC) ... Now they are telling her to go. [MII] called her in the office and she said 'I' ve had enough with you. I cannot do anything else with you. You can go to find another job. Your manners are not good against no-one'. I know that this girl speaks English and Greek and to the elderly she is the best, she is excellent.

OK What does she speak with the residents?

SEN Greek.

This Greek-speaking RN employed as a PC referred to in the discussion above was 'too outspoken'. She apparently undermined MII's authority by expressing her anger and resistance publicly. She stated that 'I am not going to go to the meetings. Meetings are a waste of time, and an arena where we collectively are treated like shit'. The Manager was informed by another RN about this PC's behaviour.

Many times I heard senior managers encouraging the Greek-speaking RNs, and the Greek-speaking nursing students who worked there, to leave and go and get general nursing experience elsewhere. It is my belief that Nurse Managers genuinely thought they were advising them 'for their own good' and could not see any better options for them. This, however, is deeply troubling for it may indicate their unconscious priorities indicating that they saw aged

care as low status nursing and were seeing ethnospecificity as either irrelevant or 'dead end' professionally. MI had high standards and was expecting staff to have clinical skills; but the particular clinical skills which she expected them to have were not clear to the RNs generally. MI, however, was indeed preoccupied with her responsibility of seeing that the nursing home met the set government Residential Care Standards and thus ensured its funding and survival.

Greek-speaking RNs suffered harm in a number of ways. They were devalued and set apart in the eyes of their colleagues, residents and the community. This devaluing process occurred because these nurses were placed under a permanent cloud of doubt about their hard-earned professional knowledge, and authority to practice.

The nursing home deprived these RNs of the opportunity to use their professional knowledge and skills and their cultural experiences and understandings to open up possibilities for transformative action in the nursing home. It also fostered in Greek-speaking RNs, some of whom were grappling with an identity struggle, a predisposition to perceive their own people that is, the Greek Board of Directors, the CEO and the Greek community in general in a negative light. In addition, further harm could be expected to be done to the nursing home as Greek-speaking RNs who had experienced such practices warned others not to seek employment there.

The value of cultural knowledge, experiences and Greek language which Greek-speaking RNs and PCs offered had relative power. This relative power derived from the fact that the nursing home was a Greek ethnospecific space where the presence of Greek aged residents and the involvement of the Greek community gave some power to Greek-speaking staff, were vital for the well-being of residents.

The PC power also derived from the fact that the Board of Directors and CEO were committed to the Greek community. The Board of Directors and CEO had ensured that, in the home's regulations, one of the most important criteria to be taken into account in staff selection should be Greek (this would apply regardless of who

selected employees). Regrettably, this regulation was applied particularly when personal carers were employed, and because it tended to be limited to the personal carers level, this encouraged unequal Greek versus mainstream capital distribution and the institutionalisation of a segregated staff employment practice. In turn it also encouraged 'mainstream' institutional structure to remain which was in tension with Greek culture. While the criterion of giving priority to Greek language should have been retained in the selection of staff, I believe it was also crucial that it be enforced at all levels of employment. For example towards the end of 1997, DON (MII) employed two PCs who spoke neither English nor Greek because she believed they had more 'skills' and 'potential' than the Greek-speaking applicants. It was common knowledge that Greek staff were perceived as 'not wanting to learn' 'not wanting to change' and, as individuals, as being 'unable to learn'. These were presented as 'ethnic' characteristics rather than understood as their resistance to their subordination, the devaluing of Greek culture and language and the imposition of hegemonic ideals of care delivery.

The dominance of English language

Language as power-silencing and marginalisation

Participatory and effective communication is fundamental to the empowerment and well-being of any human being, and for competent and quality health care delivery. Without effective communication it is not only easy for a person to be degraded and to be perceived as animal-like, but such a lack dooms a human being to a cultural and social isolation and might hasten an undignified death. While the Greek-background management in general recognised this fact at a certain level, they and senior nurse management did not seem to think that Greek-speaking staff needed to be fully informed of mainstream discourses which influenced their practices, personal development and empowerment. In the first instance, no formal mainstream information and/or government documents or formal internal managerial communications were translated into Greek. The only formal document in Greek language was the 'Residents Rights and Responsibilities', which government authorities had produced. It was apparent that the formal use of Greek language within the nursing home was not considered

important. The mere fact that personal carers did not have access to essential written information contributed to their oppression and exploitation. It precluded them from valuable information and knowledge that could be used to contribute to internal dialogue and transformative enlightenment.

It appeared that one of the senior nurse managers (MII) considered such an omission to be a significant issue and she undertook to convince her superior nurse manager (MI) to correct this situation. It seemed, however, that the M I had no intention of allowing the relevant translations to be undertaken. This was confirmed by many carers during informal discussions I had with them. MI was pressurising the carers to learn English; her view was that they had to understand the world around them via the use of English language. In one informal discussion, a carer who represented personal carers in the nursing home's Occupational Health and Safety Committee (the only committee with a carer representative), relayed to me the following:

> Carer — I reminded at the meeting MI [chair] that the CEO suggested we [carers] should ask at the meeting the members of the Committee, to suggest which parts of the OHS document [should] be translated in Greek. She replied, 'I don't think we should translate them because all documents they become procedures and they are in English. Carers must understand them in English'. Anyway, she just dismissed it.

Later in my presence this carer discussed this event with the then Director of Nursing (MII), who was attempting to gain permission to translate some procedures into Greek. MII then looked at the carer with a knowing look, communicating to her that she knew that MI was not intending to allow the translation of government documents, rules and procedures into the Greek language. The MII, added (directing her comments to the carer) 'Good luck to you, because I have tried so many months to no avail'.

> Carer 2 — We have asked them to translate many things in Greek. They have these books there which they have the rules and principles. We say to them, 'Translate them in Greek, since all of the care

> workers are Greek who work here. I do not understand English. Translate them in Greek. How do you want me to tell you [meaning the nurses and auditing committees] the rules and principles in English?' She MI says, 'Well it will cost too much. Who is going to translate these?'

When I first arrived in the field I queried the lack of official documents in Greek. I was most surprised to find myself within a Greek space that was basically reinforcing the status quo while Greeks and other immigrants in mainstream institutions were aiming to change such practices. On a number of subsequent occasions I asked the reasons why translation of such documents was not made. No-one seemed to have an answer. The carers, however, told me that they were told that the concepts in the official documents were too hard for them to understand; thus, there was no point in translating them. They relayed this information to me with a sense of bitterness and hurt. Many times carers told me that, 'We are treated like shit,' 'We are rubbish to them,' and two domestics commented that 'Even if we were slaves we would have had more understanding'. Other carers suggested that this lack of translation may have been because of the costs to the nursing home.

Translating the documents in to Greek would have given the carers direct access to important power/knowledge. Thus nurses would then have had to negotiate care practices with more informed, but not assimilated, members of staff. Nurses themselves would have had to be accurate and relevant in their use of such information for the purposes of disciplinary practices. Better informed staff could well have challenged the cultural relevancy of the established information, rules and regulations in the nursing home. Thus perpetuating practices of mainstream normality would have been made more difficult for the managers, as challenges launched by informed people would have been more effective.

Nevertheless, inaction on the part of the Board of Management and CEO in this area is rather perplexing. Personal carers needed to read the policies and regulations pertinent to their work. Lack of access to language disempowered Greek speaking staff and did not permit a two-way communication, and/or dialogue nor it encourage genuine

participation in the affairs of the nursing home. Such a serious neglect can be interpreted as a weapon (power) used in this case to silence, on the one hand, and, on the other, to reproduce and sustain oppressive and exploitative practices to benefit the interests of those who dominate interculturally and intraculturally.

Pressure to learn English

As stated previously both managers (MI and MII) considered that even though they did not speak Greek, this was not a problem for them. Their statements indicated that they were not under pressure nor did they feel any kind of pressure, to learn Greek; also, they did not perceive their lack of ability to communicate effectively with in a Greek-people dominated context as being significant in any way. This stance indicated their lack of concern about and indifference to management issues relating to ethnospecific perspective of the Greek staff and residents. The dominance of English language and the managers' lack of concern about ethnospecific management indicated their lack of interest in encouraging Greek-speaking staff to participate or involving them in the nursing home's affairs in any effective and empowering way.

Managers on the other hand argued that carers should learn English so that they could *document the care* they gave to residents and that they would be able to read documents. They perceived the pressure being brought to bear on them to learn English as being ultimately for the benefit of the professionals and management and not for them. That is, they would be expected to take extra work (documentation) rather than be invited to participate in the decision-making processes that affected them as a result. Their anger at the managers' lack of understanding and at their being used as fodder again, but this time in a Greek nursing home, increased their resistance to pressure management applied on them to learn English.

The formalisation of mainstream communication modes and the pressure applied on Greek staff to learn English were powerful means of silencing them and reproducing and sustaining their oppression and exploitation. The push by managers for carers to learn English can thus be seen to have exploitative affects and/or to

have been used as a bluffing mechanism to stop carers feeling that they had the right to ask for the Greek translation of English documents. It was also true that the government was offering funding to institutions such as the Greek ethnospecific nursing home to be used for staff to learn English, and the desire to obtain such funds might have been a major motivation for the pressure brought to bear on the carers to attend English classes. It is interesting to point out however, that the government did not offer to such institutions funding for ESBID Australians to learn the relevant community language.

It could be argued here that their resistance to learn English further disadvantaged them. For them, however, such resistance was essential as it made them feel that they had some control, and gave them a sense of their own humanity and dignity in an otherwise oppressive and dehumanising environment. Their immigrant experiences, their feelings of exploitation, their cultural notions regarding learning, and their disappointments as forgotten people are indicated in the discussion below:

Carer — We remained illiterate workers in the beginning. They [the Australian Government] did not force us to learn English. It is strange! Now they pressure us. They say to take you to school. Now, do I learn English? I am in my fifties!

Unfortunately for these particular personal carers, at the time they lived in Greece it was believed that, once you were beyond your 'normal' schooling years, it was inappropriate to attend formal school and, in any event, you could not learn as easily as a young person. It was clear to me that this belief was held by a number of personal carers/domestics. To convince them to learn English thus would require a well-thought out plan, one constructed with their full participation and with real possibilities on sight for them improving their life chances.

OK — Can you tell me why they [management] pressure you to learn English?

Carer 1 Because from somewhere they give them money, I think [meaning management wanted the relevant government funding]. I came to Australia when I was eighteen years old. I worked in a hospital and they did not ask us to speak English then. I have aged in Australia, and from one person to another I have learned some English. If they [government] was squeezing us then, when I was eighteen years old, when I was in the height of my learning ability... On fire I was then (Ημουν φωτια τοτε). Then the country [Australia] should have put pressure on me to tell me to learn English. Now, why do they apply pressure? What can I learn now?

Carer 2 Now we do not even know our rights. We do not know anything. We would have had a better position if we had been helped to learn English those years. We do not know. Greece sold us... You go to Greece and they say, 'She is Australian'.

Care 3 **They do this so the foreigners do not 'lift their head',** (για να μην συκοσουν το κεφαλη). People had qualifications and they were working in factories. Someone who had a scientific degree would not have come here. This is the last land [the other end of the world from Europe].

Carers' dismay and resistance to the pressure applied on them to learn English was evident. I witnessed their distress and feelings of anger and oppression as this requirement was announced to them by a Greek-speaking RN. (In situations such as this it was also revealed that Greek-speaking RNs asked to interpret the instructions of management often did not have adequate information or the authority to answer carers' queries, and were thus placed in an in-between, ambivalent cultural position. This position reinforced Greek-speaking RNs' subordination and ethnicity, which they did not want imposed on them, and, consequently, their lack of power to influence in any significant way nursing home practices).

The Greek-speaking RN had been instructed to gather all personal carers together and tell them what the MI had decided for them. The MI was also present, and carers were thus instructed that they had to go to school to learn English, and that they had to do it after work and without pay. The announcement was made in a way that left

them feeling that their job security was threatened if they did not comply. MI left before members of staff had the opportunity to ask any questions. The Greek-speaking RN was left behind to manage the situation. Carers, angrily showered the Greek-speaking RN with questions and complaints. She could not answer all of them as she was merely the messenger of MI and had no additional information of any kind, nor the power to pacify them. The personal carers' and RN's distress was evident. The RN felt she was being unfairly 'grilled' by the personal carers, and that she had been left exposed and unsupported by MI. Such situations with the Greek- speaking RNs were common.

I asked the PCs/domestics why they were so fearful and distressed by being asked to learn English. The drama of the unskilled immigrant woman locked into a disadvantaged social location, was unfolding in front of me. Statements emerged which revealed their social location, fears and resistance, as well as their relative economic vulnerability and powerlessness in the situation. 'I have a family to support and grandchildren to mind so their parents can go to work. I have not got the time!' And another: 'I cannot learn English now. I am too old'. And another: 'What do I need English now for? I am working in a Greek home. I am not a manager'. And another: 'When I applied they told me, they wanted me because I spoke Greek and that it did not matter if I did not speak English'. And another: 'I was working at the laundry and the MI came to ask me to be a personal carer. She knew I did not speak English. I said to her, "I do not know how to care for elderly". She said to me, "Of course you can. You have a family and you grow up a family. You can do it". 'They just do not care. They want to use you as it suits them'.

Personal carers and domestics felt that they had no time to spare at this stage of their lives to learn English, and were curious as to why they were being pressured to learn English. Working in a Greek nursing home and at the lowest level. Greek was essential for them to communicate with the residents and relatives. They argued that, 'we are in this position and we have no power or authority to make managerial decisions or to participate in the management of the home, so why do we need to learn English?' They felt that their interests were not taken into account in the managerial decisions

made about them, and they saw this as demeaning and exploitative and that their interests would not be served by learning English at this stage of their life. When they were young and had time to learn English, access and interest from the host country had not been forthcoming. At that time they had believed that, the less they knew, the better it was for those who stood to gain from their exploitation.

The pressure applied on them to learn English was based on management's argument that they were expected to read Commonwealth government documents, policies and regulations, and for the purposes of writing up the care they delivered to residents. If carers had been able to read documents, management would not have been under pressure to translate them into Greek. Documentation of care delivery was another matter. Such documentation was used to verify the achievement of residents' care standards and, as such, would have to be performed by well-prepared staff with nursing knowledge. Carers did not possess such knowledge and skills, and learning English alone would not have changed the situation. It would, however, and without question would have been of benefit to cares and domestics in many other ways which at the time they could not see or accept their significance.

Managerial lack of understanding of or indifference to this migrant women's experiences was visible in the lack of sensitivity and empathy in their approach to this issue of learning. Several of the carers had high school level education (and one of them was studying at TAFE). Most, however, had only primary school education. At least one carer, I believe, could not read or write Greek, even though she tried to disguise this very skillfully. These women, as 'unskilled' women without English language proficiency and without any help from the host society, were struggling to survive economically as were seeking to provide for a better life for their children. An understanding of these women's sensitive position and respect for them would have called for their full participation in managerial decisions which directly affected them, rather than a bald demand for compliance. On grounds of reason alone, it would have been easier, and more beneficial for residents and staff if the Australian staff had had to learn Greek. Australian ESBID staff, however, did not seem to be concerned or even think that it was

important for them to have the ability to communicate in a meaningful and effective way with residents all of whom were Greek, and Greek staff who cared for them. These kinds of events indicated that managerial staff perceived themselves to be ethnically dominant, and related to staff and residents on a political level, treating them as 'ethnics' resistant to assimilation. The consistency with which managerial staff reminded the carers about their responsibility to speak English revealed their underlying ethnocentric interests of assimilation.

These inequities in the distribution of Greek capital in the nursing home field reproduced mainstream dominance and the larger society's cultural and ethnic boundaries that, in this case, generated bicultural spaces and practices but at different levels in the institution. Thus any internal dialogue between the groups involved or struggle to encourage critical examination of both groups' 'normality' that could be used to transcend these boundaries was precluded. This in turn mitigated against transformative transcultural practices and sustained mainstream cultural superiority and domination and Greek cultural inferiority and subordination.

CHAPTER EIGHT

PRIVILEGING MAINSTREAM NORMALITY

Introduction

The previous chapter discussed how the nursing home's field of power was ethnically constituted. The unequal distribution of mainstream and Greek capital (cultural, social and symbolic) resulted in the dominance of mainstream requirements in the nursing home's formal managerial structure and governance. This generated a competitive environment, mediated in the nursing home's field of power, which disadvantaged Greek-speaking staff, residents and their relatives.

The field struggle and competition between English-speaking British/ Irish descent Australian (ESBID) staff and Greek speaking staff, residents and relatives to define social reality in the nursing home (that is, which of the two groups' cultural capital was to be legitimate and/or 'normalised') illustrated both groups' resistance to each other's 'commonsense' expectations and practices. Ultimately, however, the power structure of the nursing home privileged mainstream interests in the same terms as they are privileged in the larger society. Further, the resistance of Greek staff, residents and relatives to comply with the normality of mainstream 'commonsense' and with the institutional regulations which perpetuated them affirmed the stratification whereby ethic differences were conceptualised as inferior. Finally, the privileging of mainstream normality (including discourses) over Greek normality generated oppressive and exploitative processes and practices in the nursing home.

Nursing home processes and practices: elements of oppression

Oppression in the nursing home is not interpreted here in the traditional sense, which refers mainly to the active tyranny of a

ruling group and to colonial domination (Young 1990). It is used in the newer and broader sense as discussed by Young 1990:41):

> In its new usage, oppression designates the disadvantage and injustice some people suffer not because a tyrannical power coerces them, but because of the everyday practices of a well-intentioned liberal society. In this new left usage, the tyranny of a ruling group over another, as in South Africa, must certainly be called oppressive. But oppression also refers to systemic constraints on groups that are not necessarily the result of the intentions of a tyrant. Oppression in this sense is structural, rather than the result of a few people's choices or policies. Its causes are embedded in unquestioned norms, habits, and symbols, in the assumptions underlying institutional rules and the collective consequences of following those rules. It names, as Marilyn Frye puts it, "an enclosing structure of forces and barriers which tends to the immobilisation and reduction of a group or category of people"(Frye, 1983a, p.11). In this extended structural sense oppression refers to the vast and deep injustices some groups suffer as a consequences of often unconscious assumptions and reactions of well-meaning people in ordinary interactions, media and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms - in short, the normal processes of everyday life.

Nursing home practices were informed and justified by the use of discourses external to it such as legislative policies and guidelines on residential age care that guided the development of institutional rules and regulations. By their nature, while they were meant to promote humane and liberal practices, these were interpreted ethnocentrically as they were mediated by agents' habitus, that privileged mainstream practices. As a result, these legislative policies and guidelines negatively affected the most vulnerable and disadvantaged people in the nursing home.

It is not surprising that managerial practices privileged mainstream institutional processes and practices in the nursing home, as senior nursing managerial positions were held by Australian ESPIED Division One nurses who had not received formal education in either transcultural or gerontic nursing. Similarly, they relied on managerial skills they had gained through experience in other nursing fields as none of them held any substantial administrative or managerial and/or cross-cultural postgraduate qualifications.

Greek cultural (lay) knowledge of healing and beneficial care was not transposed into their practices; they were merely tolerated. Indeed, senior and middle nurse management often could not recognise cultural lay care much less distinguish between beneficial and non-beneficial cultural care practices. For example, the interest and concern expressed in the act of bringing food to the nursing home was not interpreted as a form of lay care, or as an important element of community relations. It was consistently seen as a practice that risked residents' 'health' rather than enhancing their quality of life. This perception, together with the subsequent passage of State government food legislation, put an end to this community practice. It seemed that options for transforming such practices to benefit residents were not considered. Similarly, the way community members wished to interact directly with the residents rather than with the 'institution' was not understood. The lack of recognition of community Greek lay care indicated that the community eagerness to be involved was not perceived as a positive resource (capital) to be nurtured and utilised for the benefit of the residents, staff and the nursing home generally.

Since most Greek-born members of staff were, as a group, relegated to the lowest rank of the institutional hierarchy, it is likely that they may have been more vulnerable to the everyday institutional oppressive practices that mainstream oppressive 'normality' imposed on them than those who occupied positions on higher levels of the institutional structure. While the nursing home Board of Directors (BD) and Chief Executive Officer (CEO) were Greek-born, they were in the main, remote from the home's daily practice, and their responsibilities were not directly related to the nursing home alone.

The BD and CEO did struggle to improve aged health care delivery to the Greek community and they advocated for the community's rights and needs in mainstream society. It is suggested here, however, that, because they had been educated and had lived most of their lives in Australia, dominant scholarly discourses and mainstream 'normality' had been, to a significant degree, embodied by them and not questioned. Their mainstream capital accumulation

(professional credentials, social networks, information/knowledge, social skills, English language, earnings, life-style and so on) had positioned them in a different social field in relation to most first-generation Greek immigrants. Thus while some members of the BD (mainly men) may been the children of working-class immigrant parents, they had entered a different (educated and professional) class in Australian society. This also set them apart from the Greek workers (mainly women) in the nursing home. Indeed, the BD and CEO had no formal institutional infrastructure for direct dialogue with this group. All information in both directions in the hierarchy were mediated by the senior nurse managers who did not speak Greek. All formal communication within the nursing home was in English.

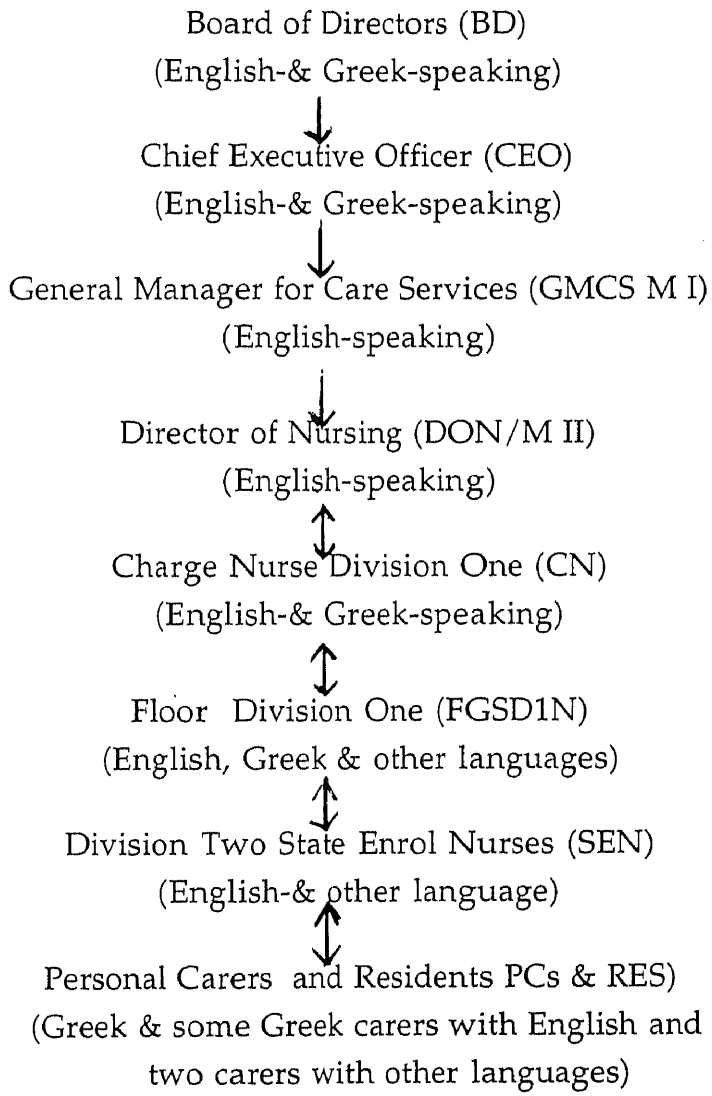
The Directors' and Chief Executive Officers' acceptance of dominant society's administrative and managerial structures and patterns of behaviour ultimately helped to 'normalise' inherent institutional injustices. Unexamined acceptance, meant that transformation of nursing home practices was effectively precluded.

Social justice and the struggle against institutional oppression demands the recognition and legitimisation of group differences. A struggle for social justice requires the institution of stringent infrastructure measures to mitigate against 'normalised' oppression. This would have required a management that, through critical reflection, were made fully aware of the vulnerability of the lower ranked groups due to their ethnicity, gender and class. Such awareness would have led to the acknowledgment and formal legitimisation of group differences in the nursing home that could have ensured the institution had relevant infrastructure to facilitate genuine dialogue and decision making amongst different groups and individuals without oppression (Young 1990: 47).

The effects of institutional field power in practice

Formal lines of authority, responsibility and accountability, as well as lines of communication, were hierarchically structured, as indicated below (Table) Staff were expected to perform according to and to follow these **formal lines of communication and authority**.

Table 5: Hierarchy of power relations (formal institutional lines of communication, authority, responsibility and accountability) within the nursing home, and language spoken at each level.



This institutional structure did not take into consideration Greek ways[1] of relating and communicating, including Greek cultural use

1 In Greece, communication with authority and community leaders (at the time when residents and staff lived in Greece) was varied in its nature. But it was not constrained by bureaucratic and hierarchical processes, as no-one followed them. People used long-inculcated ways of communicating which had been shaped by 'practical logic' that arose form their social conditions. As they had to face the and often urgent demands of daily life within a harsh and competitive environment, they learned to improvise and to use strategies to manipulate such an environment in order to survive. Rules and regulations were perceived as priviliging the powerful and thus as obstructive mechanisms of the state which disadvandaged the people generally and which interfered with their individuality and independence. In particular,

of power and authority. Nor did it consider that many PCs and residents could not effectively communicate in English and thus were obstructed in making their concerns known (or participate in decision making) to senior Greek managerial staff and the Board of Directors. Residents and staff were only interpreted and represented by the nurse managers to the higher levels of authority, and yet the nurse managers could not directly and effectively with them (the residents and carers) in a common language and 'commonsense' normality. Nor did many staff and residents feel that mangers had the required cultural understanding and skills to help them with specific socio-cultural concerns.

This formal process of communication with management was challenged, however, by personal carers, who took the issue to the General Manager of Residential Care (M I). In response, the M I advised them, 'You can write a letter to the CEO if you are not satisfied with how your concerns are handled by nurse managers (M II and M I). The CEO will receive the letter, and he will give it to me to deal with the matter'. This indicates that the CEO supported the formal mainstream arrangement of communication and that he did not consider such an arrangement to be problematic or oppressive to Greek-speaking staff and residents who were located at the bottom of the nursing home hierarchy.

These formal institutional expectations were often violated by Personal Carers (PCs) particularly in relation to the CN registered nurses and the M II levels. Staff, residents and relatives had direct physical access to M II because her office was in their vicinity. Thus PCs (those who spoke some English) often would bring their concerns directly to MII rather than to the CN (an Australian Greek-born and Greek-speaking RN), whom they perceived both as not having any power and as being positioned against Greeks. They also attempted (and here expressed their desire to overcome the barriers

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personal face-to-face contact (and not through a third person) was considered the most effective way of communication and was the only way that was trusted. In cases where individuals felt that a mediator/advocate was required for influencing powerful people, then such mediators (usually community leaders with accumulated capital and thus symbolic power) were approached to act on an individual's or family's behalf and to represent their interests. (This way of communicating with authority was adopted particularly at times of difficulty or emergency).

that formal lines of communication imposed on them) to directly communicate with the CEO who spoke Greek and who they felt could understand them. He, however, discouraged such practices by emphasising that they must follow the formal hierarchical communication and reporting system. This system was perceived (by Australian ESBID and Greek management) to be the 'right' way of communicating and superior to the Greek processes of direct communication. Such misrecognition on the part of management makes visible the hegemonic effects of mainstream normality on them. At the same time, it acts to conceal the disadvantaged position that Greek-speaking staff and residents were placed in by privileging mainstream normality.

While formal line management communication processes were expected to be followed, there were violations. These were considered legitimate when managerial staff were involved; however, they were considered alien and illegitimate when Greek members of staff were responsible. It was the Greek groups who were rendered visible in such practices, and it was they who were constantly reminded to observe formal lines of communication. Also, management tended to reinforce formal communication processes to reassert control. These practices produced staff anxiety, fear, tensions and mutual mistrust and fueled arguments between PCs and Greek-speaking Division One nurses (RNs).

It was noted that MI and MII often used the informal Greek 'managerial-line jumping' communication style to obtain information that was useful to them. It was well known by all staff that MI obtained information directly from the 'floor' through her close relationship with one key Greek[2] member of staff. MII also attempted many times to obtain direct information about the Greek-speaking RN from PCs, and information about the PCs from the Greek-speaking RN.

2 It is interesting to note here that, because this staff member had developed a friendship with the M I, she was regarded by all other members of the staff, Greek and Australian, as an informant and not to be trusted. Staff came to this conclusion because M I was using information against them which she could not have obtained unless someone had informed her from the floor. By association, therefore, the staff member with whom she was friendly was held to be the informant.

These practices were well known by staff and helped to generate mistrust and many arguments between them. It was widely believed among PCs that the Greek-speaking RN (Australian Greek-born) in charge of the floor was informing the senior manager (MI) of their activities, and that she was highly critical of their 'unprofessional' behaviour. The Director of Nursing (DON or MII) expressed her concerns about this to me in one of our discussions in the following way, 'I know that they [MI and the key Greek staff member] are friends and that she reports everything to her that goes on in here'. She also told me that 'MI keeps company with Greek PCs and she observes and asks them about Greek culture so that she can then use the information to manipulate them'. PCs and residents were well aware of this: 'We have to be careful in front of her [the key Greek staff member]. She reports everything to MI'.

Nurse managers discouraged Greeks in a variety of ways from using informal lines of communication. My observation was that they did this by reminding them of their status as ethnic Greeks and of their 'inferior' cultural practices, which included their communication styles. The following brief interaction I observed, took place between MII and a Greek-born and Greek-speaking registered nurse with regard to this situation.

> The switchboard woman (SBW) was on leave and she was not replaced. Thus all community inquiries (via telephone and in person) were received and managed by the floor staff who were already overburdened with their own work. On one occasion, when under enormous pressure, a Greek-speaking RN received a telephone call from an administrator who had some responsibility for organising clerical staff replacements. MII was not on duty this day and, in the course of their conversation, the RN attempted to convince the administrator to replace the switchboard person while she was on leave to take the pressure off staff. This discussion, without the knowledge or permission of the RN concerned, was brought to the attention of MI and CEO. MII was subsequently informed of the discussion by MI. MII was most upset that her superior had been approached about this concern before she herself was made aware of it. She thus felt that her authority had been undermined.
>
> MII then confronted the Greek-born and Greek-speaking Division One nurse and asked him, 'Why did you go over my head'? The GSD1N stated 'I did not go over your head. It was a

discussion I had with the administrator, as the opportunity had arisen with her calling me. You were not here. I was under pressure because of the shortage of staff and because of the constant inquiries to the home from the community. I did not tell her to report this issue and I was not aware that she was going to'. MII did not believe him, however, and as she was walking away, she stated sarcastically and in a tone full of contempt, 'You Greeks and your Greek ways. You have done it again'. The registered nurse, addressing me, stated, 'You see, **they always put us down**'.

This non-institutionalised form of information giving and receiving could be viewed as appropriate as members of staff (managerial and non managerial) not only had different dispositions in relation to formal communication but also faced linguistic and cultural barriers in relation to the different levels of the nursing home hierarchy.

'Normal' mainstream institutional communication practices that were transplanted into the ethnospecific home were less than effective. This, however, was not recognised as a structural problem. The above incident further demonstrates that, in such environments, acceptance of mainstream 'normality' can obstruct the potential for human inquiry and the use of imagination in discovering alternative options which could lead to transformative action for the benefit of all concerned.

Nursing home infrastructure of governance - mainstreaming and silencing

The following committees constituted the infrastructure of the nursing home.

1. Relatives' Committee
2. Residents' Committee
3. Personal Cares' and Domestic Staff Committee
4 Registered Nurses'(Division One) Committee
5 Health and Safety Committee
6. Nurse Managers I and II and CEO
7. Others (not related directly to the running of the home).

Managerial authority and the dissemination of information in the nursing home flowed hierarchically. Meeting processes illustrated the dominance of the mainstream habitus in strategies to discipline, shape and control staff, residents and relatives. In this regard, formal nursing home committees (those still in operation) seemed to be social spaces where the weight of mainstream symbolic capital was focused and made visible its networks of power and the interests they served.

Committee processes

Committee meetings are usually venues that give opportunity for people to information exchange, dialogue and participate in the formation of policies and procedures likely to affect them.

During 1995 and part of 1996 the then DON chaired most committee meetings. I attended several meetings during this time and had the opportunity to observe the meeting processes.

In 1995 I was strongly influenced by the DON. Much of my time in the nursing home up to that point had been spent with nurse managerial personnel, and particularly the DON. The influence she had upon me was extremely positive as, on first impression, demonstrated qualities that seemed to be most important for the effective running of the home. In particular, she exhibited a constant striving to achieve high standards of care, as well as a general involvement and concern with the affairs of the nursing home.

In mid-1996, however, this DON was appointed General Manager for Care Services (MI). In this capacity, these same qualities seemed to generate a working environment tinged with fear and with a sense of powerlessness. Staff often made comments such as, 'She, [M I] uses tactics of fear against us'. This was particularly experienced by personal carers and was transferred to residents. It seemed that even a 'Greek space,' a space itself marginal to larger society and to the mainstream aged care field, reproduced oppressive behaviours. This was because priority was given to mainstream 'normality', a dominant force inevitably experienced as oppression.

Relatives' meeting

I present here my observations and comments about one particular relatives' meeting as they were made at the time in order to illustrate the control and power the DON (MI) could exert. In practice she improvised strategies which silenced those who were adversely affected by her power (that included symbolic mainstream power) in the system and who were dependent on her judgments and decisions. This meeting was important for at least two reasons: (I) it reveals how individuals (in position of power) habitus mediates and is constitutive of culture and structure, and (ii) that, even though I was significantly biased towards DON (MI) in a positive way, I felt very uncomfortable and embarrassed (and at times angry) because of the manner in which she was interacting and communicating with relatives. She indicated that participation and dialogue was not the aim of the meetings, or even a priority. Often, culturally-specific issues that were raised were silenced by the arbitrary invocation of Government Residential Care regulations to justify unexamined decisions. Culturally-specific needs were overlooked or dismissed by the imposition of 'normalising' discourses that quash any possible alternatives. It was also apparent that free speech in such meetings was constrained by the formal requirement of English and by the practices of the chairpersons. The following is my field account of the relatives' meeting:

> All participants in the meeting were sitting in a circle. She [DON] welcomed the relatives and myself and then commenced the meeting by referring to the previous meetings minutes. She informed relatives that, according to Government policies on funding, they could not provide PCs and nurses to escort residents to doctors, dentists or hospitals if they had appointments. She emphasised that 'already three appointments were canceled in the last couple of months, because relatives did not bother to come and take them [residents] to their appointments'. She added, 'Residents were very disappointed because no member of the family came to take them to their appointments'.
>
> She went on to say that 'volunteers, unfortunately, were not readily available and, sometimes, volunteers who said they would come would ring an hour before the appointment to say

that they couldn't make it'. So she informed the meeting, 'This is an issue I want to follow, and clarify the **commitment** of volunteers'. [At the end of my fieldwork there was one volunteer left out of fifty].

During the discussions, I felt a number of times emotional and upset and rather embarrassed for some of the things that the DON was saying. I felt at the time very 'Greek' and, as a Greek, I thought I would be embarrassed to say to relatives what she was saying; I also thought that I would not like to be spoken to the way she was speaking to them. She spoke to them authoritatively and as though they were ignorant children who needed to be shown 'right from wrong'.

I also felt that she was trying to do the best she could in a difficult position; but her style was most ineffective and could be described as inappropriate. Once she had finished all she had to say, she asked the relatives, 'Do you want to make any comments'? Most of the relatives remained silent. And then she said, 'Perhaps we can start from the beginning, and you can introduce yourselves and then say if there are any issues that you want to raise'.

A few minutes passed in silence and then a couple of relatives stated timidly, 'I have no complaints'. Again, after a short silence, a relative quietly stated, 'Residents can have a little bit more food variety'. The DON explained, 'What we are allocated from the government comes to $5 dollars per meal. For example, olives are very expensive and fetta [a popular Greek cheese] is expensive'. Relatives remained silent.

I didn't particularly agree, since many foods used in Greek cooking can be extremely cheap. A carefully planed menu could easily achieve a variety of Greek food with economic balance.

After a few minutes of silence a man said quietly, 'You need to put extra staff on at night time. I know the nurses are excellent and they do give excellent care, and they do their best, but they can't run all the time. They are only two people. Residents get very frightened and want to have somebody to go and reassure them when they call. Because if they call and the carer does not go for an hour or a half an hour...'!

This relative explained, 'My mother feels very scared in the night time, because the carers delay in answering her calls. Even if you cannot employ more staff, could the nursing home do something like, for example, install some technical device that actually residents could use to communicate with carers? To be able to hear a voice, like an intercom, or something like that. And then, for example, the nurse might say, "Yes, I hear

you Mrs. So and So, and I will be there in five minutes", or I am in such and such a room and I will attend to you" ' .

I thought this was an option that could be examined, among others. The DON, however, dismissed him. She stated, 'No. We can't possibly do that. Because, first thing, we will violate the Residential Care Standards. Specifically, two of them. One is noise, and the other one is dignity and privacy'. The relative explained, 'But she and others in the room are not concerned, I asked them. Their priority is to feel safe and secure'. The DON ignored his explanation and moved on with the meeting.

At the time I was thinking, 'What kind of dignity is she talking about, and what kind of privacy'? I felt surprise and anger at the way she had dismissed their concerns. I thought that this is how Residential Care Standards are used both uncritically and for the purpose of justifying mainstream practices devoid of cultural specificity, in this case Greek cultural specificity.

The above observations opened a new window in my mind, a window which allowed me a brief glimpse behind the front stage of self- presentation (Goffman 1961) where the cultural battles were fought and won. I also realised that the power used by the DON was in constant supply from the larger society's unquestioned 'normality' and from Government discourses in the form of aged care regulations as well as from standard nursing and medical discourses.

After this DON became the Manager of General Care Services (MI), the DON position was filled by another Australian ESBID Division One nurse from the floor.

During 1997 relatives' and residents' committee meetings were rarely held. By the end of the year they had been discontinued. Residents' meetings were seen as a waste of time and as an interference with the institutionalisation of residents. This was communicated to me by a PC who had asked a resident whether there was a residents' representative on the Board of Directors. She gave me the following account:

Carer 'Do you have a representative on the Board of Directors'? And he said, 'Representative'? He said, 'We used to have resident meetings, but they said that we were intrusive, that the meetings were intrusive to us, and that they didn't help'.

At a later date I was told by a resident:

RES We had monthly residents meetings. We used to exchange ideas. They [management] cancelled them.

OK For what reason? Did they tell you?

RES They told us, 'I inform you simply that the meetings have been canceled'. Simply it was silenced.

Carers and domestic staff meetings

Committees functioned as forums where, in the main, information and instructions were disseminated by management to staff. At times, too, members of staff raised issues of concern for them. There was no evidence, however, that the committees functioned as forums for dialogue or as venues for genuine participation in the decision-making processes in the nursing home. Fluency and ability to argue their cases could not be compared with that of the MI or MII who usually chaired the meetings. As the meetings were held only in English, English-speaking members of staff were privileged from the start. For all others, communication was impeded, not only because of their relative lack of fluency in English, but also because of the power/knowledge that fluency in English gave access to. So Greek speaking staff often felt collectively trapped and disempowered as they heard their few utterances reinterpreted and given a new meaning that usually placed them in a negative light. At the same time, they were reminded of their 'unreasonable' requests and 'inferior' behaviours and thereby were publicly criticised and humiliated.

Consider the following discussions I had with carers:

Carer 1 Tonight we have a meeting. I said yesterday, 'What do we have to go for? If we go, she [MI] when we speak and express an opinion or a grievance she turns them around to mean something else'. In the end, when we speak we find out that we end up worse and incriminated by our own words. She gives new meaning to our own words. She makes them the way she wants. We agree that things are not like that, they are this way. In other words, we

waste our time with a culture like that. She also shows with her body language that she thinks we are inferior.

OK For no cause? How does she speak to you?

Carer 1 At times she will tell us off. Other times she will speak to us like we are the last rubbish of the rubbish. Not once did she say, 'These women... they work hard. They do a good job. They have value'. But what can she feel? [emphatically]. Will she feel that every one of us has a family, that they cannot be here for 24 hours as she expects us to be? But she does not think to say, 'These women, they need to go to rest. They will come, tomorrow again to work after so much tiredness. I do not see this as right, to have us here at 7 in the evening and to have a meeting to last till 10 pm.

OK Do they pay you when the meetings are out of hours?

Carer 1 No. Not for any meeting. Why is she holding the meetings at this time?

It is obvious by the accounts reported below that the carers were aggrieved by the professional and cultural boundaries they perceived were imposed on them. These boundaries once again, reflected for them, the lack of worth and regard which professional nurses accorded them.

Carer 2 We are looked at as rubbish. In the meeting I am always hearing **'them, them, them'** [meaning RNs' criticism of personal carers]. We are rubbish. I know for the RNs we are the lowest of everything.

GSD1N Not every body thinks that. Qualify that.

Carer 2 [Emphatically] I know that, between you, when you meet, when you are among yourselves, everybody agrees [all RNs perceive PCs as rubbish]. They are here and we are there. And we, the Greek PCs, do not do anything we are supposed to do. [Big emphasis and loud voice] I told a thousand times to nurse managers, 'Do not categorise us! Do not criticise according to your standards! We are not professionals. We just...

[With emphasis] You know, they want to keep their standards. We are here, you are here [indicating by arm and hand movements that RNs perceive the two groups as occupying different social spaces].

OK — She [MI] said to me however, that for her you have great worth.

Carer 2 — [Loudly and angrily] BULLSHITT! They always talk about **this team and that team.** I know what a team is and what team work is and we are a team. But they compare us and talk this team is that, and this team is that. [Here, she infers that the RNs comparisons of the nursing home's two Greek PCs teams is one of the instrumental factors which influences their infighting and disharmony].

My own experience when I attended a meeting held by MII for Greek staff was revealing. During the course of the meeting I realised that MII was either unaware of how her actions might be affecting participants or, worse she was confident that she had the 'right' to run meetings in a way that could be described not only as ineffective but also as oppressive. I recorded the following observations:

> While MII was imparting some important information that would impact upon all members of staff, a Greek member of staff was seen to talk to the person next to her. MII stopped talking. She looked sternly in their direction and, an authoritative and stern tone, said, 'Stop talking. What are you talking about'? The person who had been talking looked terrified and almost shrank in her chair. Similarly, all other members were stone silent in anticipation. Her partner timidly answered, 'She was asking me to tell her what you were saying. You see, she does not understand'. MII responded, 'She can wait till after the meeting and you can translate to her then'.

In many of the discussions I had with the Greek-speaking (Australian Greek-born) registered nurse, she expressed her anger towards the nurse manager as well as towards the carers. She felt very hurt because the managers 'put down' the Greeks, and she was angry at the Greeks for not standing up for themselves, for just sitting there and taking it. This RN seemed to be caught uncomfortably between two cultures. She liked the Australian ESBID staff and wanted to be accepted by them; equally, she wanted Greeks

to accept and like her. However, she felt that she was not entirely accepted by either group. She disliked hearing Australian ESBID staff criticise Greeks. Their criticisms made her feel angry and offended her as she was born to Greek parents. At the same time, the behaviour, described as 'unruly' and 'exuberant', of Greek PC's was a constant reminder of her mainstream internalised experiences of her inferiorised cultural background, and her anger was directed at them. This situation placed her in a very difficult position that, finally, made her leave the nursing home after having worked there for five years. Unfortunately, this situation was also fueled by the less than desirable behaviours of nurse managers seemed to 'normalise' prejudicial attitudes. These in turn engendered, in Greek staff almost racist attitudes towards their own people - as they struggled to form a comfortable identity in the situation where they felt the pressures upon them of two unequal and competing cultures. The Australian Greek- born-speaking RN nurse expressed her frustration, pain and feelings of shame:

GSD1N You know, when she [MI] sits down and puts the Greeks down, in a meeting, they [PCs] sit and laugh...They laugh! (stated with anger and [emphatically]. They take it [She says this emphatically and angrily]. No-one says anything. I tell them it is their responsibility to tell her to stop it.

OK Are they frightened of her?

GSD1N Yeah, that is what it is. It is fear.

Sometimes she [MI] is totally below the belt. Very inappropriate. I have heard comments. I have never been a part of [it]. People have come back to me and said comments she's made and I've been horrified, and it's blatant racism in my opinion. And if I was there I would have said something.

Personal carers constantly reported that going to such meetings was a waste of their time and irrelevant to their concerns. But most importantly, according to their information, at such meetings they felt they were put down and devalued as human beings and as Greeks. They felt powerless, as their English language skills were not adequate to skillfully respond to managers' interpretations, and

representations of them. Similarly, staff felt most of the time that they were there to be told how bad they were and how they did everything wrong; they were insulted and humiliated by the manager's comments and by the lack of understanding and disrespect shown towards them.

All carers reported to me that MI had told them in a meeting that 'if you cannot work here then go and pick cherries or go and work down at Bosch [a factory]'. They were insulted and hurt by this, especially as it came from someone from whom they expected acceptance and approval. Their response was not simply to the criticism, but to the degrading image of Greek immigrants as 'factory fodder' in Australian industry. This characterisation drew on the stereotype of the Greek migrant as unskilled, incapable of working in any environment apart from the factory. Historically, it derives from the period of mass immigration to Australia in the 1960s when the industrial hierarchy located Greeks (and other migrants) at the lowest level of the workforce - part of a 'pool' of undifferentiated and unskilled labour (see Chapter Two) .

Use of mainstream disciplinary discourses[3] to control and shape Greek behaviours and practices

Management, had available cultural and social capital (national language, mainstream discourses, information, and educational credentials) whose normality legitimated their opposition to Greek cultural capital (language and culture, including lay care). Greek cultural capital had **vital currency** among residents, relatives and Greek staff; however, only some aspects (superficial) of it were

3 Discourse: 'Discourse is not simply the means by which a human subject–existing prior to the discourse–expresses itself or accomplishes something. Rather, the discursive conditions (rules and criteria) set up specific places or positions in which subjects can form as, for example, 'patients', 'doctors', 'perverts', 'schizophrenics', 'criminals', and so on (McHoul & Grace 1993:48). Foucault, according to McHoul and Grace (1993:44), also sees that 'dependencies exist within discourses (between their objects and operations), between discourses (such as the complex relations between the discourses on life, labour and language) ... and between discourses and the broader forms of socio-political change in which they arise. Foucault sets out the various criteria by which to examine discourses in their specificity. Any discourse may be seen to have a number of components which are fairly easily identifiable: objects (the things they study or produce), operations (the methods and techniques or 'ways of treating' these objects), concepts (terms and ideas which are routinely found in the discipline and which may constitute its unique language) and theoretical options (those different assumptions, theories and perhaps even hypotheses available within the discipline, and which might oblige physicists, say, to 'decide' between relativity theory and quantum mechanics').

tolerated (considered necessary) by managerial staff of the mainstream. Deep and complex cultural symbolic systems of meaning often embodied and unconsciously practiced (e.g. about care, communication, illness, health, protection, humour, family, community and so on) were not accessible to them. Competition thus occurred over the value of forms of capital and over definitions of what was legitimate capital. The nursing home institutional field structure, constructed as it was in mainstream terms, the unequal distribution of cultural capital that helped to reproduce mainstream social distinctions and classifications in the nursing home. Consequently 'normal' managerial cultural practices obscured the role of cultural and social capital in the perpetuation of social inequalities based on ethnicity, gender and class.

Discourse of 'professionalism' and its role in mainstream cultural imposition

The discourse of 'professionalism' also contributed to the formation of power relations between those who worked in the home. People who had formal qualifications 'managed' and controlled those who did not. Within this context 'professionalism' had little to do with 'ordinary' social understanding of the term. Rather, it meant adherence to habitus of traditional nursing, practices that were in fact expressions of 'commonsense' and ethnocentric customary behaviours of individuals in nursing management. These behavioural expectations were frequently focused on embodied comportment: ways of walking, voice levels, movements, gestures and ways of signaling deference to authority.

In nurses, noise, free interactions, exuberant body movements and gestures and the use of Greek language, familiarity, dress, grooming and general appearance and expressive behaviours were perceived by nurse managers as 'unprofessional' and indicative of cultural inferiority. Also, they were indicative of departures from traditional ideals of nursing practice that emphasised control, reserve in involvement and interactions with patients and relatives, deference to authority, sacrifice, obedience in following superiors' orders, obedience to institutional rules and regulations, and 'coping' with enormously difficult situations without complaint. If one complained, one was a rebel or trouble maker (Muff 1982).

As an active participant in a number of events in the nursing home, I gained direct access to notions of legitimate professional comportment promoted to control 'unruly' and alien Greek behaviours and practices.

> A resident requested me to take her to the toilet. As I knew very little about the health status of this resident, I scanned the corridor to find a PC to ask for help. I saw a Greek PC at the other end of the corridor and I called her to come over and help me (in a Greek way in voice, tone and body gestures). I saw her leave what she was doing and walk swiftly over to me in a controlled manner. When she was close enough for me to hear her, she advised me with anxiety and concern:
>
> Carer [Whispering] Please do not call like that. It is not supposed to be professional.
>
> OK Why?
>
> Carer The MI says it is not professional, to call from far and wave our hands to each other. [MI was actually at the other end of the corridor. The carer, aware of this, was concerned and anxiously warned me]:
>
> Carer You will be in trouble now. She (MI) will tell you off now.

'Professionalism' was thus used to influence and control the behaviour of staff. Expectations of 'professionalism' justified the devaluation of and the formation of perceptions of PCs behaviour as 'other' and inferior. The 'professional' discourse emerged as a mixture of nurse managers' (particularly MI) dispositional practices and those they derived from their training. They presented themselves as an embodied form of 'professionalism' and asserted their behaviour as the standard by which they could then judge Greek staff behaviours. 'Professionalism' was offered as the solution to the Greek 'problem'; its success meant not only cultural colonisation for the Greek PCs/domestic staff but also the success of mainstream institutional practices. The failure of PCs and domestic staff to conform to internalised 'normal' expectations of managers was interpreted as a failure to perform not only professionally, but also 'rationally'.

In discussion I had with MII 'professionalism' was perceived as meaning obedience to rules and regulations. Consider the following:

OK So what is professionalism?

M II It is not seen as 'professional' if you do not come in early and work till late. [Here she refers to MI's expectations].

OK So really this has nothing to do with professionalism. It has to do with rules and regulations.

MII It is rules and regulations. That is what a lot of people see as rules and regulations. Particularly some of the old registered nurses.

I noticed at handovers Greek PCs would often talk among themselves as the RN was giving information about a resident. Since I understood the language, I realised that at these times, because the handovers were in English, the PCs were clarifying and sharing additional information regarding the residents' health status. At these times, too, RNs anger was obvious. Often they would tell the PCs to 'stop talking' and 'speak English'. The PCs behaviour indicated to the Division One nurses that they did not recognise their authority - or the nursing pecking order - which demanded deference. At the same time, it indicated the privileging of English language and mainstream professional 'normality' and the Division One Nurses lack of recognition of their incompetence in relation to Greek cultural lay care knowledge and their insensitivity to the Greek speaking staffs lack of English language understanding.

There was, however, among the Australian ESBID Division One nurses, one who thought it was important to find out what the PCs were talking about. Every time the PCs would start talk among themselves in Greek, she would stop her talking and invite them to share their discussion with her. This RN was learning Greek and openly encouraged staff to employ beneficial Greek cultural care practices. This registered nurse, next to the Greek-speaking registered nurses, had the most comprehensive understanding of Greek staff,

residents and relatives, and was identified by Greek PCs, residents and their relatives as the most helpful and understanding registered nurse in the nursing home.

Professionalism and government discourses and their power in institutionalisation and mainstreaming

Greek members of staff, because they spoke Greek and understood the culture, were often left to explain or defend professional and managerial decisions or actions to relatives and Greek community members. At times, therefore, managerial responsibility appeared to have been made the responsibility of Greek members of staff. Such situations emerged because professional and managerial decisions were made which were culturally insensitive or inappropriate. Some Greek staff nevertheless, reinforced these professional decisions. Decisions about such things as food restrictions and dietary prohibitions, restrictions on access to the kitchen area (particularly for staff, relatives and community members), bringing food to the nursing home, directly distributing food to residents, and residents' incontinence programs. These restrictions affected residents and staff in different ways. Rules associated with such restrictions, however, facilitated the generation of staff cultural dissonance and anxiety and in some instances, provided grounds (often scientifically unsubstantiated) for staff to make decisions about the control of residents and relatives based on their own discretional judgment influenced by mainstream 'normality'.

While such restrictions made good sense from a managerial point of view, they contributed to institutionalisation and to conflicts among staff, residents and relatives. They also contributed, according to the PCs/domestics, to the deterioration of community relations making staff and residents feel that the community was abandoning them. Ethnospecific lay practices were often obstructed because they were perceived as dangerous rather than as having healing potential. Such perceptions also exposed unconscious assumptions that constituted the 'other,' relating to residents and staff who attempted to deviate from mainstream values. These supported notions of irrationality, lack of control, ignorance, an inability to distinguish between beneficial and harmful practices, inferior intelligence and an inferior culture. For example, the daughter of a resident wanted

to provide her 94-year old mother with some of her favourite meals. However, she encountered much resistance from Australian ESBID and several Greek staff that frustrated and angered her. Her frustration was expressed in the following way:

Relative Well, my mother was very, very ill, and I was complaining. I know I shouldn't have been, but I was.

OK. I am glad you did.

Relative And there were three-barrel shotguns coming at me together. The DON, the other one and the other one. Three of them. And they were firing things at me. I said to them, 'Listen, I can't argue with three of you. Why is there three of you against one'?

OK Ah, good!

Relative And they said to me, 'Well, we just want the best for your mother'. I said, 'Do you think I don't?' And all this went on and on and on. And it was all because we were taking food, we were giving her too much food, she was eating too much food. So even the chefs (i.e.) in the kitchen, they annoy me dreadfully. They say that, This is your home; you've brought your mother home.

OK Yes, but we do what we want at home.

Relative But they are to do what they [the staff] want, because that's the regulations. I agree with that, but not to get offended if we bring something or want something extra. And so I stood up to one of them, and I said, 'Now listen here to me, 'If your mother was here, wouldn't you bring something extra for your mother'? I said, 'I had my mother home for ninety four years. She was there with me, and it's just for the last eighteen months that she's come there'. Do you know how hard that was to do that? That was the worst thing that I have ever done in my life. I cried. I cried so much beforehand and I cried afterwards.

The residents' views (below) also indicate that MI did not hesitate to use government regulations to generate insensitive comments that

threatened relatives in such a way that would tend to ensure their silence. Relatives' choices were extremely limited as at the time there were only a few Greek nursing homes in Australia. My observations were that the line of approach indicated below was used with relatives in instances where residents were taking longer than a designated time to 'settle in' at the nursing home–or become institutionalised.

Relative I am talking with constructive criticism because, they've got so much going for them, it's only those little things that they've got to iron out. It's still the best place. Where ever she goes, it's an institution. No matter what you do, it's an institution and it always will be. But if you don't like it, as M I said, take her wherever you like. Not to me, she said it generally. They had a meeting. We all went.

OK I don't think it's a nice thing.

Relative She stopped everybody having a beef, because everybody was there with questions, and she said, 'The way the things are going...' That was when money came out for them to pay before they went in and all that, and she said, 'Well, all I have to say to you is, if you are not happy here, you are very welcome to come and take her out'. **Now, how threatening is that? How demoralising?**

Some Greek-speaking PCs however, would break professional instructions. For example, they would break dietary restrictions by giving an extra biscuit or piece of cake to residents, or break incontinence programs by responding to residents' requests and taking them to toilet before the time designated in their care plan. Others would alter managerial decisions when they communicated them, in Greek to residents, relatives and community members to lessen their negative impact. Personal carers who broke the rules in relation to restrictions were perceived by residents and relatives to be caring and understanding and to be concerned about their well-being and quality of life.

Managerial and professional impositions that were undesirable to Greek residents, staff and relatives were possible because the managers and professionals were in a position of power. Often the

decisions, interactions, evaluations and judgments of managerial ESBID Australian-born staff in relation to Greek staff, relatives and residents reflected the larger society's stereotypical views of immigrants. Differences exhibited by Greek staff, residents and relatives and which did not fit the dominant 'normality' were often interpreted as inferior and undesirable.

Some staff became docile in the face of institutional cultural practices that produced oppression and undermined their well-being. Others continued to resist and to use tactics which, in turn, engendered further disciplinary practices and further resistance and stereotyping.

The use of mainstream discourses together with negative preconceptions of migrants seemed to be operating in the use of disciplinary tactics to eliminate resistance and the force the subjugation of an unfamiliar and different 'normality'. Such tactics reflected culturally imperialistic tendencies, with their inherent violence, that dehumanise 'others' and marks them as undesirable. Such tactics can be destructive towards their targets but effective nevertheless in achieving the goals of management. Consider the discussion (below) and the kind of strategies (constructing the relative as an illiterate immigrant, and so on) used by MI to gain advantage in the power struggle between herself and a relative in the process of pursuing the satisfaction of their interests. This is a field account of how a relative experienced the imposition of MI's habitus on her mother. It also indicates how ethnicity was used to undermine the competitive position of the 'other' (Greeks) in the field of struggle for domination. Stereotypes and larger social classificatory distinctions of disadvantage with regard to gender and ethnicity, immigrant, non-English speaking, unskilled female are made visible as well as and how they operate to disempower and inferiorise 'others' The discussion is a good example of how people in power can interpret and construct the 'other' in negative terms, and how they can draw on dominant discourses, whether accurately or not, to impose such constructions to serve their interests.

Relative Mum, the way she was and how she has changed, is remarkable. And this is what annoyed me. They

couldn't understand that there was a big change in my mum. And the other side of it is that M I and everybody wanted to say that I was controlled by my mother. For this reason, I would never understand their side of it nor see the problem, right? Because Mum controlled me. This is a story - this is a beauty - and this is what gets me.

OK That's a common perception about Greek parents in Australia, really.

Relative That **I was being the puppet of Mum**. So I would never understand. The problem they didn't understand which has upset me greatly was that **M I was speaking to me as a Greek.** Now, **what she didn't understand was, I was more English Australian!**

OK Now let me ask you something. When you say 'as a Greek', what do you mean?

Relative **As a migrant. Not knowing. Not knowledgeable of the system.**

OK Of what? Of the Aussie system?

Relative Of the Aussie system.

OK Ah!

Relative Because, you know, there are different types of categories. There probably would be about three of my type who have got parents in there who would actually stand for the cause and crusade for the purpose. All of the rest [Greek] It's the fear. And, also, **I was treated like I was a migrant. An illiterate migrant.**

OK So what you are saying, then, is that... and this is what I am interpreting now. Please correct me if I am wrong. Basically, the Aussies have, or in the hospitals I worked in they had, an idea that illiteracy meant stupidity.

Relative Well, yes, almost. You have to be dictated to because this is the system.

Below, the relative indicates that, while mainstream discourses were used to impose mainstreaming, it was also MI's dispositions

(habitus) that mediated their interpretation and application. The discussion illustrates that there was no participatory discussion or negotiation in the development of care plans for residents, but rather that care was imposed according to agents who were in charge of the nursing home.

Relative But the system was not the Australian system, because I have the book - you know, the book you have when you first go into the home. The book of your rights? There was no rights interpreted that way. It was a little bit of Greek rights and a little bit of MI's rights. MI is a theory lady. Fantastic with theory. Could quote you every law, principle, regulation or whatever But, wait a minute, I am in a nursing home because somebody is sick, right? I don't want the technicalities. Congratulations, have fifty-five awards! But I want somebody who can communicate and not be so much scrutinising the person. I want us to come to an agreement of how we can care best for this person. So they made all these assumptions of Mum because she was a little bit hard to settle down, and she was overweight.

This resident was an 85-years-old woman who constantly and vehemently opposed attempts to institutionalise her and to diminish her rationality and autonomy - which meant, for her the unwanted imposition ('for her own good') for example, restricted food intake and water, having to get up for shower at a particular time, share a common shampoo to wash her hair, and so on). The discussion (below) indicates that the relative felt she was placed in a disadvantaged position because she was a woman and unmarried. The question that can be raised here, however, is whether women from a dominant culture treat ethnic women differently or, in this case, whether women generally were intimidated by the forcefulness of Greek men. It could well be that both propositions might be possibly in such a context.

OK But she didn't think that she was overweight.

Relative Exactly. From day one we had **harassment on food, and harassment on water.** Harassment. I am happy to call that harassment now, and intimidation. And the more I think about it... Sometimes I used to think to myself, 'I wish I had a lot of money because I'd like to take this to a human rights court'. Because

this is ridiculous. This is stretching it to the stupidity side of it because this was singling out people. There are other people with the same cases and, I might add, because they are married. I am single. I don't have a male supporting me and I have no male. If I had a male husband... That's where the other-twenty eight residents, where they've got husbands. They go in to M I and they state their case, or they stop their donation.

OK So you are saying that, because you are a woman you also suffered from other women?

Relative From women. A single woman. Because the point is, they thought I was sloppy, or just being puppeted to come in and whatever because I was listening and I was sympathising with her [her mother].

Relative The next thing was, MI then decides that Mum wasn't settling because the staff were then picking on stupid things, because Mum is a very polite person, always says please and thank you. But we were starting to get that Mum was demanding, Mum was telling them, wanting them and demanding them, and no please and thank you. And I thought to myself, 'Wait a minute'. If any of those residents were there who were saying please and thank you it would have been Mum, because she has never, ever been not polite.

OK I know, because I have being interacting with her.

Relative That's one trait that both of us daughters, me and my sister, have got as far as politeness is concerned. I couldn't accept that.

OK So, Ρωξανη, who was saying that she was demanding?

Relative MI.

Barriers were raised according to stereotypical perceptions of Greeks, particularly those related to rural background Greeks and Greek women - such negative images helped discount familial concern. Negative attitudes not only weakened managers' ability to critically examine the complex cultural situations they were confronted with,

but also blinded them to their own oppressive and exploitative practices.

Exploitation, powerlessness and cultural imperialism [4]

Exploitative practices in the nursing home were evident, particularly at the level of the personal carers. These exploitative practices were permitted to exist as a 'normal' condition, unquestioned because of taken-for-granted differences that existed between the groups working within the nursing home. This differences entailed the stigmatisation (Bottomley 1992) of ethnicity and Greek culture and language, particularly of ethnic women who were non-professional.

Anything judged to be outside 'normality 'was considered inferior, undesirable and, at times, with aversion. The construction of the 'other' determined by the prerogative of the dominant group to define reality and meaning, also permitted them to portray the 'other' with negative stereotypical and often dehumanising characteristics. This made Greek-speaking carers invisible, concealing their enormous contribution (and, thus, their exploitation). The exploitation I observed and which informants discussed in a variety of situations and at different times related to:

> (I) the status of Greek women as wage earners dependent on their employers (nurse managers and institution); their relatively powerless position, with loss of autonomy and control; their exclusion from participation in the formulation of the rules and regulations that governed their working life;

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4 Cultural imperialism: Here, Young's (1990) notion of cultural imperialism is most relevant insofar as the discussion in this chapter which illustates how mainstreaming is imposed in the nursing home) is concerned. 'To experience cultural imperialism means to experience how the dominant meanings of society render the particular perspective of one's own group invisible at the same time as they stereotype one's group and mark it out as the Other. Cultural imperialism involves the universalization of the dominant group's experience and culture, and its establishment as the norm. Some groups have exclusive or primary access to what Nancy Fraser (1987b) calls the means of interpretation and communication in society. As a consequence, the dominant cultural products of the society, that is, those most widely disseminated, express the experience, values, goals, and achievements of these groups. Often without noticing they do so, the dominant groups project their own experience as representative of humanity as such. Cultural products also express the dominant group's perspective on and interpretation of events and elements in the society, including other groups in the society, insofar as they attain cultural status at all' (Young 1990:58-59).

(ii) the lack of time available for the work they were expected to complete;

(iii) undertaking work that was work for professionals because non Greek-speaking managers could not perceive it was required. They lacked the necessary knowledge and understanding of Greek language, culture and lay care to appreciate its value

(iv) their use as interpreters, and the expectation of nurse managers that Greek staff were obliged to interpret for them;

(v) unpaid work related activities encroaching on their own private space and time (such as being required to attend meetings out of work hours and being expected to attend English classes in their own time;

(vi) the institution taking the credit for work which the PCs/domestics did (that contributed to the institution's success with residents and Greek community) without acknowledging the PCs/domestics;

(vii) PCs/domestics used as scapegoats for nurse management's inability to implement managerial and professional nursing skills and knowledge outside the ethnocentric world from which they drew their power/knowledge.

Young (1990) explains:

> [e]xploitation can only occur if a relation exists between groups. Social rules, what work is, who does what for whom, how work is compensated, and the social process by which the results of work are appropriated operate to enact relations of power and inequality. These relations are produced and reproduced through a systematic process in which the energies of the have-nots are continuously expended to maintain and augment the power, status, and wealth of the haves (Young 1990:50)

Personal carers lacked mainstream symbolic capital and were further disadvantaged by their ethnicity and, paradoxically, by their

competence in Greek culture and language within the nursing home, and by their non-professional status that helped to segment them as a group. This situation was comparable with their experience in mainstream society as unskilled immigrants.

Thus, even though they worked in a Greek nursing home where their culture and language competence was essential to the effective running of the home, they occupied positions which disadvantaged them. Their work was menial, heavy and at times unpleasant, and also unrecognised. Their situation not only exacted their energy, it also enslaved their bodies structurally and socially. They were fenced off from opportunities, and even those who desperately tried to enhance their position continued to be perceived in negative terms, and management seemed to be indifferent to their needs, as they had no institutionalised means which could help their development and advancement.

Society, generally speaking, looks to women for nurturing, caring and support. Their gender situates them in a social domain that is 'normally' exploitative of them and that, generally speaking privileges men. The labours of women usually benefit others - in the main, men, with women not receiving reciprocal rewards. In this context, women of ethnic background (and colour other than white) are even more vulnerable because of their ethnic or race status that is usually inferiorised and devalued relative to others in society. As a group these women are usually relegated to social and employment positions where their labour benefits and maintains the positions of others more privileged than they are - 'capitalist superexploitation resulting from a segmented labour market. Capitalist market tends to reserve skilled, high-paying unionised jobs for whites' (Young 1990:51) in this case for dominant Australian (ESBID) professional Australians and Greek professional men.

As unskilled migrants these women stand as a perfect example of capital exploitation in the Marxian sense as they form a group that is located at the bottom of the social hierarchy. For Greek women working in the Greek ethnospecific nursing home, their designation

as 'uneducated' rural Greek women locates them, as a class within a class, in a doubly disadvantaged position group.

As ethnic women with a subordinate culture and language, their highly useful labour remains unacknowledged and unrecognised (even though it is vital to the nursing home), while the benefit of their labour adds to the prestige and power of their superiors. Personal carers, domestics and Greek-speaking staff generally were fully aware of this situation and critical of the Board of Management and Chief Executive Officer for their lack of interest in them. All of them made comments that reflected their disappointment at not being recognised. For example, a Greek-speaking RN who resigned after 5 years of service to the nursing home lamented, 'I have been here for five years. I worked so hard in this place. I gave all I had. I left and the Greek-speaking management did not even come to say good-bye'. She added, 'When Australian [ESBID] RNs leave even if under a cloud, the CEO comes and presents them with a farewell gift. The only one who acknowledged me was MI. She thanked me and gave me a bunch of flowers'.

Many of the staff expressed the wish to meet as a group with the Board of Directors at least once a year to directly communicate and have a dialogue with them. However, there was no formal institutional mechanism set up to facilitate such a meeting. I was informed however, that the BD and CEO held celebratory gatherings for all members of staff on certain religious holidays (such as Christmas) to express their appreciation.

The construction of time (economic capital) and its affects on carers residents and nursing home practices

Management perceived time as an economic unit that could be arranged in such a way that profit could be made. Any 'surplus' of time was seen as economic loss. Thus time was perceived as a commodity which managers purchased through the labour of staff. It was not perceived in qualitative terms, nor was it allowed to be perceived as it was experienced by residents and carers.

Employee work schedules were organised in such a way that time defined carers and residents as objects and, as such, seriously interfered with the quality of life of everyone within the home. Residents had all the time in the world. Often they made comments which referred to their sense of time passing slowly and meaninglessly. They loved to share jokes and good humour with carers to 'pass the time'. Carers too, loved joking and playing with residents while attending to their needs. Their time, however, was defined as a valuable commodity that managers were (purchasing) and such practices therefore expensive luxuries.

While residents had much time which they could use in ways that could improve their quality of life, they were dependent on carers, however, who had little time. Residents and carers found, themselves being pushed along a narrow, industrial 'productivity' belt that required speed and efficiency. Shortage of time choked everyone. Staff pushed themselves physically to overcome their time limitations and perform their duties. This extra physical stress was taking its toll, not only on staff well-being but also on residents well-being. Carers' time construction imposed severe limitations upon their care practices. Care was translated into essential tasks that were prioritised. However, task prioritisation did not include residents' physical needs such as walking and exercising. Their emotional, psychological and social needs were left to be addressed by the activities woman. The activities woman, however, was also overburdened, not only with providing meaningful cultural activities but also with maintaining resident community relations. Nurses educated in transcultural nursing would view such cultural practices as falling within the domain of professional nursing care knowledge. Nurses at the ethnospecific Greek nursing home, however, viewed them as lay cultural care not of their concern.

Thus culturally-specific care in the nursing home was practised mainly by the personal carers, domestics and the activities woman, but without the benefit of nursing or cross-cultural education.

Time limitations also led residents to become insecure and concerned about their safety and so stimulated then to demand attention, exacerbating the pressure on PC's. This situation, however,

contributed to a reduction in quality of care delivery to the residents, as well as a reduction in economic gains for carers. MII felt that since carers did not attend to tasks which she though were important such as (e.g exercises that physiotherapist had instructed) they were actually wasting time (nursing home money).

This situation generated an environment which promoted competition between carers that was inflected in culturally conventional ways. As they had to finish their work by lunchtime, speed became a value that was appreciated by carers. There was one particular personal carer who was extremely fast and her team would often finish their work before the other. Subsequently, the slower team would ask them to help, or the Division 1 nurse on the floor would ask them to help the 'slower' team. This was taken to be an unfair request, as they felt that they had done the work allocated to them. The slower team thus was considered less capable, as in Greek culture to be effective is to be Προκομενη, that is, fast and competent at your work. In a world constrained by limits of time, speed was a most important commodity and well fitted capitalist logic. So speed and quality of work (according to their own judgment) became two values which added or subtracted to carers' status, prestige and self-esteem among themselves (usually according to their age and experiences) in an environment that provided no other rewards for them. Carers thus used their own cultural symbolic systems to support themselves and maintain their worth.

There was also competition over hours worked. The team who worked more hours wanted to retain them and the other group wanted to gain them. At the same time, supervision, guidance and teaching for carers hardly existed. Carers' limited time was further eroded when even new staff were employed. New staff (including registered nurses and agency staff) worked with carers as normal staff but, because they were new, carers had to help, (particularly those who did not speak Greek) teach, guide, organize, supervise their work till they got to know the residents and their care and become independent. They were also expected to be interpreters for staff who did not speak Greek.

Roster patterns including patterns of hours to be worked were established by the nurse managers. During each shift there was one RN (the charge nurse) on the floor. The morning shift had one charge nurse and four personal carers on the floor to deliver care to 30 residents. This care was expected to accord with the Residential Care Standards set by the Commonwealth Government. These, however, are based on medical, nursing and managerial power/knowledge. Personal carers did not possess such power/knowledge (and, in addition, the Residential Care Standards offer only broad statements in relation to culture that offered no guidelines to culture care content or how to ensure that cultural care was provided. The afternoon shift had one charge nurse and three personal carers, one of whom worked for only four hours. The night shift had a charge nurse and one personal carer on the floor.

The roster was changed in July, 1997 to coincide with new Commonwealth Government industrial relations legislation. The patterns of days worked were changed and, as a result, work for some carers was reduced from five to four days and for others, from four to three days. At this time too, the number of hours per day worked by some carers was reduced without their being consulted. Once the new roster had been finalised, one of the carers teams was asked which pattern they would prefer to work. The other team then had no choice but to adopt the remaining pattern.

This team felt disadvantaged and blamed the other team for their misfortune. In addition they perceived their reduced work time in terms of a negative evaluation of their work by nurse managers. They believed that the managers considered them less able and less effective workers than the other team, and felt that this was the reason why their hours had been reduced. The team working more hours conversely believed that they were better and or more valued than the other team. Such perceptions were reinforced by comments made by managers that compared them.

These perceptions produced insecurities, struggles, tensions and conflicts between the personal carers that flared up under stress. The roster patterns were the fundamental cause for these tensions and conflicts. All carers now felt vulnerable and had serious fears about

losing their jobs. Carers working fewer hours thought that they would be the first to go if anyone lost their job. These fears became more intense and real as nurse managers made it known that new government regulations expected residential facilities to ensure that staff had 'relevant education', this, however, did not refer to cross-cultural or linguistic competence. This alarmed them immensely as they knew they were not 'educated' and that it would be extremely difficult for them to gain access to 'relevant' educational programs without high school qualifications and English fluency. In this regard, carers working fewer days and hours than others felt more vulnerable and less valued.

These fears grew even more when, towards the end of 1997, MII employed two personal carers who did not speak English or Greek. MII argued that they had skills which the Greek applicants did not. The skills MII was referring to were that one of the carers had been an ambulance worker in his country of origin and the other had been a nurse technician in her country of origin. These kinds of skills are not relevant to any argument used to validate the existence of ethnospecific nursing homes. However, relevant language and cultural knowledge and skills, are and it is puzzling as to why MII would give higher priority in this case to technical skills than to communication, cultural knowledge and skills. From my observations in the field several explanations are possible. Perhaps she was seeking docile, unquestioning and unresisting staff who would follow orders as directed, as opposed to Greek-speaking staff who would often respond to residents' requests rather than managerial direction and who often expressed their dissatisfaction with managerial decisions. It was also possible that MII had formed a genuinely low opinion of Greek carers' ability with regard to learning. It was common knowledge among carers that managers labelled them as unco-operative, and unruly people, unwilling or unable to learn. Therefore MII may have perceived people born outside Greece as being more likely to be 'flexible' and better able to learn, and thus may have selected people whom she considered to have 'potential', as she herself indicated when I discussed this issue with her. She explained to me that 'these carers had more potential than the Greek applicants'. While formal training was seen as potential Greek language and culture was seen in negative terms. It

appears that the Greek-speaking staff were a threat to nursing staff as they were cultural insiders and knowers and thus could easily be their critics. This situation was indicated to me in conversations by both managers.

Such thinking might reflect nursing's unconscious and long standing acceptance of compromises made in relation to delivering care to migrants in mainstream institutions, that is normalised, and was transposed to the ethnospecific nursing home context. It also may reflect the priority nurses traditionally give to technical/professional discourses which emphasise efficiency and task-orientation rather than effective and meaningful human relations and interactions.

Commonly, personal carers and domestic staff felt that they were categorised by managers as a group, without any acknowledgment of individual ability or differences. Carers felt that they were never given credit for good work; they stated that 'we only are told constantly that we are no good and that we do nothing right. We are always told things are wrong because it is "the Greek way". Managers imply that we are Greeks and, because we do things "the Greek way" this is what causes the problems'.

It was also clear that, because of the nursing home's time economy, personal carers were working alone with no team leader. They checked in with each other and attempted to correct each other, but they had no standards to refer to other than their individual experiences. These were experiences in caring and were perceived to be equivalent to knowledge and 'truth'. They were gained, it was believed, with age and in marriage in the process of nurturing and raising a family. A pecking order had developed among carers according to age and marital status and whether one was born in Greece or in Australia. These factors amounted to experience, the kind of experience which accounted for knowledge, wisdom and an understanding of what was considered to be 'right' and 'wrong'.

As there was only one registered nurse on the floor per shift, she/he had no time to supervise and guide personal carers. RNs generally only had time to 'cope' with technical nursing care delivery

(medications, wound care, blood tests, telephone inquiries, etc.) and other managerial tasks relating to residents' documentation and problem solving. Such work was critical for government auditing and to the survival of the nursing home.

Carers had no RN with them while working to guide them, plan and co-ordinate the processes of care delivery, make detailed assessments, determine priorities, make relevant decisions in the process of delivering care and evaluate the effectiveness of their care delivery.

On shifts when no Greek-speaking RNs had been rostered there was no one outside their group who could understand or closely observe what they were doing and what their tensions and disputes were about. For example, each team of personal carers worked in smaller teams of two and on different sides on the floor, each caring for 15 elderly. On one occasion, I observed two carers, one from each team, arguing about who should have a reclining chair. There was a limited number of reclining chairs and both believed that their particular resident deserved to have the chair in question. The registered nurse was not there and, even if she had been, she still may not have understood what the argument was about as it was in Greek. What was required in this case was a registered nurse to determine the issue on the basis of the residents' health needs. This did not occur and eventually, the older carer and more forceful personality won the argument. The other carer was left frustrated and angry and convinced that her resident should have had the reclining chair.

These kinds of tensions were often observed among the carers. Personal carers who thought they were doing their work better, based on feedback given to them by residents, would try to either correct the others or control their behaviour by formal criticism (*shxolia*) and/or lay criticism/gossip (*koutsompolio*). This gave them the reputation among professional staff of being argumentative and in disharmony. This situation, however, was generated mainly because they had no training nor any professional guidance, and because they were not, indeed, homologous and undifferentiated 'ethnic Greek, unskilled, rural women' as they were perceived to be.

Management, however, appeared to lack the ability to critically examine what was happening amongst carers and thus was unable to provide appropriate assistance to help the resolution of problems. Instead, managers often scapegoated the personal carers. Dysfunctional institutional conditions often were blamed on PCs. These conditions, however, were the product of managerial decisions - or indecision and government economic constraints and employer friendly legislation that permitted the development of an employer/employee environment that facilitated practices that took advantage of workers.

The issue of time construction and limitation was critical to the production of - and kinds of - staff relations, interactions and cultural practices in the nursing home.

Carer — We have not adequate staff and our work is very heavy. We should have another person to take the residents to the toilet at least, instead of them being incontinent and to wait for us to change them. The work becomes double then. They do not employ another person, however. We asked for another person and they laughed at us. They said, 'You want another staff? We are thinking of reducing your hours, not to bring more staff on!

OK — Who told you this?

Carer — The nurse managers. They have already reduced the hours of the afternoon shift. We were all starting at 2.30 pm. Now two staff start at 2.30 and the other at 4 pm. Is this right? In other words, instead of increasing the time which we need, they reduce it, so they can kill the carers who work here. To kill them! [emphatically and with contempt for the immorality of management]. One day we will come with broken arms and backs. It is heavy work. And now they employed two people who do not speak Greek or English!

No time to care–control/power/resistance

It was clear that personal carers vulnerability was immensely increased under the employer/employee relations that were produced on the basis of time construction and limitations.

The combined forces emanating from time construction and limitations in the form of rosters, meetings, and the expectation of nurse managers that staff should be available whenever they were required, created employment conditions, that made PCs' lives very difficult. Similarly, the time available for carers to attend to the needs of residents was extremely tight and affected their care delivery. For example, 30 residents were allocated a total of 54.5 personal care hours each 24 hours. Thus personal carers had 36.3 minutes that they could devote for the care of each resident per shift of 8 hours.

Similarly registered nurses could only devote a maximum of 16 minutes for each resident per shift. In this time the registered nurse was expected to assesses a resident's health status, listen to their concerns and solve any immediate problems, plan and evaluate the care delivery of carers and domestics, dispense medications, ensure that family and relatives were cared for and supported, co-ordinate other health care professional activities, check and order medications and other supplies as required, document the care of the residents, answer any inquires from community and relatives, attend to wound care and mouth and eye toilets, measure blood sugars, evaluate continence program interventions, and attend to any urgent situations as they arose. In addition RNs were expected to supervise and guide the work of untrained staff and to teach them as required. It was simply impossible for one RN to carry out all these tasks in a shift and at the same time achieve a safe level of resident health assessment on a daily basis.

In their time allocation, personal carers had to shower residents or wash them in bed. (Many residents who had faecal incontinence had to be showered or washed perhaps two or three times during the day). They had to dress residents, toilet them as required, or as per incontinent plans, turn them in bed every two hours and make them comfortable and prepare them for lunch and dinner. They had to feed a number of residents, move them from one place to another as required and take them (or exercise their limbs) for regular exercises and walks. They felt they had to talk (and were constantly asked to by residents) and listen to their issues and problems and comfort and support them as well as have their own meals. Often I

felt exhausted just watching the personal carers work! In this context of time construction and limitation, it was almost impossible to give any other care to the resident but rationalised industrial care. For example, on a number of occasions when I was in the dining room feeding or sitting with a resident while they were having their lunch, a domestic approached to ask us apologetically to hurry up and finish. I was informed that the dining room and kitchen serving area had to be cleared by 2pm so the contracted cleaner could come and clean the floor. (The cleaner also had to finish by a certain time).

Meal-times are extremely important for Greeks in a psychological/social sense. Food and the sharing of food mediate social relationships and help to create the nature of relationships that are developed and maintained between people. Meal-times and sharing food are sacred and social events that promote positive relationships and personal and community healing. In Greek society, the offering of food, and the way it is offered, served and enjoyed in the company of others (family, friends or visitors) is perceived as an essential aspect of lay care. Such practices are significant for communicating love, acceptance, support and respect that people had for each other. They express the sociability essential for a sense of community and connection. Eating together and without restrictions demonstrates community goodwill, strengthens bonds and indicates that the community cares about and supports its members. Food is perceived as promoting and sustaining health and as symbolically healing psychologically and emotionally. Sharing food is like sharing love, friendship, comfort, support, intimacy and respect and as a social vehicle, promotes family and community cohesion. All such elements are vital components of cultural care. Thus the gathering of the residents in the dining room should not be seen simply as the physical act of filling the stomach with food to satisfy hunger. It should rather be perceived–and facilitated as a social celebration an aesthetic and joyous cultural event in caring. However, I did not observe this. Rather, the atmosphere was one of strain and anxiety and, at times, it seemed to have enslaved the bodies and minds of residents and carers alike. Meal-times had became another task that had to be achieved, and quickly. Amongst this carers and relatives chatting masked the negative affects that time limitations had on relationships and meaning of life.

I observed that domestic staff would often avoid asking residents what they preferred to eat from the choice of two meals offered (see Chapter Seven). Indeed, I observed M II attempting to convince the domestic staff to ask the residents what meal they preferred. This task might seem simple to an observer. I realised, however, that if the domestic staff were to ask every resident what they preferred and then wait for the answer, then they would need to set aside at least 20 minutes to do so. I myself tested this and found that I needed at least 15 minutes to ascertain what all residents wanted. Domestics' time in the dining room was limited, however, and they thus avoided asking the residents for their preference.

Dining tables were rarely set in ways that reflected anything more than their function as 'feeding places'. Only one Australian RN noticed the aesthetics of the dinner table settings and, when she was working, she would ensure that domestic staff prepared the tables in a way that was pleasing.

Residents were brought to the dining room and quickly served. They seemed too disrupted and involved preparing themselves for their meal to have adequate quite time to talk amongst themselves. As I observed this, I had the sense that they felt rushed or pushed to finish as quickly as possible. Some who experienced difficulties in feeding themselves thus gave all their attention to eating and finishing in time. They were very aware, nevertheless, of the needs of other residents. A number of times I was asked by one resident to help another, either by cutting up their food or feeding them or fetching an item for them. This illustrates that, for Greeks, eating is a time of bonding, caring and sharing and that the residents were attempting to retain this valued cultural practice amidst the task-oriented environment they lived in.

Economy of time and its effects on residents' safety and suffering inadequate employment of professional staff

Untrained staff, even though may have wanted to, could not perform as registered nurses. They had to care for 30 dependent residents, many of whom had become entirely helpless. They were expected to assist them or provide for all their needs where required.

Residents expected personal carers to help them to maintain their humanity in a uniquely Greek cultural way, a way that required certain frequent and intense practices and, consequently, time that could not be determined universally by government economic rules. Additionally, the expectations and anxieties of families and relatives required time to be attended to, and neither was that time adequately available.

Division One nurses expected carers, who were not professionals, to make finely-discriminated nursing judgments, observations and evaluations, and to deliver care in a 'professional' manner. However, they consistently made negative comments about carers and seemed not to take into account the pressures carers were working under. Many of the pressures were not acknowledged as legitimate because they emanated from culturally expressed needs that were not recognised to have priority or even legitimacy. They felt powerless in relation to the way they perceived carers' conduct, and they could not see the possibilities which could be created by taking action at a higher level. Instead, they expressed their frustrations in comments such as, 'They [carers] do not observe or report residents' physical changes and complaints'. 'They are task-oriented'. 'They do not wash behind the ears of the residents'. 'They do not rinse the soap from their hair well'. 'They hurt the residents when they lift them up'. 'They hear at the handover that a resident did not sleep all night, and yet they will go and get that resident up for a shower rather than getting someone else and letting them rest'. 'They are not responsible and do not work as a team'. 'They fight between themselves, and they do not help each other'.

It was essential, of course, that carers cared appropriately and effectively for and without injuring the residents. However, they were also expected to be astute, alert and skillful observers, and recognise not only actual problems that residents had developed, but also the early signs and symptoms which indicated the development of potential problems, and report these. In other words they were expecting RN nurse duties from them. Personal carers reported what they thought was relevant and what they could actually perceive as a problem. However, they might not report changes which seemed unimportant to them. Nevertheless, I was present on a number of

occasions when carers reported, for example, that 'Mr...has a cough', or that 'Mrs...had loose and dark faeces', or that 'Mr ...does not want to eat', and noticed, to my surprise, that some registered nurses seem to completely ignore what was said. Indeed, personal carers came to me several times to report something that bothered them. (In these cases I took the matters up with the registered nurse on duty).

One particular event alarmed me immensely. A resident had developed a very sore foot, and would scream out in pain with minimal movement or touch. Personal carers in this instance had not observed the residents' problem. I reported this and tried to communicate the urgency of the situation to the registered nurse on duty. I left the field for the day and returned three days later to find out that no-one had acted upon that information. The same resident was now bleeding rectally and the personal carers had reported this. Even though the doctor was informed the same day, the woman was not seen by a doctor until two days later. Investigations to find out the cause of bleeding were to be undertaken a month later, and the resident was to be given Panadol for pain. The pain relief was completely ineffective. So it seemed that residents could develop problems unnoticed or were only noticed when their health problems were extreme. Once residents' health problems were noticed, doctors were informed but often were slow to respond. Registered nurses seemed to be reluctant to call doctors and often were apologetic to them on the phone.

Two residents actually fell and suffered bone fractures and, even though they complained constantly of pain, the staff (including the RN nurse on the floor) did not recognise that the resident had suffered fractures. Another resident who had also suffered a bone fracture one morning was only recognised as having a fracture late in the afternoon. Below is the description of how a therapist with some nursing experience found an injured resident who had not been cared for appropriately. She indicates her surprise concerning the registered nurses' 'neglect' of residents and the PCs lack of observation.

Therapist I saw her and I took her to her room, and I said, 'Come on, I think you should lie down. I don't even think you should be sitting here'. So I took her

clothes off and I put her nightie on. And there was this huge scratch down her back, this long, which would have been, like, probably about three feet long, okay, from the top of her shoulder, right down to her thigh. And it had something on it; it had, like, Mercurochrome or something like that. Then I noticed her eye, a black eye.

Yes. So, and because her eyes sagged, they didn't see it, so obviously they didn't check her out. Okay, so there was this huge bruise in her eye and she was shaking, trembling. I looked at her toe, and there was this huge haematoma at the end of her second toe, and a possible fracture.

OK Oh God!

Therapist And they just threw her in the lounge room, so I was furious!

OK Who was the registered nurse on?

Therapist Australian. He was in charge that day. So I walked up to him and said: 'Mr...', I said, 'have you noticed what has happened to Mrs...'? And he said, 'Yes, she has got a long scratch'. I said, 'More than that'. So I looked for MII; I was marching around. She was at a meeting. I read the notes, because sometimes they don't even enter notes.

OK They don't actually write it?

Early in my fieldwork (1995) I was involved in a discussion that took place between the day shift and night shift staff about a fall that a resident had sustained. The night shift registered nurse was asking whether she should write an 'incident report'. She was advised by the day shift registered nurse not to write one. I was most surprised to hear this and asked why. I was informed that MI had advised them not to write incident reports 'because they go to the Board of Directors and a big fuss is made. And MI then has to explain and answer what actually happened'. So not only are residents' falls not reported as such but unless the resident has suffered a severe injury, they are not recorded at all and officially have not happened. Consider the following discussion:

Therapist They are not writing in the histories what is happening, and this one had entered only the scratch. And I said, 'Look, have you noticed she has got a black eye and a huge haematoma above her eyebrow? And all this, and he said 'No, it wasn't there this morning'. And I said 'Well, obviously you haven't really checked her'. And I said 'Has the doctor been notified'? I said 'Has her family been notified'? I said 'Why was she in the lounge room chair'? And he was looking at me like, who the hell are you? And I said, 'Look, old people need more care,' and I said, 'You should be doing it,' then I walked off, and I was trembling.

And she was afraid. She said, 'Don't tell him that I told you'. And I said, 'Mrs... I looked at you, I was about to massage you and I saw this mess.' And I said, 'Where are the PCs'? I said, 'Who found you on the floor'? She fainted, and because she fainted she is an hysterical woman, right? She would get these phobias, these hysterical phobias like she is going to die and 'I can't see'. She can't really see. And I can't see and this and that. 'Please help me, I am dizzy, I can't breathe...

And she said, 'Please don't tell them tomorrow. They are going to make my life hell'. I said, 'Who are the PCs that found you? Who found you when you fell'? And she said, 'Λιγερη and Δωρα'. I said, 'What did they say'? And she said, 'They yelled at me for being so foolish and falling off the chair'. So she is one person they don't like, and she is so frightened.

I observed the behaviour of staff when I witnessed a fall of the same resident. Two PCs ran to her assistance. They lifted her off the floor placed her on a chair, asked her whether she was hurt and went to report the fall to the registered nurse. The RN arrived and asked the resident how she felt, looked at her face and said, 'You are allright. Sit and rest', and then the RN went about her work. At the time I was rather surprised at the casual manner in which they had responded; but most important in my view was that the RN had not proceeded to assess the woman carefully. If this was an indication of their routine response in such situations, then it was not surprising

that residents' injuries because of falls or for other reasons were not discovered until they were obvious. Indeed, the above fall was not recorded in an incident report or in the resident's record.

I argue here that the employment of only one RN per shift made available very limited professional time to be devoted to the care of residents. Registered nurses thus constrained by time cannot effectively examine and evaluate residents' health status on a daily basis. Often, when residents stated that they were in pain or were seeking the company or help of staff, they were quickly responded to and then ignored. There is a possibility that Division 1 nurses had ceased to hear them or take them seriously. They may have developed a disconcerted disconnectedness, coupled with an unconscious mental attitude, that contributed to the failure of their observational skills. It is also possible that because they worked in an environment where constant pain and suffering was present, they had shut down psychologically and emotionally in order to cope with their own feelings of helplessness and maintain their survival (or interest) in this situation. Expertise in pain management and psychological care seems to be lacking in medical and nursing practice despite it being essential for the care and the quality of life of the elderly.

Time economy, managerial practices and PCs/domestics' resistance

Many of the Greek staff did not speak or could not read English. Consequently, they possessed minimal understanding of their rights and of how to use the system to gain access to help. Nurse managers were well aware of this, and seemed to take advantage of the lack of industrial issues awareness and the consequently vulnerable position of Greek staff and other non-English speaking staff. When I asked carers whether they were union members they stated that 'we are frightened to become members or call the union because the management prefer us not to join the union'. Whether this perception was accurate, however, I was not able to discern.

An example of their vulnerability in this regard was that MI expected domestic staff who chipped or broke plates to pay for them. These people were making just enough money to survive and such petty

pressures could only be interpreted as inhumane, disempowering and punitive. The production of docile bodies[5] was pursued in various ways already discussed. Consider, though, the discussion (below) that I had with one domestic staff and which all domestic staff confirmed.

> Domestic We are in a hurry in the kitchen and we may place the plates and cups in the washing machine in a hurry. Sometimes we chip them. We are told by the MI that we have to buy new plates. [I remember when I was training as a nurse in 1960s early 1970s that if we broke a thermometer we were told by nurse managers that we had to pay for it and actually buy it]. If we break a plate, or chip a plate, we have been told that we have to buy it.

Carers felt very hurt because they perceived that MI thought they were careless rather than limited by time, and that was the reason why they chipped or broke plates. They believed she was punishing them for their carelessness by expecting them to pay for them and actually buy the plates and teaching them to be more careful. This they perceived as an additional insult to their exploitation, and to their intelligence as adult human beings.

> Domestic One day I dropped a plate from the trolley and she [MI] happened to be there. And she says 'Πηνελοπη'! [emphatically and with authority] I said I am sorry [συγνωμη]. It was an accident, the plate slipped from the trolley. I was insulted because she thought I was careless. And yet it was an accident. She tell us that we are careless because we do not have our mind at work but are interested on other things [χαζεβωμαι].

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5 'Docile' bodies: The historical moment of birth of the disciplines was the moment when an art of the human body was born, an art directed not only at the growth of the body's skills or at the intensification of its subjection, but at the formation of a relation that makes it more obedient as it becomes more useful, andvice versa. What was then being formed was a policy of coercion that acted upon the body, a calculated manipulation of its elements, its gestures, its behaviour. The human body was entering a machinery of power that explored it, broke it down and rearranged it. A 'political anatomy', which also had 'mechanics of power', was being born; it defined how one may have a hold over others' bodies, not only so that they may do what one wishes, but so that they may operate as one wishes, with the techniques, the speed and the efficiency that one determines. The discipline produces subjected' and practised bodies, 'docile' bodies (Foucault 977:137-138).

The carers and domestic staff continually emphasise the lack of consideration and respect they received from managers. To impress upon me how MI in particular did not care for or respect them, a domestic related to me how she was treated when her husband was hospitalised and she asked permission to have days off to be with him.

> Domestic [Quoting MI] 'Are we going to look after your husband and close the nursing home? [Carer reflects sarcastically] And I will leave my husband for the nursing home? What will I do? No, the nursing home will not close, with one person missing!

This domestic continued in anger:

> Domestic The management and the Australians - they do not care for their family, husband or children, they do not care. Why would they care for me?

The domestic, almost in tears and with deep hurt, related to me how the nurse manager had responded when she called to request a few days of work following surgery for a serious medical condition.

> Domestic [Quoting MI] 'If you cannot work, sit in your home and give your work to some one else'. Do you know how many nights I did not sleep?...

The above discussion with this informant was not uncommon. Domestics and PCs felt like they had to live only to serve the nursing home, or lose their jobs. They also were expected to be ready to replace anyone who could not be on duty at any time on any shift. They were rostered to work three or four days per week. Some were working five- and-a-half to six hours, and others seven-and-a-half hours. Most PCs wanted to work more hours because they needed the extra money for survival. Therefore they were all willing to undertake and welcoming of additional days or hours of work. Thus, because of their financial situation, they were vulnerable to exploitation (which was reflected in their roster patterns).

After the new industrial relations legislation had come to force, management made it clear to the PCs and domestic staff that they were expected to be on call (that is, available to replace an absent staff

member any time they were called). The PC's and domestic staff felt they had to agree to work the shift offered to them. The managers presented this as a choice that they could freely make, whether to accept the particular offer or not. The issue was that all PCs and domestic staff wanted to work additional hours; earning some more money was important to them. But they also wanted to have the freedom to accept the offer or not, without fear of reprimand and/or punishment.

Carers attempted to convey to me that they were human beings and had a life beyond the nursing home, including family responsibilities. 'We have a life beyond this nursing home [Gerokomeio], we have other family responsibilities. We cannot live just for this place'! I observed how, on one occasion, MII dealt with staff refusals to work beyond 'normal' working hours. With stern body language and appearing frustrated and angry, she entered the staff room where several of the PCs and myself were having morning tea. She stated, 'I am not going to ask *some* PCs to work any more additional hours because they are not flexible'. (As stated above all PCs wanted additional work as they were short of money). For the purpose of giving an example, she indicated a PC who was sitting with us as not been 'flexible' [a most caring PC, but with many family responsibilities]. Then she addressed me, 'What do you think, Olga? Is this fair is it not'? Not wanting to take sides, I simply stated that I did not have adequate information at that time to make such a judgment.

Later in the day, MII told me that staff took sick days without being sick. She explained how difficult it was to find staff to replace them. She informed me in a serious manner, 'I have to teach my staff what sick leave' is. They have to learn that they cannot take sick leave without being sick'. She added, 'They have to be hospitalised before they should think to take sick leave'. Nurse managers did not believe that staff who took sick days were ill (and this included Australian ESBID staff). At the same time, they did not think of critically examining the situation in the nursing home to explore issues of staff relations and conditions that might have shed light on why staff were becoming sick or were forced to use such excuses. I made some inquires and found that the nursing home did not have

contingency plans for replacing staff in emergency situations. I was also informed of - and witnessed of MI's unwillingness to use nurse agency staff, as she believed that they did not 'earn' the money they were paid.

Division 1 nurses (RNs) and MII therefore had no alternative means by which they could obtain staff in emergency situations such as when staff were absent due to sickness. Nursing management thus faced a difficult situation, but placed responsibility and accountability on staff. Rosters were designed to suit the needs of the institution but neglected to take into account the needs of the PCs and domestics. Consequently, carers were expected to be 'flexible' (in other words consent whenever asked to replace someone who was not at work). Bourdieu (1998) considers the demands made on workers currently for flexibility to be exploitative and expresses this in renaming flexible to 'flexiploitation'. Similarly, if they wanted a day off for a special occasion or event, they themselves were expected to arrange a replacement. Most of the staff were in financial need, so they did not take the loss of work days lightly. They were not given full-time work; indeed, they were rostered to serve the institution in the most cost-effective way. They felt that their needs were neglected and that they were held captive by the managers because of their financial need. Carers and domestics felt even more vulnerable because of high unemployment generally, and thus would only miss work if there were absolutely no other alternative for them.

Personal carers/domestic staff vulnerable position made them easy prey for exploitation. They were exploited in many detailed ways to serve the interests of the nursing home as the managers determined, while they worked under the enormous pressures that time constraints generated. When the MII reduced their working time in 1997, she simultaneously gave extra duties to several domestic staff. They were thus pressurised to produce more. At the same time, all PCs and domestics were experiencing the force, on their bodies, souls, minds and psyches, of their profound feeling of being dehumanised, of being disrespected and devalued as worthy human beings. One of the domestics said to me in despair: 'Hitler killed his victims'. They keep us here in slavery to suffer'.

Their emotional connection with the residents propelled staff to push themselves to extremes to provide for the residents' needs. The enormous pressure they were working under, however, and the continuous devaluing and disrespect that they were experiencing, forced them to start becoming more self-centred.

Carers had begun to try to disconnect emotionally from the residents so that they could cope with ignoring some of their requests and protect themselves from the burdens of overwork. They were starting to feel that they had to learn to see the nursing home as an uncaring institution, without a soul, even though the elderly with whom they were connected lived there. Some staff had started to vacillate between connecting and disconnecting emotionally with the residents. PCs had also started to become aware of their exploitation and were collectively preparing for some kind of resistance. In discussion among themselves they were threatening to slow down rather than speed up in the performance of their allotted tasks. They were also preparing to itemise what tasks could not be attended to because of time limitations, and present the list to the management. My fieldwork however, was completed before the PCs had actually taken any such action.

Nurse managers: Linguistic and cultural incompetence a burden for Greek-speaking staff

It is suggested here that because Australian ESBID division One Nurses lacked confidence in Greek culture, and because of their lack of Greek language skills, they avoided dealing with issues which required deep Greek cultural knowledge, as well as cross-cultural managerial skill. Often, in such situations involving tension and conflict, passed on responsibility, and mainly by not attending or nor perceiving such problems, for dealing with the problem to the PC's and Greek-speaking RNs. This often caused much unnecessary pain to staff who did not hold positions with the relevant authority and who were not paid to deal with such issues. In this way, managerial staff removed themselves from awkward situations.

It is important to give an illustration of how nursing management (excluding MI, who generally confronted rather than avoided such

issues) avoided issues which they felt were difficult to solve or for which they required Greek language skills, cultural knowledge and competence - as well as time - to facilitate their successful solution. Consider the following three events that carers related to me.

Event one : Gifts of sweets

Some community members who used to take food (including sweets), for residents in the nursing home believed that such food was not distributed to residents but was taken home by staff. One day a couple brought some sweets and they asked a carer whether they could give them to the elderly. I [carer] asked MII who was there at the time and she said, 'No they cannot have them. They already have eaten'. I relayed this to the couple. I explained that by eating these sweets it would hurt the residents because it would cause their blood pressure and blood sugar levels to rise and so it would be best if they did not give the sweets to the residents. I told them that they could leave the sweets and that we will give them to the residents at a later time. The wife insisted, however, that she wanted to give the food to the residents because she had heard that food that was brought to the nursing home was taken home by staff, and she wanted the elderly to have it.

Carer

I explained to MII why they were insisting that they give the food to residents directly. She angrily instructed me to say to them, 'Take your sweets and go away from the nursing home'. Then she went away. I thought if I send them away, it will be the wrong thing to do and we would not have accomplished anything. I then said to them, 'Come here. Where did you hear this? Tell them to come and observe us, to sit a few hours with us and see what we do. How can we take things away from the elderly? We love them like [gods] and we will dare take things away from them? Do you want to give these sweets to them? Give them. But you have to stay and clean their vomit when they get sick, to treat their sugar and their blood pressure that will raise'. They understood and felt shame. Then she [the wife] also understood that she was aggressive and she behaved like she was 100% sure that we were taking the food home. So I solved the problem. It is not creating good community relationships, to say to people 'Take what you brought and go'! It is

unacceptable. Within the community, for these things to be said are hurtful.

OK Why do they have such ideas?

Carer It is because they mistrust the nursing home because of the restrictions imposed upon them by the nursing management and because of the way they have imposed those restrictions.

Event two : Concerns about euthanasia

A resident was dying. Her son, who apparently only visited her 'once a year', was on the phone seeking information about her. I had had discussion already with the husband and knew the family situation (which explained the son's behaviour towards his mother). Staff, however, were critical of him for not visiting his mother, and felt that he had lost his right to be concerned about her. MI came to the floor from her office. She appeared upset and frustrated, and she instructed a non-English-speaking background (NESB) Division 1 nurse, on her first day of employment, to take the call. She instructed, in dismissive and angry way, 'Take this man's call, I was on the phone with him yesterday for one hour. I cannot stand talking to him again. He does not seem to want to understand what I say [he was born in Australia and spoke perfect English]. I cannot be bothered with him anymore'. The new RN took the phone call at the nurses' office. I followed her to observe how she might facilitate understanding. My observation was that this RN was patient, supportive and understanding, and she was actually trying to prepare the son for the death of his mother over the phone. From her responses to the son (whose queries I could not hear) I understood that while she was extremely respectful and caring, she was not understanding a critical issue that the son seemed to be concerned with.

I assumed that the son, wanted to know whether they were 'killing' his mother by giving her excessive morphine (narcotic for pain relief). that is, know whether they were using active euthanasia on his mother. I sensed that this may have been the case because my previous research with Greek people clearly indicated that this issue was of concern to many of them. So I whispered to the RN who was

on the phone to tell him that 'we only give her the amount of morphine required to relieve her pain and keep her comfortable, nothing more'. She repeated this to the son over the phone. It was stunning how effective this reassurance given was. The telephone discussion had already taken half an hour; subsequent to my information being given, however, issues that concerned the son seemed to have been solved, and the phone call subsequently, ended within a few seconds.

This situation illustrates that effective managerial and professional practice in an ethnospecific nursing home requires not only nursing managerial and relevant linguistic skills for the effective care of residents and support of their families, but also specific transcultural care (nursing) knowledge. The MII had no such knowledge and thus was not able to recognise the son's cultural cues, which he not doubt had given during this discussion with her. So he was labeled as difficult and not wanting to understand, and was thus dismissed. The NESB nurse who took his call had experience of another culture and spoke another language and, while she was sensitive, sympathetic and caring, she did not have transcultural knowledge to help her recognise the son's cultural cues and thus could not give him the reassurance he needed. I was able to assist, however, not only because I was a cultural insider but also because I had used culturally-embedded lay care knowledge the discovery of which was based on research. This event illustrates that nursing knowledge and its application remains ethnospecific without transcultural knowledge, whether delivered by Australian ESBID staff or staff from any other background educated in their own country's education system. In the case of the Greek nursing home nursing care delivery without transcultural knowledge is ethnospecific to Australian ESBID people, and *not* universal (appropriate for different cultural groups) as it is claimed to be.

Event three: Changing a rostered day

Senior nurse managers (MI and MII) respectively constructed the staff rosters while they were in the position of Director of Nursing. They would determine who was to work and when, the make-up of the teams and the hours to be worked per day and per week by each member of staff. However, they had given the responsibility for

cyclically producing the rosters, and responding to staff requests for roster variations, to the Australian Greek-born switchboard operator. She had to ensure that, when a member of staff was unable to be at work, a replacement was found. This situation, however, was made difficult by management limiting options for replacing unavailable staff. In fact, the switchboard operator had to contact, members of staff, one by one, who were on their days off and ask them to work the required shift. Management had already made known to staff that refusing to accept such an offer would be against their interests (as mentioned in previous pages).

Greek personal carers, therefore, who were contacted and asked to work a shift to replace someone else, and staff generally who wished to change a shift would have to argue their case with the switchboard woman. This woman had no managerial or nursing skills, and her Greek language proficiency was not as high as the Greek-born carers; she was also younger than most of the Greek-born carers/domestic staff. While she spoke Greek it can be argued that on account of her lack of managerial skills, authority and as an Australian Greek-born person feeling the pressure of in-between two cultures, this woman was unsuited for the task. She was perceived by the Greek carers/domestic staff as having no authority. Similarly, she was not expected by Greek-born women to understand their position and make accurate assessments and decisions about the life issues they were facing, and to accept graciously a refusal to work. She was perceived by the PCs/domestics as not having appropriate experiences of Greek life (migrant life) to understand them, since she was young and was regarded as having more understanding of and preferences for Australian mainstream (rather than Greek) life and values. Her Greek language skills were limited and served to disrupt the flow of communication with Greek-speaking staff. Her impotence in this role frustrated and angered her in turn and led her to stereotype Greek PCs/domestics according common dominant generalisations, for example, 'they lie', 'they do not want to help each other' 'their husbands tell them what to do' and so on. While the above characterisations may have been accurate for some particular individuals, they were by no means accurate of the group. Indeed, PCs/domestics wanted to work extra time to earn extra money; for them to say no to such opportunity would lead one to think that

they had important reasons for doing so. If they had been forced to lie, for example, they probably had a very good reason for doing so (apart from the fact that they were in fear of losing their job and felt that they had little or no understanding or support at their workplace).

Senior nurse managers seemed to have no awareness or sensitivity to cultural issues and/or inter-generational conflicts and tensions that can occur among those living between two cultures and that particularly affected the Australian Greek-born staff in the nursing home. It seems that RNs did, perhaps unconsciously, use Greek-born staff as mediators without understanding that, in some instances, their situation as members of the Greek community would have been made difficult as a result since they were perceived as being without authority or legitimacy in relation to without relative legitimacy to that of Australian ESBID nurses.

It is my view that the majority of nurse managers were often forced to abdicate their responsibility because they had no appropriate preparation to work in such a complex environment. Such an environment requires staff well-prepared in cross-cultural nursing management and transcultural care knowledge and with the will and patience to see another group's point of view. Many at the ethnospecific Greek nursing home did not have the will, patience or time to learn and appreciate another group's point of view. The registered nurses' (senior and middle management) main focus was to run the nursing home efficiently, as they were expected to. Concern about the welfare of the staff was not evident and was not a priority. One Australian ESBID was an exception. Indeed, she would have been a fine mentor for others in the effective use of people management skills in an ethnospecific nursing home; but she felt the pressure of being so disposed in an unsupportive environment and resigned.

Australian Greek-born members of staff occupied in between-cultural borders and spaces and liminal cultural positions. Others in the nursing home could not understand the complexities of such a positioning, nor did they have the skills to accommodate them.

Indeed, senior nurse managers unwittingly exploited these staff members. Naively, managers thought that Australian Greek-born staff could solve 'difficult' socio-cultural issues often caused by the existence of nursing home conditions, simply because they spoke the language and had Greek cultural experience. They were indeed ignorant of the problems associated with identity formation and shifting subjectivities in an ambivalent cultural context, that caused them to confront their worst fears and re-live their own cultural rejections/aversions. Below is an incident that took place involving the switchboard woman and a domestic staff who desperately wanted to take a particular day off work (she wanted to attend to an important but unforseen event). The exchange (below) indicates that not only were difficult tasks given to the least prepared to manage them, but also that management did not take into account Greek cultural elements to construct managerial practices which reflected the ethnospecificity of the nursing home. Instead, they simply imposed mainstream administrative and managerial practices that were devoid of Greek cultural meaning or sympathy for Greek staff members' difficult social situation and life- ways, and that often were the cause of difficulties for Greek staff, residents and relatives alike.

Domestic [To switchboard woman (SBW)] Change me with someone because I cannot come on Sunday.

SBW You must find another person to change with. Ring Mrs... and ask her.

Domestic She is coming back from Greece tomorrow night. I cannot ring her, she is not here.

[Manager II arrives at the switchboard]

SBW [To domestic staff] Explain to MII, now that she is here, what you want and what you cannot do, so that she can clear the issue.

[The domestic staff in broken English, explains to MII that she wants the day off]

MII [To the SBW] Tell her, if you are rostered normally it is not our responsibility to find someone to replace you. You must find somebody to do your shift if you want to take it off.

Domestic [In Greek] To find someone? I? [Stunned and in disbelief] Who will I find? I have already asked a number of staff and they all are working. One of the staff is working five hours, the other four, and that is a problem also. The woman who has the five hours does not want to change to work the four hours is less money. I told [another PC] I have such a need! You can take my money for that hour. I will give it to you, if you change with me.

MII [Addressing both the SBW and PC] You see! You do not help each other.

Domestic [Upset and insulted] Whatever it happens, I cannot be here. [While walking away] I am stupid. I should have rang tomorrow to say I was sick and could not come.

[The Nurse Manager II also walks away and leaves the switchboard woman without any solution to the issue].

OK [To the SBW] Ring an agency and get someone from there to replace her.

SBW I am not allowed to ring an agency.

OK Why?

SBW I do not know. I think that MI does not like agency staff.

OK Well, have you got a bank [a list of staff who have agreed to work on call and when required in emergencies?]

SBW We have no such a thing. You see, this is what happens. They put me in the middle and I have to argue with the Greek people all the time. They do not understand the pressure I have. And they do not want to understand. Why can she (the domestic staff) not ring the other staff to ask her if she can work for her? [Here, of course, the SBW does not understand-nor do the managers, incidentally - the

Greek cultural notion of obligation[6] and what that may entail].

OK — It is difficult for her because she knows that she has no authority and that the other staff can easily tell her no. If you ring, however, the staff member may be more willing to change. She also thinks that it is a managers' job to do and this not hers. She is not employed or paid to do this kind of work.

SBW — Nor am I. But they give it to me. And they PCs are difficult and uncooperative [with frustration and anger].

It was obvious that managerial decisions and practices were seriously affecting residents and staff alike, but still, managers seemed at times to lack sympathy, particularly for the staff. It was common practice for the nurses who did not speak Greek to avoid becoming involved with relatives or residents. They also appeared to have abdicated supportive responsibilities in relation to helping family and community nursing care. They lacked skills in helping and giving support to people in distress and grief, and in solving problems involving Greek-born staff, residents or relatives. Managers appeared to make situations worse in some instances because of cultural misunderstandings and perhaps because of a lack of confidence and an inability to communicate with some of the relatives.

It was observed, however, that MI did not abdicate her responsibilities in this regard but managed difficult situations with only the skills available to her through her dispositional actions (which reflected mainstream culture and traditional nursing practices). Indeed, she ignored the cultural aspects of such situations and imposed dominant Australian interpretations and solutions (as illustrated in Chapters Seven and Eight). On the other hand, MII and several other Australian ESBID nurses who only stayed for short periods at the nursing home would avoid getting involved with

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6 Obligation: In this sense, of obligation can be developed when someone in the community offers assistance or answers request or undertakes a task on someone else's behalf. This obligation, however, has the power of a debt, with the debtor obliged to return the favour without necessarily having a choice about the kind of favour selected for the pay-back, since they have to respond to the need of the debtor when asked. This is perceived by many Greeks to be an unwanted burden and an interference in one's freedom within the community.

issues they found difficult. They would pass their responsibility on to Greek staff, mainly personal carers who were not prepared or paid to discharge such responsibility. This was observed particularly in the heated debates that occurred in the nursing home involving Greek members of staff over rosters, and in interactions that took place between relatives, managers and staff.

Ethnospecific nursing homes are vital for the provision of humane and meaningful care services to people who, for cultural and language reasons would be most vulnerable in mainstream health care institutions that still remain basically inflexible. Such nursing homes or care facilities should be managed by people who are very clear about the complexities and difficulties they face. As such, they would need to be prepared with the knowledge, skills, attitudes, willingness and commitment necessary to ensure the delivery of relevant, appropriate and meaningful care. In addition, they would need to be extremely careful that the larger society's and their own particular cultural group's inequitous distinctions and social classification systems were not reproduced, and that oppressive and exploitative practices were actively discouraged.

CHAPTER NINE

CONCLUDING CRITICAL REFLECTIONS

Introduction

This study illustrates that the provision of ethnospecific services in the Greek nursing home, occurred at the expressive cultural level, but was overshadowed by an institutional structure, and the larger society's hegemonic symbolic systems that inadvertently promoted assimilation. Greek migrants, therefore, who are structurally marginalised and excluded from the dominant mainstream society, remained marginalised and excluded as residents and carers of the ethnospecific nursing home because its structure and its processes privileged dominant Anglo/Australian hegemonic 'normality'. The establishment of the Greek nursing home nevertheless created a 'Greek space' within the larger society where ethnospecific care practices were legitimated. This made possible the bringing together of residents and Greek-speaking staff who formed a *critical mass* which, via the *habitus* praxis of its constituents, posed resistance to hegemonic normalisation. The Greek cultural and linguistic forms of interactions and relationships within this group produced a context within which Greek residents felt a 'sense of place' and the right to demand their own construction of themselves.

The study elucidates the ways that dominant taken-for-granted Anglo/ Australian derived 'normality' was imposed in the Greek nursing home via 'cultural capital' (language, credentials, culture, skills, comportment, etc.) distribution. This capital distribution was supported by hegemonic forces that had devalued and subordinated Greek capital within the larger society, and that continued to act to

devalue Greek capital in the Greek nursing home. In practical terms, the imposition of Anglo/Australian derived 'normality' ensured the pre-eminence of the dominant *structure, habitus* and *culture* within the nursing home and, at the same time, facilitated institutional processes that sustained the larger society's established distinctions and inequalities in relation to Greek migrants, (that is they occupied a disadvantaged position as second-rate citizens).

A relational examination of the Greek nursing home field therefore, revealed the 'heart' of the society it was shaped by as well as the society's political and moral fabric. It also revealed that institutions do not only deliver services and serve interests, but, through their processes, uphold or violate justice - to the degree that individuals within are helped to develop and exercise their capacities and express their needs, thoughts and feelings or are inhibited (Young 1990). Institutional injustices were visible in differential access to decision making and the way institutional processes treated and affected those who received and/or provided services in the nursing home.

Cross-cultural capital distribution and the reproduction of hegemonic power relationships

The valuation, legitimisation and distribution cultural (Greek and Australian British/Irish descent) capital in the nursing home reproduced a structure homologous to that of mainstream Australian nursing homes. This involved structurally-bound cultural fields where boundary crossings were difficult. These structural borders reflected Australian hegemonic symbolic social and cultural stratification that were based on ethnicity, migrant status, cross-cultural patriarchy and conventional power

relationships that marginalised and oppressed the most vulnerable people in the nursing home (Greek ethnic women and residents and, particularly, those who spoke only Greek).

This hierarchical structure produced barriers similar to those experienced by migrant Greeks in dominant mainstream institutions. Power relationships within the Greek nursing home were structurally established and were visible at the interactive level of *culture, habitus* and *structure*. The provision of Greek lay cultural care was visible at the interactive level of Greek *culture* and *habitus,* within the particular Greek cultural space occupied by residents and carers.

Greek-speaking agents' sources of power lay in their capital (cultural and linguistic) which was valued by management for its usefulness but not for its symbolic power. However, this usefulness assumed, among carers and residents a moral force (that is, they felt that since they were in a Greek nursing home they had the right to speak Greek and to practise Greek culture) which offered considerable resistance to Australian English-speaking British/Irish descent registered nurses' (AESBIDRNs) hegemonic forces. This situation was very fragile however, as the distribution of Greek capital could easily be changed (as indicated in Chapter 7) by nurse managers who selected and employed staff.

AESBIDRNs' source of power, on the other hand, lay in government policies, in their professional and the dominant mainstream discourses, and in the 'common sense' that they had access to and symbolic authority over. Within this context, ethnic and gender stigmatisations continued to mark Greek-speaking staff as 'Other'. Nurse managers' power valence, therefore, in combination with

their structural positions, outweighed Greek power valence in the nursing home.

Hegemonic structural oppression sustained a system that permitted the exploitation and alienation of Greek-speaking staff from power to effect change. Hegemonic discourses and mainstream 'normality' were inaccessible to them and yet mediated their practice. Participation in the affairs of the institution was segregated, determined as it was by language (English was the formal language in the nursing home) by the institution's meeting processes and by general interactions that brought cross-cultural agents' habitus together in an unequal structural context. Thus Greek-speaking staff were effectively barred from participation by the institutionalisation of dominant mainstream infrastructure processes which acted to delegitimate and devalue their language and culture, and which were incongruent with their embodied experiences and understanding of non-institutionalised Greek-born women with an oral culture. Greek language and culture were tolerated only because of their usefulness in the nursing home.

The interpretation and understanding of social reality that incorporates human interactions and relationships is promoted by, and becomes increasingly meaningful, a shared language, historical past and social background (constituted by *class but stratified* with distinctions according to ethnicity, nationality, race/colour and gender). Such understanding and meaningfulness derives from the sharing of socially situated personal experiences, locally and historically embedded knowledge, and other forms of knowledge and world views which help people to construct and contextualise themselves as part of a community or society.

In the Greek nursing home, however, the legitimisation and distribution of capital (language, culture, credentials, social status, prestige, etc.) made such understandings difficult. The hegemony of dominant mainstream normality and cross-cultural patriarchy exerted its silencing and oppressing influences on Greek women and residents (men and women) by expecting them (and without them being proficient in English), to operate successfully within an alien structure. The structural constructions within the nursing home reaffirmed the larger society's subordination of Greek capital (language, culture, communication modes, behaviours and general comportment, together with their symbolic power) and the subordination of Greek women in relation to Greek men and Australian English-speaking British/Irish descent (AESBID) women. Once the nursing home's structure was established, its nature and survival was ensured by the constitutive interaction of culture, structure and agents' habitus.

The hierarchical distribution of mainstream Australian and Greek capital in the nursing home generated a microcosm of the larger society's bound cultural spaces, occupied in this case by Greek-speaking and AESBID staff. The majority of Greek-speaking staff in the nursing home occupied subordinate carer and domestic staff positions. They delivered care to residents and created the Greek cultural context of the nursing home. The majority of middle and senior managerial positions were held by AESBID registered nurses. They were the supervisors and the interpreters of government policies and professional discourses that determined residents needs and how they were to be met.

The two Greek-speaking registered nurses occupied middle managerial positions, but only after going through a humiliating process of employment practices that acted to reduce their professional confidence and that placed under question their identity, formed as it had been 'in between' two cultures. Their structural position in the nursing home as charge nurses (CNs) placed them in between the cultural borders of the two dominant groups. In this position, because of the Greek linguistic and cultural capital they possessed, they were expected to mediate between the two staff groups and residents and relatives. There was no recognition of, or attention paid to the inter-generational cultural tensions and/or ethnic identity issues that complicated and frustrated nursing home care practices.

Equally, there was no acknowledgment of the extra and unfair demands made on the Greek speaking registered nurses, that such a position required staff who were aware of the intricacies and difficulties that cross-cultural intersections can bring to a situation, that required well prepared staff. There was no understanding that such staff needed to be confident and to have strong but flexible bicultural identities in order to be able to withstand the conflicts, tensions and different pressures inherent in their mediatory role and to coach others in transcending any ethnocentric views or attitudes that they might have. This situation was tragic as not only were these nurses not supported but, at the same time, also their Greek cultural heritage and language was symbolically and materially made subordinate within the nursing home (mirroring their situation within the larger Australian society).

Most carers, domestic staff and residents were from rural Greece, without educational credentials and marked as 'women' and 'ethnic' with 'inadequate English skills'. By normalising English as the formal language in the Greek nursing home, the status quo was effectively reinforced. It also barred most carers, domestic staff and residents from accessing institutional processes, official documents and the relevant government policies and professional discourses that influenced the production of the conditions which oppressed them. This made them depend for the fulfillment of their interests on people situated in more powerful positions in the nursing home structure and privileged by being the inheritors of hegemonic forces.

Situated and local social realities in the Greek nursing home

The experience of reality in the nursing home was different for Greek-speaking women compared with professional RNs and Greek Australian-born and educated staff who had internalised dominant mainstream values and beliefs. These groups interpreted their experiences and realities differently and in relation to their institutional positions and social situations. For example, the senior manager, the majority of the Board of Directors and other Greek-speaking administrative staff were all men educated in Australia. The Greek-born carers, domestics and residents stood in relative disadvantage to these men, who held dominant capital and consequently symbolic power. Greek-speaking carers and domestic staff on the other hand, did not have the same identification or relationships, nor did they have access to the dominant mainstream normality that symbolically and materially overshadowed the Greek nursing home's 'Greek space'.

Greek-born and Greek-Australian-born registered nurses and other staff members who had grown up and/or been educated in Australia experienced and interpreted reality in the nursing home from various positions as the inheritors of two cultures and histories that they had had no part in constructing. The lived reality of these people was that they were marginal to both Greek and mainstream Australian cultural groups and, by having expectations placed on them (as mediators) that were extremely difficult to fulfill, they were therefore vulnerable to negative constructions by both groups. The 'in between borders' position of mediators that these staff members occupied brought them to confront both the conflicts and tensions of both dominant groups. Conflicts and tensions that emerged because each group viewed the world through its own cultural lense and moral frameworks that served its own particular interests.

This space, therefore, was an ambivalent and dangerous space. (At the same time, it was also the space that held the potential for the emergence and development of bicultural understandings and cross-cultural transformations). In any event, the bound cultural spaces of these two groups created an 'in between borders' space that forced Greek and Australian Greek-born and educated staff to resist both groups' domination. They had developed, as Young (1990) explains, the 'double consciousness' that commonly develops when one is growing up in between unequally valued cultures. This 'double consciousness' opens up spaces for critical reflection, but also may indicate different and troubling phases of identity formation - that may require special attention when such staff are employed to care for vulnerable people. The individuals, in these in-between positions, if they had had comfortable bicultural identities, relevant cross-cultural, ethnic and race relations knowledge and skills and

with managerial support, might easily have provided the leadership and opportunities for the development of a non-oppressive and empowering nursing home structure and environment.

Often, however, the AESBIDRNs expected Greek and Greek Australian-born educated staff to abide by their decisions, and to transmit their decisions and instructions to the Greek-speaking staff without consultation. This placed these staff members in an ambivalent and difficult position. On the one hand they felt diminished in the eyes of the Greek-speaking staff who expected them to act as their advocates; on the other, they felt themselves failures in the eyes of AESBID staff if they were unsuccessful in 'making' Greek-speaking staff comply with management decisions.

These Greek and Australian Greek-born educated staff had embodied the symbolic systems of both cultures and, in the process, they had often learned to see their own background in a negative way. Thus negative hegemonic representations of lower-ranked Greek-speaking staff made them feel shame by association. They felt part of this group but, at the same time strove to reject the object of their shame because they wished to be seen in a positive hegemonic light. Under these conditions they were caught 'in between' without the power, knowledge or confidence to mediate new understandings. This in turn produced a situation where both groups constructed them negatively. The AESBIDRNs saw them as 'ethnic' women with an inferior culture and ability. The Greek-speaking staff saw them as their young daughters, holding more 'Australian' than Greek values and beliefs and being Australian-born and educated, without the understanding of their parents' Greek - and immigrant - background.

Thus, these staff members often faced ambiguities and challenges in their interactions and relationships with individuals in both groups that threatened their identity, since it was influenced by both cultures' symbolic systems.

The field of the nursing home, therefore, made different demands on staff members in relation to their habitus, position, and ethnic and cultural identification and/or ascription. These factors placed staff in different situations which in turn generated different experiences, perceptions and social realities. The resistance of the different groups to each other was an attempt to ward off domination and the normalisation of the others' capital. This situation, however, was not balanced in terms of power. Rather, the AESBIDRNs held the currency of dominant capital and structural positions congruent with their habitus, as well as, the hegemonic symbolic power of the dominant mainstream 'normality'. Greek-speaking members of staff and residents thus found their capital devalued and inferiorised. They were marked as women (indeed, a male nurse of Greek descent was feminised by being a nurse but as a member of Greek culture he had more authority amongst carers and residents than Greek women) and segregated from dominant mainstream and Greek classed power relationships.

In the main immigrant Greeks (other than some of the new hegemonised middle class) are still at the margins of Australian society. Within their own community, gender and class distinctions (as described in Chapter 6 & 7) exclude them from participation in areas that other more privileged members of the culture are free to reign. This study reveals that, because of historically constructed social inequalities in the host society Greek people who are not

educated and particularly Greek women are excluded from full participation in policy development and decision making processes that affect their life chances.

Ethnospecific service provision in the Greek nursing home - Greek culture and habitus interacting

Greek-speaking residents and staff of the Greek nursing home embodied Greek culture as derived from similar backgrounds and history and a similar immigrant experience in Australia as labourers and housewives. This created the possibility, taking into account the structurally oppressive and exploitative nursing home conditions, to deliver to residents ethnospecific services and care. These ethnospecific services however, were clearly most successful at the expressive cultural level. The Greek-speaking staffs and residents habitus in interaction mediated culture and improvised within restrictive nursing home conditions in order to provide Greek lay cultural care to residents.

This was achieved mainly by the generation of powerful symbolic family roles that guided their relationships and acted to resist the pressures of hegemonic normalisation. The taking and giving of symbolic Greek family roles ensured, the development of a Greek cultural context and power relationships among residents and staff that guided their praxis.

Cultural capital and its legitimisation within the home was a constant source of tension and conflict between professional nurses and carers. Similarly, within the carers groups, tensions arose over who had the right to determine what was quality care. This revealed

Greek cultural classifications and differentiations made on the basis of age, marital status and gender, that determined who was knowledgeable and what knowledge was legitimate.

The carer/resident relationships extended beyond the simple interactions associated with their respective duties and needs to what Gilligan calls the "web of connection" (Bishop and Scudder, in Chin 1991:18). In this case, the web of connection enabled carers to see and respond to the needs of the residents within the bureaucratised hierarchical and 'instrumentally' driven of the nursing home, whose processes, by their nature acted to dehumanise people. This web of connection was based on symbolic caring relationships that were acknowledged by residents and carers. These intense bonds between residents and cares opened the way for their mutual engrossment and felt responsibility. Within the Greek family as explained in Chapter six, the cultural inculcation of the young sets the kind of relations that makes a moral life possible and the kind of values and relationships such a moral framework supports. Sharing family-like relationships and the responsibilities, particularly for vulnerable and dependent members, is profound and embodied. Carers in their praxis and under unfavorable nursing home conditions struggled valiantly to fulfill such responsibilities, but at times they failed.

Greek family relational paradoxes however, created for residents and carers a space within which they could shift their responsibilities in order to gain relief from unbearable and pressures they had no control over. Analysis of the carers' and residents' interactions, however, revealed that, under favourable nursing home conditions, carers guided by their responsibilities provided cultural care that enhanced the quality of residents life, their self esteem, and trust.

Under unfavourable nursing home conditions however, hidden family power relationships emerged that exposed family members unequal moral and social positions with their corresponding burdens. Analysis also made clear the integral part that social conditions and situations play in cross-cultural care practices, as well as the vulnerabilities of individuals involved in such practices. Similarly, the improvisation of within such an environment illustrated that *habitus*, in practical terms, mediates *culture* and *structure* but that, at this interactive level, each is constitutive of the other.

This family model of care provision in the nursing home also made visible that cross-cultural *care models* cannot be taken at face value, but need to be critically examined as local and situated, culturally, socially and historically embedded, and stratified according to gender, age and other *culturally specific* distinctions. Similarly, cultural models of care need to be examined critically in context and in action. This is necessary in order to expose the constraining and distorting affects idealised cultural care practices suffer under pragmatic situations. In particular such examination is fundamental when cultural care practices are divorced from their constitutive *structure* and *habitus* as well as when they are implemented within dominating structures to reveal how they might change, that exposes underpinning power relationships and the interests they serve. This is particularly so in a society where many different cultural groups live, but have unequal access to dominant social and institutional participatory and decision making processes that affect their lives and life chances.

Instrumental and mechanical contexts constructed according to efficiency often force caring individuals, for their own survival, to

disconnect, to remove themselves from responsibility and to cease to care. This was starting to occur amongst carers in the nursing home. In situations, such as this, however, the most vulnerable and those who depend for the fulfillment of their needs on others suffer the greatest harm. Such situations, can force the improvisation of uncaring demands and practices, particularly in situations where culturally and socially constructed care ideals and practices are held to be the duty of a section of the community (women) and they are expected to discharge their duty regardless of situation or social conditions and without adequate and appropriate support.

The findings of this study also illustrate that the majority of carers were guided in their practices by compassion which ensured the personal availability of carers to the residents when and as needed, and fostered self-direction (Bishop and Scudder 1991). However, in this regard, imposed time constraints and need prioritisation as determined by an institutional budget worked against the carers compassion and stood as a barrier to the delivery of quality health care to residents and therefore to their quality of life and well-being.

The nursing home structure was a product of the dominant mainstream that historically had excluded most Greek migrants from actively participating in the construction of the larger social institutional services (such as nursing homes) that affected them. Greek expressive culture in the form of Greek food, traditional celebrations, dancing and songs were made available to the residents at the nursing home. These were tolerated in the nursing home by AESBID staff much as they are tolerated in larger society. Intolerance and ignorance were evident, however, in relation to the daily interactions of the residents, Greek-speaking staff and the Greek community, and in relation to the details of deep (or embodied) and

most meaningful Greek cultural care practices, (eg fasting practices, what food is appropriate at what seasons, etc) individual and community behaviours, and orientations to quality of life, dress and general comportment.

In this regard, the infrastructure of the nursing home and its processes acted to segregate and control Greek staff in order to institutionally shape them in accordance with hegemonic normality. In the Greek nursing home therefore, *structurally*, Greek migrant residents, and particularly women, were faced with the same situation they faced in dominant mainstream health care institutions. Nevertheless, because the establishment had made available a 'Greek space' it was also possible for Greek aged residents to receive a level of care that was interactive, meaningful and indeed relevant. However, this was only because carers and domestics spoke Greek, were not professionalised and were not under the control of an internalised hegemony of the dominant 'normality'. They were able to resist external pressures and ward off hegemonic normalisation. Indeed, hegemonic normalisation at the practical level in the Greek nursing home, would be inevitable without the presence of the Greek-speaking carers and domestic staff - and/or without staff who speak Greek and are cross-culturally prepared and are directly involved with the nursing home at all levels: managerial, administrative and at the bedside. Such normalisation would mean that ethnospecific care delivery might be decontextualised, delivered by disconnected individuals and via culturally mute task processes (such as the provision of Greek food and religious ceremonies as tasks rather than as shared significant cultural events). This situation could also occur, particularly if staff are unable to establish meaningful relationships with residents because they do not speak Greek, nor they do not have a deep

knowledge of Greek culture because their habitus emerged from a different historical and cultural background and social conditions. A similar situation could result from the employment of bilingual and/or 'bicultural' staff who had educated themselves in Australia and not escaped the hegemonic forces of dominant ideologies, values and beliefs, and who might because of this, have internalised negative dispositions towards the 'Other' that is, migrants from their own cultural background . In such cases ethnospecific care delivery would suffer serious restrictions and pressure for assimilation to the dominant normality might ultimately win in situations where oppositional resistance is weak or non-existent.

Insights, criticisms and possibilities

Ethnospecific services should *aim* to ensure that residents and staff share the same language and cultural and social habitus. Ethnospecific services should also aim to employ staff with a *current* gerontic and planned transcultural (cross-cultural, incorporating ethnic and race issues) nursing education who wish to avoid oppressing (as explained by Young [1990]) while providing high quality care to the aged residents in their care. This would require much more social and political action and mediation than just the establishment of 'ethnospecific' nursing homes.

Conditions in the Greek nursing home might have been made much more favourable for Greek-speaking residents and carers if there had been a horizontal nursing home structure and if the institutional infrastructure and its processes had formalised Greek language, group formations and forms of speech. For example, forms of speech such as *sizitisi, kouventa, scholia* and *koutsombolio,* over

time would have fostered empowerment and confidence and would have provided a space for transformative developments. For transformation to take place, however, critical examination of hegemonic forces and how they affect the nursing home conditions, as well as the critical examination of Greek cultural distinctions within (such as gender, age, etc) has to be made wisely and systematically and with all members concerned fully participating in transformative action. Critical paedagoy, feminist and other participatory research approaches informed of and sensitive to cross-cultural issues might help in transforming nursing home processes.

Additionally, formal legitimisation of Greek *and* English language in the nursing home, with equal expectation (with appropriate support) that all nursing home staff would learn both languages, might have produced entirely different conditions in the nursing home. To this end, a systematic, organised recruitment program for registered nurses, division 1, that offered special incentives to attract and keep Greek-speaking and other better qualified nurses might have been successful. Equally, it would have been an indication that management recognised not only the difficulties faced by Greek-speaking division 1 RNs in the nursing home, but the reasons why they had difficulties attracting Greek division 1 RNs in the first place - related not only to experiences and identity formation of Greek people who are growing up between two cultures, but also to the treatment they received in the nursing home as second rate professionals and, within the Greek framework of patriarchy, to their perceived diminished authority as Greek women.

In addition, the offering of a carefully planned *critical* cross-cultural, ethnic and race relations education program that also gave serious attention to gender relations could produce a complete different

environment in the Greek nursing home, avoiding institutional oppression and exploitation. Such initiatives might require economic support different to the kind which government authorities might consider reasonable, in which case Greek leaders and nurse managers would have to make a case for differential economic support, such as the culturally relevant satisfaction of residents' health needs would require. Such initiatives in the case of the Greek nursing home could have subverted taken-for-granted normality - exposed its specificity and the interests it served, as well as producing new opportunities for creative developments and explorations.

Cultural care services are subjected to the improvisations of individuals habitus. The habitus mediates and improvises between culture and structure. It is to be understood that individuals who hold structural positions which have emerged from the same social conditions and culture that their habitus was constituted by, will be privileged over those who do not. Incongruence of structure, habitus and culture on the one hand creates spaces for critical awareness and creative action; on the other hand, it also creates the social conditions for social and cultural exclusions and stigmatisations that in turn, act to stratify social inequalities.

While the employment of unqualified carers in the Greek nursing home was not the best way of delivering ethnospecific care to the aged residents, particularly in professional terms, they offered significant and beneficial Greek lay care to residents that was not available in dominant mainstream institutions. Nevertheless, while the Greek aged may have received culturally specific lay care that was vital to their well-being and quality of life, their unqualified carers unfortunately lacked the basic biological, physical, nursing and

medical knowledge necessary for the care of aged people with complex disease and illness states and responses.

What Greek residents gained in cultural lay care they stood to lose by not having professional nursing care delivery, and vice versa. In this regard, too, it was apparent that professional nurses in the nursing home were not able to provide current nursing care, or care beyond an instrumental and task-oriented level. This situation is understandable in part as the nurses did not speak Greek nor were they prepared in gerontic and/or cross-cultural (transcultural) nursing. Even if they had been, one could still question whether holistic and culturally relevant care was possible in such a complex environment where the nurse was as the only qualified person on the floor, having responsibility for the delivery of care to 30 dependent residents.

Ethnospecific practices, because they remain at the cultural expressive institutional level remain invisible, specific or silenced, while dominant care knowledge and practices, themselves local and specific, are normalised and made universal. This ensures that hegemonic ideologies, values, beliefs and ideas dominate, reproduced via the health and educational institutions that help to constitute health care agents' disciplinary habitus. Nor does the invisible nature of ethnospecific care knowledge and practices help their development or refinement, which could come from insights gleaned in the interactions and care practices of carers and residents. Such knowledge and skills, if acknowledged and consciously encouraged, could be made visible and available to dominant mainstream institutions, and for health professionals' education, and could thereby help bring about changes benefiting society at large.

Without transformative initiatives, ethnospecific practices are limited; any insights that come from resident/carers interactions and relationships are segregated, controlled, guarded and evaluated by dominant normality and its vested interests. Indeed carers, residents and Greek-speaking staff who could have relevant cultural input into policy development and decision making have no access to these processes. Nor were they the interpreters of government policies or professional discourses. They have no access to dominant mainstream information that could empower them and facilitate their making such input and subsequently help them to challenge aspects of dominant structural 'normality' that disadvantages the most vulnerable people in institutions. Rather Greek aged residents and carers in the Greek nursing home, while they resisted hegemonic normalisation, nevertheless remained ineffective beyond their immediate field of practice and experience, constrained and controlled by dominant mainstream 'normality'. They felt trapped in oppressive conditions, forced to be victims by depending for the fulfillment of their interests on the benevolence of the host society and privileged groups from their own ethnic background.

Greek cultural care, moreover, was significantly affected by nursing home structural conditions, and was controlled and regulated by them. Many times the most useful and beneficial aspects of Greek cultural care were lost in the nursing home's conversion to industrial care processes. Time constraints by necessity determined which of the residents health needs were to be recognised by carers and in what order of priority attention was to be given. This prioritisation was determined mainly by the urgency of the residents' physical needs. In this way, carers' cultural care practices and

expressions were not only mediated by their habitus, but also by the constraining nursing home conditions that were generated by economic rationalism and employment relations policies. In addition, carers and residents were living and working under pressures that emanated from ethnic stigmatisation and stereotypical ethnic gender perceptions.

Professional nurses identified and legitimated the health needs of residents according to universalising government policies and the assessment tools as set out in the government's Aged Care Standards. These assessment tools have already being criticized for being inequitable and inefficient, and 'likely to significantly reduce funding to nursing homes' (McLean 1998:1; Newman, 1998). Such criticisms have emerged, even without taking into consideration cultural issues that could further expose their inadequacy and inequitable affects on ethnospecific nursing homes. In the case of ethnospecific nursing homes, such policies and tools, in order to be made culturally relevant would require the employment of RNs who could effectively communicate with residents and relatives. Additionally, they would need to have expert gerontic and cross-cultural knowledge and an understanding of how ethnicity, class and gender might affect their relations and interactions. These, combined with individual professionals' willingness and cultural empathy, would give room for hope that hegemonic transformations could occur. Universal assessment understandings would then give way to the specific cultural assessment, identification and prioritisation of residents' health and care needs, and to the relevant satisfaction of those needs.

Conceptions of *quality of life* and states of *well-being* are culturally embedded and defined. As such, quality of life and well-being are not

necessarily achieved by the imposition of conditions consistent with dominant mainstream nursing and medical 'normality'. Indeed, dominant 'normality' has been cited as contributing to the formation of the barriers that Greek and other ethnic aged have faced and continue to face in accessing mainstream aged health care services. It is proposed here that high quality and emancipatory ethnospecific aged care services and care provision can only be provided in the Greek nursing home in a *fully participatory,* culturally and linguistically contextualised and empowering environment. Such an environment would honour residents and relatives as fully human and as owners of their bodies and themselves, able to determine their own health needs and how they should be met by enabling access to relevant information and knowledge. Enabling residents and staff thus to choose stands to enhance the *quality* of their lives and their well-being as well as the empowerment of the Greek community at large. Making visible and encouraging, rather than controlling, ethnospecific care practices will legitimate them and help to eliminate the sense of oppression and self-devaluation that currently permeates the lived experience of carers and residents.

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APPENDIX A

28th November, 1994.

Ms. Olga Kanitsaki,
Head Centre for Environmental
& Social Health Nursing,
School of Nursing,
Faculty of Health Sciences,
LaTrobe University,
BUNDOORA, 3083.

Dear Olga,

Thank you for your letter of 25th October, in which you outlined the proposed research for your Doctoral Studies.

Your request was considered by the Committee of Management at its meeting of the 23rd of November, 1994.

The unanimous view was that the study would be of enormous benefit to the Society and the Greek community. You are welcome to have access to Steyi and other facilities at Springs Road.

Of course the usual protocol and ethics relevant to the circumstances would apply.

I look forward to seeing details of your research project.

Yours faithfully,

CHIEF EXECUTIVE OFFICER

APPENDIX B

APPLICATION FOR ETHICS APPROVAL
LA TROBE UNIVERSITY HUMAN ETHICS COMMITTEE

Candidature: Doctor of Philosophy
School of Sociology and Anthropology La Trobe University

Project Title: Ethnospecific Health and Care: A Critical Ethnography Greek Nursing Home Case Study

Applicant: Olga Kanitsaki
School of Nursing
Faulty of Health Sciences
La Trobe University

8 March 1995

LA TROBE UNIVERSITY HUMAN ETHICS COMMITTEE
APPLICATION FOR ETHICS APPROVAL - RESEARCH PROJECTS
INSTRUCTIONS FOR RESEARCHERS

1 GENERAL

To avoid delays in the process of approving your application, please ensure that:

- it is typed and that lay language is used;
- all relevant questions are answered;
- there is a full description of what the participant is required to do; and
- that the original plus two (2) copies of the application are sent to the Secretary.

Your application will be included in the University's Register of Human Ethics. Any information of a commercial or patentable nature should be forwarded separately and marked "**CONFIDENTIAL**". It should also be noted that the application form is designed for use by all Faculties within the University. Some questions will not be applicable to your specific discipline. Please utilise the "not applicable" tick boxes where appropriate.

Researchers conducting collaborative research projects with external institutions may submit the application used to gain approval at the external institution. Do not fill out attached application. Simply submit a copy of the external application for the Committee's review. The Committee will request further information if necessary.

2 INFORMED CONSENT REQUIREMENTS

You are required in general to prepare a written statement describing the project so that potential participants may make an *informed choice* as to whether or not to participate. A duplicate copy should be provided to the participant. The information to be included in the informed consent is set out below, and should be stated in language at a level appropriate to the participants. If this model is inappropriate for your group of participants, alternate models may be devised. It is advisable to discuss or obtain alternate models from either the Secretary or a member of the Committee.

TITLE OF PROJECT:
(BLOCK LETTERS)

NAMES OF INVESTIGATORS:
(BLOCK LETTERS)

PARTICIPANT'S NAME:
(BLOCK LETTERS)

Point 1 — A clear explanation, in terms the participant can understand, of the purpose of the investigation, and the procedures to be followed including identification of those which are experimental.

Point 2 — A description of any discomfort and possible hazards involved.

Point 3 — A statement of how much time will be needed.

Point 4 — A description of the potential benefits for the individual and society.

Point 5 — A statement that the participant is free to withdraw consent and to discontinue participation in the study at any time.

Point 6 — An offer to answer any questions the participant has concerning the procedures, in the following terms:

Any questions regarding the project titled:
can be directed to the Senior Investigator,
of the School of
on telephone number

Point 7 A statement advising the participant to write to:

The Chairperson, Human Ethics Committee, La Trobe University, Bundoora, Victoria, 3083, telephone number 479-1443

in the event that the participant has any complaint about the way he/she has been treated during the study, or a query that the Senior Investigator has been unable to satisfy.

Point 8 A signed agreement to take part in the activity from the participant, in the following terms:

I (the participant) have read (or, where appropriate, have had read to me) and understood the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I may withdraw at any time.

I agree that research data collected for the study may be published or provided to other researchers on the condition that my name is not used.

NAME OF PARTICIPANT (BLOCK LETTERS)

SIGNATURE DATE

*NAME OF AUTHORISED REPRESENTATIVE (BLOCK LETTERS)

SIGNATURE DATE

NAME OF INVESTIGATOR (BLOCK LETTERS)

SIGNATURE DATE

NOTE:
** See Section B Item 4 (b) of the application form. Use this signature block only in such cases where the participant is not capable of providing his/her informed consent.*

2.1 Implied Consent

For the purpose of applications to the HEC or FHEC, a questionnaire which is returned by a participant **implies consent**. A signed agreement to participate is not required if the project only requires the return of a questionnaire, and only if the questionnaire does not contain subject identifiers.

However, if the project includes any other methodology, the signed agreement must be included, with provision for both the participant and the researcher to sign the form.

3 ATTACHMENTS

Please ensure that the attachments specified on the **CHECKLIST** (page 7) of the application form are submitted, if applicable.

4 DESPATCH OF APPLICATION

You should refer to your copy of the Human Ethics Committee's brochure on the processes for obtaining ethical approval of your project. If you need a copy of the brochure or if you have any further queries, please contact the Chairperson or the Secretary, Human Ethics Committee, 479-1443 or Faculty Human Ethics Committee. A membership list of your FHEC can be obtained from the Faculty Registrar's Office.

La Trobe University
Faculty Human Ethics Committee
Faculty of Health Sciences
APPLICATION FOR ETHICS APPROVAL
RESEARCH PROJECTS

OFFICE USE ONLY
LHS/FHEC Register
Number: _____
Date received
/ /199

YOU ARE REMINDED THAT PROJECTS SHOULD NOT COMMENCE WITHOUT PRIOR WRITTEN APPROVAL FROM THE HEC OR SHREC

SECTION A GENERAL INFORMATION

1. **PROJECT TITLE** *(block letters)*

ETHNOSPECIFIC HEALTH AND CARE: A CRITICAL ETHNOGRAPHIC GREEK NURSING HOME CASE STUDY

2. RESEARCHER

Name : OLGA KANITSAKI Department: Nursing

Position : Senior Lecturer and Head: Centre for Environmental and Social Health Nursing Telephone No. 418 6913 W 470 3427 H

SUPERVISOR'S NAME (where applicable): Dr M. MACINTYRE and Dr. P. L. RICE

Type of Project (where applicable):

[ ] (a) Research by Academic Staff Member [ ] (c) Contract Research

[ ] (b) Supervised Postgrad Research or RA [ ] (d) Supervised Undergrad Research

* If you have ticked (b) or (d) please attach a brief description of the student's qualifications for carrying out research.

3. ANTICIPATED DURATION OF PROJECT From 1995 To...1005.....(Part time)....

4. EXTERNAL FUNDING (where appropriate)

Yes [ ] Name of Funding Body:

No [ ]

5. AIMS AND BRIEF DESCRIPTION OF PROJECT THIS STUDY AIMS TO:

1. examine how ethnospecific health and care is understood, interpreted and practiced by the Institution and its members of staff within a Greek aged nursing home occupied by Greek born people and run by culturally diverse members of staff.
2. Investigate, compare, and critically reflect upon (residence and their families, all health professionals and other members of staff) meanings, perceptions and understandings of health, illness, healing and care practices, in a Greek ethnospecific nursing home within the Australian context.
3. Analyse how health professionals culture, professional education, and health care practices affect health care delivery in a ethnospecific nursing home for the care of the aged, and how the institutional structures and processes affect them and their practices.
4. Provide a critical examination of how health, illness, care knowledge and practices, are constructed, contested and mediated by human agency, interests, and culture within a multicultural health care institution embedded within a dominant (socio-cultural, economic and political) Anglocentric society, dominated by Western medical sciences, nursing knowledge and practices.
5. Use findings to critically reflect upon broader issues that relate to the effectiveness of health and care delivery to a multicultural population at large.

SECTION B PROJECT PARTICULARS

1. **PARTICIPANT DETAILS** (If your project involves human participants, complete Point 1. If the project involves body/tissue samples only, proceed to Point 2), proceed to complete Paragraph 2)

(a) **Number involved:** Males not known as yet Females not known as yet

The Nursing home has 30 beds, and are all presently occupied.
In total 42 members of staff (including nurses, volunteers, occupational therapist and social workers) work at the Nursing home. There are a number of Greek born and Australian born visiting doctors who are caring for the residence.

(b) **Age range:** 50 to 95

(c) **State of health:** [ ] Normal [ ] Other (specify)

Residence will suffer from a variety of medical conditions, such as, diabetes, cardiac failure, Parkinson s disease, cancer, and other medical conditions.

(d) **Method of recruitment:** (indicate how names of potential participants will be obtained.) **Note:** Where participants are obtained from schools, hospitals, prisons or other institutions, permission /approval from the institution or appropriate authority must be sought. See Point 4.

The Greek Nursing Home has already been approached and permission has been obtained to undertake this ethnographic study in their premises. (Please see attachment 1)
During the participatory phase of the research process however, I will be selecting informants that I will invite to participate in this study. Residents and their families as well as members of staff will participate in the project via formal and informal interviews and group discussions.

(e) **Compensation:** (Provide details if any financial or other reward is being offered to subjects for participation)

[ ] N/A

(f) **Involvement of special groups:** (if project involves groups involving special permission (e.g. Aborigines), or persons in dependent relationships (eg. children, disabled) requiring permission from a quardian, describe the nature of the groups and procedures to obtain permission, and complete Point 4).

This project will involve planed and unplanned individual and group interviews. Individual aged persons, their families, individual nurses, doctors, administrators, social workers and members of the domestic staff will be approached to volunteer for interviews and or group discussions. All involved will be given full information of the purpose and process of the research, and will be given a consent form to sign. However, it is anticipated that some Greek born individuals may not wish to sign a consent form for a variety of reasons, in which case verbal consent will be sought. (Please see attachment 2 and 3)

[ ] N/A

2. SAMPLES (If research involves access to data banks, human pathology or diagnostic specimens provided by an institution(s) please indicate source(s) and number of samples. See also Point 4)

Residence medical and nursing histories which include pathology or diagnostic tests will be accessed (Institutional permission has been obtained). Permission will be sought from individual residents to access their records. This however will be done after rapport and trust has been developed between myself the residence and their families. It is impossible to gain consent from each resident and their families before they get to know me. Greek born people do not 'normally' trust people before they know them as individuals and before they are given an opportunity to test the character of the person. The manner by which consent is obtained from different cultural groups is itself an important cultural issue, and does not necessary fit the predetermined way by which Anglocentric ethical procedures require. It is important that a trusting relationship is establish before consent is obtained, and this requires time to be spent with the relevant people. In addition it will not be useful to obtain consent forms from informants that may not be in the nursing home at the time of the research process. I will be selecting relevant residence and staff to invite for interviews, and group discussions, during the participatory observation phase of this project (during a period of eighteen months) and the residents and staff who are presently in the home may not be there at the relevant time of the research process.

3. LOCATION OF STUDY (Identify the location of the study, if research will not be carried out at the University. If permission is required, indicate how permission will be obtained. See also Point 4)

Greek Nursing Home (please see attachment 1)

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4. EXTERNAL APPROVALS (Note: If a project requires approval from other institutions or ethics committees, next of kin (in case of Special Groups)etc., a copy of such approvals must be provided to the HEC at the time of application or be made available as soon as possible. No project may commence until such approvals are provided)

Please indicate as appropriate if formal clearance/permission has been obtained or sought:

(a) [ ] Institutional

[ ] Yes - If yes [ ] Attached [ ] To follow (estimate when likely to be obtained)

[ ] No (please explain)

(b) [ ] Next of Kin (for Special groups)

[ ] Yes - If yes [ ] Attached [ ] To follow (estimate when likely to be obtained)

[ ] No (please explain)

---

5. INFORMED CONSENT (Indicate whether individual Informed Consent forms will be used)

[ ] Yes (if yes, attach copy to the application) Only for residents who feel free (not coerced) to sign a consent form

[ ] No (please explain) Only for residents who feel threatened (or coerced) in signing a consent form

---

SECTION C RESEARCH PROCEDURES

1. DESCRIPTION OF PROCEDURES (describe all procedures to which the participants will be subjected, and emphasise any which may have adverse consequences. *If a questionnaire will be utilised in the project, please attach a copy to the application form.)

1. Participant observation which will include working in the nursing home, at different shifts and days for a predetermined time (i.e. eighteen months). Government and institutional policies, regulations and procedures will be examined as they relate to the running of the institution and to the care delivery of the residence and their family. This will also include participating in extra curricula events such as attending some Institutional and staff meetings, ceremonies, and other cultural events which may be of relevance to the study.
2. Some residents and members of staff of all professions involved in the delivery of care to the elderly will be interviewed. Interviews will be individual and unstructured and followed with more structured interviews at a latter date. Group discussions will also be undertaken, formally and informally as the need may arise. It is anticipated however, that the researcher, and research processes, techniques and strategies will be influenced by the institutional and human conditions and interactions in process at the time.
3. Participant demographic data will also be obtained during individual interviews.

2. ADMINISTRATION OF SUBSTANCES/AGENTS (any chemical compounds, drugs or biological agents, dosage, frequency of administration and anticipated effects)

Name of substance(s):
Dosage per administration:
Frequency of administration:
Total amounts to be administered:
Anticipated effects:

Not applicable [ ]

3. SAMPLING OF BODY FLUIDS OR TISSUES

What will be sampled and how?
Frequency and volume
How are samples to be stored?
How will samples be disposed of?
Who will take the samples?
What are their qualifications for doing so?

Not applicable [ ]

NOTE:

(A) If the research involves administration of foreign substances or invasive procedures please attach a statement accepting responsibility for those procedures by a medical or paramedical practitioner with Indemnity insurance.

Not applicable [ ]

Statement attached [ ]

(B) If the research involves possible physical risk, a first aid person must be on call

Not applicable [ ]

Details of arrangements attached [ ]

4. IS THERE ANY RISK TO THE SUBJECT/DONOR? [ ] Yes [ ] No
(If yes, explain and describe protective measures to be taken)

5. POTENTIAL BENEFITS

(a) To the Participant:

It is anticipated that direct involvement in the research process via individual interviews, group discussions, members of staff, and residents will enhance their understanding of any particular concerns and issues which may exist by living and working within a culturally diverse but ethnospecific health care aged institution. This understanding may assist in the enhancement of effective human relations and meaningful human interactions between members of staff and residents, between staff residence and their families, and between families and residents.
Informants will be given an opportunity to vent their feelings in relation to any concerns, anxiety and or frustration that they may be experiencing which may assist them psychologically.

(b) To humanity generally:

This research project has the potential of providing some useful insights to the kind of social conditions (political, economic, cultural, educational) and to the kind of human agency required in creating an effective health care delivery and health educational system within multicultural societies.

SECTION D CONFIDENTIALITY OF RECORDS

1. RECORDING OF DATA

(a) How will data be recorded?

Field notes will be made, Tape record will be used , and a personal journal will be kept.

(b) Will confidentiality of results be maintained? [ ] Yes *(detail below)*
[ ] No *(explain)*

This will be maintained by the safety of field notes, journals, and tape records by keeping them locked. With permission from the participants the project will be published. Any information which can give cues to the identity of the participants, institution or professionals will not be revealed.

(c) Will participants be anonymous? [ ] Yes *(explain how anonymity will be assured)*
[ ] No *(give reasons)*

Names, and addresses of the participants will not be revealed on tapes, field notes, transcripts, or when results will be published. Field notes, tapes, and transcripts will be coded by numbers, dates and colours. The name of the Greek Nursing Home will not be revealed. It is anticipated than within two years three more Greek nursing homes will be operating in Victoria. Despite this however, it may be some risk involved regarding confidentiality and anonymity if the name of the state is revealed, for this reason the state within which the Greek home operates will not be revealed.

2. SECURITY OF DATA *(indicate how security will be maintained)*

(a) During study Locked in a file cabinet at my own home and at my office at the university.

(b) Following completion of study Transcripts will be destroyed. Tapes and field notes will be locked in a suitable file cabinet at my own place, for five years according to university regulations..

NOTE: Normally unidentified records should be kept for a period consistent with University guidelines for good scientific conduct (5 years following publication). These records may be kept as computer files.

SECTION E DISSEMINATION OF RESULTS

Will participants be informed that results from the study may appear in publications? *(This information is normally to be included in the information given prior to obtaining informed consent)*

[ ] Yes *(give details)* [ ] No *(please explain)*

SECTION F ETHICAL ISSUES

1. ETHICAL ISSUES
(Please indicate *(by X as appropriate)* what in your view are the ethical issues involved in this research. The following is a checklist of possible ethical issues)

(a)	Is deception to be used?	[ ] Yes	[ ] No
(b)	Does the data collection process involve access to confidential patient data without the prior consent of subjects?	[ ] Yes	[ ] No
(c)	Will subjects have pictures taken of them? eg., photographs, videos	[ ] Yes	[ ] No
(d)	Will participants come into contact with any equipment which uses an electrical supply in any form? eg., audiometer, electrical stimulation, etc.	[ ] Yes	[ ] No
(e)	If interviews are to be conducted will they be tape-recorded?	[ ] Yes	[ ] No
(f)	Will participants be asked to commit any acts which might diminish self-esteem or cause them to experience embarrassment or regret?	[ ] Yes	[ ] No
(g)	Will any treatment be used with potentially unpleasant or harmful side effects?	[ ] Yes	[ ] No
(h)	Does the research involve a fertilised human ovum?	[ ] Yes	[ ] No
(i)	Does the research involve any stimuli, tasks, investigations or noxious, aversive or unpleasant during or after the research procedures?	[ ] Yes	[ ] No
(j)	Will the research involve the use of no-treatment or placebo control conditions?	[ ] Yes	[ ] No
(k)	Will any samples of body fluid or body tissue be required specifically for the research which would not be required in the case of ordinary treatment?	[ ] Yes	[ ] No
(i)	Will subjects be fingerprinted or DNA "fingerprinted"?	[ ] Yes	[ ] No
(m)	Are there in your opinion any other ethical issues involved in the research?	[ ] Yes	[ ] No

NOTE: If the answer to any of the above questions is "yes" please explain and justify below.
It is most important to tape record information at interviews and during group discussions. It is essential in order to obtain detail and accurate information and in order to be able to devote my full attention to the human interactions which will be taking place during the interviews, and during group discussions. It is also necessary that I be free to facilitate the group discussions. Any interaction must be given full attention on the individual level, or I will be risking the establishment of rapport and trust with participants. Trust and rapport is a necessary condition (particularly with Greek born people) that enhances disclosure from informants and the success of the research process.

2. ANY OTHER COMMENTS

3. DECLARATIONS

We, the undersigned, are familiar with, and have access to copies of the National Health and Medical Research Council's **Statement on Human Experimentation and Supplementary Notes.** We accept responsibility for the conduct of this research in accordance with the principles contained in the NH&MRC guidelines and any other conditions specified by the Human Experimentation Committee of the University.

NAME *(block letters)*	SIGNATURE	DATE
Researcher OLGA KANITSAKI		
Supervisor DR MARTHA MACINTYRE		

CHECKLIST

The following documents are attached *(please indicate)*

COPY OF PROPOSED INFORMED CONSENT FORM	[ ]
EVIDENCE OF PERMISSION TO USE PLACES OFF CAMPUS *(if applicable)*	[ ]
EVIDENCE OF APPROVAL BY ANOTHER ETHICS COMMITTEE *(if applicable)*	[ ]
COPY OF STATEMENT FROM MEDICAL/PARAMEDICAL PRACTITIONER ACCEPTING RESPONSIBILITY FOR PROCEDURES [Section C, Paragraph 3] *(if applicable)*	[ ]
DETAILS OF ARRANGEMENTS FOR FIRST AID	[ ]
QUESTIONNAIRE	[ ]
COPY OF ANY ETHICAL APPROVAL FORM REQUIRING SIGNATURE *(eg. NH&MRC Attachment 1)*	[ ]

YOU ARE REMINDED THAT PROJECTS SHOULD NOT COMMENCE WITHOUT PRIOR WRITTEN APPROVAL FROM FHEC OR HEC.

PLEASE RETURN THE COMPLETED FORM AND RELEVANT ATTACHMENTS TO THE SECRETARY, FHEC *(as per the Instructions to Researchers)*

APPENDIX B

LA TROBE UNIVERSITY

School of Nursing
FACULTY OF HEALTH SCIENCES

ΕΓΚΡΙΣΗ ΣΥΜΜΕΤΟΧΗΣ

ΕΙΔΙΚΗ ΕΘΝΙΚΗ ΥΓΕΙΑ ΚΑΙ ΠΕΡΙΠΟΙΗΣΗ: ΕΘΝΟΓΡΑΦΙΚΗ ΚΡΙΤΙΚΗ ΜΕΛΕΤΗ ΤΟΥ ΕΛΛΗΝΙΚΟΥ ΓΗΡΟΚΟΜΕΙΟΥ.

ΕΠΙΣΤΟΛΗ ΠΟΥ ΕΞΗΓΕΙ ΤΗΝ ΕΡΕΥΝΑ ΣΤΟΥΣ ΚΑΤΟΙΚΟΥΣ ΤΟΥ ΓΗΡΟΓΟΜΕΙΟΥ ΚΑΙ ΣΤΗΝ ΟΙΚΟΓΕΝΕΙΑ ΤΟΥΣ

Αγαπητε (τη/οι) συμπαροικοι

Σπουδαζω στο Πανεπιστημειο για δοκτορατο. Για να μπορεσω να αρχισω ομως και να τελειωσω τις σπουδες μου πρεπει να κανω μια ερευνα.

Εγω εργαζομαι πολλα χρονια τωρα για την βελτιωση των νοσοκομειων γενικα. Επισης και για την δημιουργια Ιατρικης και νοσηλευτικης περιποιησεως που να εξυπηρετει ολους τους ανθρωπους που ζουν στην Αυστραλια. Για αυτο το λογο απεφασισα να μελετησω το Ελληνικο γηροκομειο για να μπορεσω να καταλαβω τι ειδους ζωη εχετε και ζητε μεσα σε αυτο το νοσοκομειο, και να βγαλω συμπερασμα τι περιποιηση ειναι καταλληλη για σας. Φυσικα ειναι πολυ σπουδαιο και απαραιτητο πριν βγαλω κανενα συμπερασμα να ρωτησω εσας να μου περιγραψετε τη ζωη σας εδω μεσα. Θα ηθελα πολυ να μου πητε εσεις πως αισθανεσθε και τι σας αρεσει απο την περιποιηση που εχετε, επισης εαν θελετε να αλλαξετε τιποτα.

Γενικα ο σκοπος μου ειναι να εξετασω το ποσο καλυτερα ειναι να εχομε ειδικα γηροκομεια για τους ανθρωπους που ερχονται απο αλλα κρατη του κοσμου στην Αυστραλια. Επισης ενας ακομα σκοπος της ερευνας ειναι να μαθομε τι πρεπει να κανομε για να βελτιωσομε ιατρικες και νοσηλευτικες περιποιησεις και θεραπειες για ολους τους ανθρωπους που ερχονται απο αλλα κρατη του κοσμου στην Αυστραλια. Σας ζητω λοιπον να μου δωσετε την αδεια να συζητησω μαζι σας και να μου πητε τη γνωμη σας για την περιποιηση που λαβενετε απο τις νοσοκομες, γιατρους και γενικα απο ολους που σας περιποιουνται.

LA TROBE UNIVERSI
BUNDOORA, VICTOR
AUSTRALIA 3C
TELEPHONE: (03) 9479 59
FACSIMILE: (03) 9479 5

Επισης σας ζητω αδεια να ηχογραφησω την συζητηση που θα κανομε μαζι, γιατι δεν ειναι δυνατον για μενα να γραφω ολα οτι λετε και συγχρονως να σας ακουω. Η συζητηση που θα κανομε θα κρατηση οση ωρα θελετε εσεις. Εαν προτιματε να βρισκεται εδω καποιο μελος της οικογενειας σας ειστε ελευθεροι να εχεται μαζι σας οποιον θελετε.

Η ερευνα αυτη ειναι πολυ σπουδαια διοτι θα μπορεσετε εσεις να μου πητε τη γνωμη σας ελευθερα, γιατι εγω δεν εργαζομαι εδω και ουτε θα αναφερω σε κανενα ποιος μου ειπε τι. Επισης ειναι πολυ σπουδαιο να μαθομε απο σας πως τα καταφερνετε με τις νοσοκομες, γιατρους και ολους γενικα που εργαζονται εδω, και που δεν μιλουν Ελληνικα, και πως τα καταφερνετε με νοσοκομες, γιατρους, και αλλους που εργαζονται στο γηροκομειο που μιλουν Ελληνικα.

Επιση εχετε το δικαιωμα να σταματησετε τη συζητηση μας οποια ωρα θελετε, και να μην συνεχισετε να λαβενετε μερος στην ερευνα. Εαν θελησετε να λαβετε μερος και σε συζητηση που θα γινη με αλλους ανθρωπους απο μεσα απο το γηροκομειο μαζι, η ωρα που θα κρατηση η συζητηση θα συμφωνηθη πριν αρχισομε με ολους μαζι.

Οτι ερωτησεις εχετε για την ερευνα μπορειτε να ρωτησετε και τους καθηγητες που με επιβλεπουν σε αυτη την ερευνα. Τα ονοματα τους ειναι Μαρθα Μακανταρια και το τηλεφωνο της ειναι 479 1685 και Πρανη Ραις και το τηλεφωνο της ειναι 479 2123.

Επισης σε περιπτωση που εχετε παραπονα για μενα κατα την διαρκεια της ερευνας αυτης, η ερωτησεις που οι καθηγητριες που με επιβλεπουν δεν μπορεσαν να απαντησουν ικανοποιητικα μπορειτε να γραψετε στο, The Chairperson, Human Ethics Committee, La Trobe University, Bundoora, Victoria, 3083, telephone number: 479 1443.

Θα ειμαι πολυ ευγνωμων εαν συμφωνησετε να συζητησωμε μαζι και να με ενημερωσετε για τη ζωη που κανετε στο Ελληνικο γηροκομειο.

Σας ευχαριστω παρα πολυ για την συμμετοχη σας σε αυτη την ερευνα.

Ολγα Κανιτσακη
Υφηγητρια Νοσηλευτικης
Λατρομπ Πανεπιστημιο

APPENDIX B

ΕΙΔΙΚΗ ΕΘΝΙΚΗ ΥΓΕΙΑ ΚΑΙ ΠΕΡΙΠΟΙΗΣΗ: ΕΘΝΟΓΡΑΦΙΚΗ ΚΡΙΤΙΚΗ ΜΕΛΕΤΗ ΤΟΥ ΕΛΛΗΝΙΚΟΥ ΓΗΡΟΚΟΜΕΙΟΥ.

ΕΡΕΥΝΗΤΡΙΑ ΟΛΓΑ ΚΑΝΙΤΣΑΚΗ

ΕΠΙΜΕΛΗΤΡΙΑ ΜΑΡΘΑ ΜΑΚΑΝΤΑΡΙΑ

ΣΥΓΚΑΤΑΘΕΣΗ ΣΥΜΜΕΤΟΧΗΣ

Εγω το συμμετεχον ατομο.....
εχω διαβασει (η και μου εχει εξηγηθει την ανωτερω μελετη στη γλωσσα που καταλαβαινω και καταλαβα τις ανωτερω πληροφοριες, και για οποιανδηποτε ερωτηση ειχα μου δοθηκαν ικανοποιητικες απαντησεις. Συμφωνω να λαβω μερος σε αυτη την ερευνα, κατανοωντας οτι μπορω να αποσυρθω απο την ερευνα οποιανδηποτε στιγμη θελω.

Δεχομαι να χρησιμοποιηθει μαγνητοφωνο για να συγκεντρωθουν οι πληροφοριες της ερευνας, και οτι οι πληροφοριες που συγκεντρωθηκαν κατα το διαστημα της μελετης ερευνας πιθανον να δημοσιευθουν η και να διδονται σε αλλους ερευνητες, υπο τον ορο οτι το ονομα μου, και το ονομα του γηροκομειου δεν θα χρησιμοποιηθει.

ΟΝΟΜΑ ΣΥΜΜΕΤΕΧΟΝΤΟΣ (ΜΕ ΚΕΦΑΛΑΙΑ)

ΥΠΟΓΡΑΦΗ ΣΥΜΜΕΤΕΧΟΝΤΟΣ ΗΜΕΡΟΜΗΝΙΑ

ΟΝΟΜΑ ΝΟΜΙΜΟΥ ΑΝΤΙΠΡΟΣΩΠΟΥ (ΜΕ ΚΕΦΑΛΑΙΑ)

ΥΠΟΓΡΑΦΗ ΗΜΕΡΟΜΗΝΙΑ

ΕΠΙΚΕΦΑΛΗΣ ΕΡΕΥΝΗΤΡΙΑ (ΟΝΟΜΑ ΜΕ ΚΕΦΑΛΑΙΑ)

ΥΠΟΓΡΑΦΗ ΕΠΙΚΕΦΑΛΗΣ ΕΡΕΥΝΗΤΡΙΑΣ. ΗΜΕΡΟΜΗΝΙΑ

LA TROBE UNIVERSITY

SCHOOL OF NURSI
FACULTY OF HEALTH SCIEN

APPENDIX B

CONSENT FORM

ETHNOSPECIFIC HEALTH AND CARE: A CRITICAL ETHNOGRAPHIC GREEK NURSING HOME CASE STUDY

Dear Colleagues,

My name is Olga Kanitsaki, I am a registered nurse and midwife, and have eighteen years of clinical nursing experience. Since 1983 I have been teaching nursing at the Shool of Nursing La Trobe University.

This year I have started PhD studies at the school of Sociology and Anthropology La Trobe University. In order to be able to complete these studies however, I am required to undertake research. I have decided to investigate how ethnospecific health and care is delivered in a Greek Nursing Home.

(In this instance ethnospecific health and care means the development and delivery of specifically geared health and care services to meet the needs of people from different cultural and linguistic backgrounds)

The main aims of this study is to discover how residents, and members of staff understand and achieve the delivery of ethnospecific care, and how effectively is this accomplished. In addition it is most important to understand how people from diverse cultural backgrounds can live and work together in a nursing home within a framework of a broader British dominated society.

The main benefits of the study can be: (i) to understand how and whether or not is possible to achieve successfully the delivery of ethnospecific care in multicultural societies, and through this understanding to enhance the successful developments of ethnospecific health and care services; (ii) to use our insights from this study to influence changes in the mainstream health care delivery system; and (iii) to give feedback and make relevant suggestions (if need be) to the Greek home to enhance the delivery of ethnospecific health and care to residents and their families, and increase staff job satisfaction.

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In order to undertake such a study I require to work in the nursing home and observe the activities and interactions of residents their families and staff for a set period of time. During this time I will invite you to volunteer to be interviewed and or to participate in group discussions.

The time we spend in an interview will be controlled by you and you can stop the interview at any time. The time we spend in a group discussion will be agreed upon by all participants before we start the discussion, and will be reviewd at regular intervals as the members may wish. You also have the right to withdraw from the study or discontinue your participation at any time.

A tape recorder will be used to tape our discussions, however, names of the participants and of the nursing home will not be recorded.

Any questions regarding the project titled: Ethnospecific Health and Care: a Critical Ethnographic Greek Home Case Study, can be directed to the Senior Investigator, Dr Martha Macintyre, School of Sociology and Anthropology La Trobe University telephone 479 1685 and Dr Pranee Rice telephone 479 2123.

In the event that you have any complains about the way you have been treated during the study, or a query that the Senior Investigator has been unable to satisfy, you can write to: The Chairperson, Human Ethics Committee, La Trobe University, Bundoora, Victoria, 3083, telephone number 479 1443.

With sincere appreciation

Thank you

Olga Kanitsaki

APPENDIX B

CONSENT FORM

I (the participant) have read (or, where appropriate, have had read to me) and understood the information above and any questions I have asked have been answered to my satisfaction. agree to participate in this activity, realising that I may withdraw at any time. I also agree for tape recorder to be used, but my name and the nursing home's name not to be recorded.

I agree that research data collected for the study may be published or provided to other researchers on the condition that my name and the nursing home's name is not used.

NAME OF PARTICIPANT BLOCK LETTERS)

SIGNATURE DATE

NAME OF AUTHORISED REPRESENTATIVE (BLOCK LETTERS)

SIGNATURE DATE

NAME OF INVESTIGATOR (BLOCK LETTERS)

SIGNATURE DATE

APPENDIX C

Cultural imperialism and the ethics of written consent

Constant vigilance on my part was important to ensure that what I was doing was acceptable and fully understood by all people involved in the research process. This stance required that when I approached individual residents, staff and relatives for an interview I would offer an explanation to them and further clarification of the purpose, nature and research processes of the project. I asked their permission to use the tape recorder, and invited them to sign a consent form. All research participants and informants gave me their verbal consent. Out of 26 key informants interviewed, ranging from the president of the nursing home's Board of Directors to personal carers, residents and relatives, only three signed a consent form. All the others, including those who have lived and studied in Australia, did not sign a consent form nor did they seem to think it was a problem.

It seemed that trust was the most important factor for the agreement and consent of individuals to participate in the research. Trust was not gained by a signature, but by the manner in which I interacted with and related to people, and by my whole presence which embodied relevant cultural nuances. Nevertheless, as indicated above, all participants and informants were asked to sign a consent form; however, it was made clear that it was up to them to decide whether they signed or not. In order to illustrate how people from different cultural backgrounds may interpret and perceive what we call an ethical requirement for a written consent, and to reveal the moral complexities associated with an invitation to furnish such consent, I will quote a resident directly. He stated:

> When you ask for a signature you force by necessity the speaker to be very conscious and self-protective because the speaker knows that, with his/her discussion, he/she signs and declares that he/she bears responsibility for his/her declarations. One who does not sign speaks more freely. One feels coerced, uncomfortable and suspicious by being asked to sign official forms. Why does one have to sign if they agreed verbally

anyway? Having a signature on a paper, one wonders where the paper is and for whom that signature is.

It seems that asking for a written consent, in this instance, interfered with free speech and, paradoxically, had the effect of silencing informants/participants. In such cases, therefore, free expression without fear or concern would be hard to achieve in the research process. Insistence on a signed consent, therefore, could bring about anxiety, fear and suspicion and interfere with free speech. Further, the above resident statement reveals that informed consent can be obtained in different ways from people with different socio-cultural backgrounds and in ways that are ethically appropriate in such situations. By insisting on gaining consent in written form, one may not only violate the wishes of the participant but also may instill fear and unnecessary anxiety in the participant which would hinder their free expression and helps to maintain their silence. Also, such fears or sense of responsibility as expressed by the above resident might act to compel such an informant to scrutinise and reflect upon his/her thoughts, feelings and emotions and sanitise his/her responses. Such sanitisation would inevitably interfere with the quality of the research results. It was also clear to me that other residents were irritated when I mentioned consent forms, and they would look at me as if I were stupid or slow in understanding them. Asking for a written consent in this instances did not reassure the residents that such an act was meant for their benefit; instead, they would tend to become suspicious, anxious, fearful and uncomfortable.

This, of course, does not mean that a researcher should not obtain informed consent. What this means, is that a researcher should carefully explain their project in culturally meaningful and appropriate ways and thus gain consent in culturally acceptable and meaningful ways. In this case, trust is essential before individual verbal or implicit consent can be gained. Gaining trust requires human interaction, during which the potential informants and/or participants can assess the credibility and integrity of the researcher from their own socio-cultural perspectives. They can thus use their own cultural standards and criteria to evaluate the interactions and, accordingly, form relevant relationships. Asking for a signature on

consent forms (as is required) does not require much time; gaining trust and thus informed ethical consent, however, takes more time. While I was in the field residents got to know who I was as an individual through our daily interactions and developed the opinion that I was worth trusting. I become aware later in the research process, however, that their trust was to be limited insofar as they would not talk about two specific issues. The residents considered it vital to keep these issues private because they believed that their quality of life as residents and their integrity as family members could be damaged if they were made public.

I explained verbally to residents many times and in culturally meaningful ways what the research project was about, its aims and value, and verbal consent was gained. Similarly, with members of staff and other relevant informants, I provided information and consent forms in culturally appropriate ways but did not pursue written consent. All, however, gave their verbal consent. After some time in the field I ceased asking for permission to be present at events or in informal and formal conversations, debates or contestations with staff, residents or relatives.

I found that it was extremely disruptive of the research process to ask for consent every time I was involved with a discussion. All knew about my research and had been informed of its aims and purposes. Now and then, however, when I felt that perhaps reassurance was required, I reminded staff and residents what I was doing. Even with such precautions taken, the following instance indicated to me that there was always a risk. One afternoon I wanted to tape-record the handover of nursing and personal care staff. I asked permission from the head nurse to tape record the handover and, in the presence of the staff permission was given. However, as I discovered later, one staff member present was not regular staff but was from an agency and did not know of my research project. She did not object at the time but, at the end of the handover, she approached me to ask why I wanted to tape record the handover. To my horror, I realised that she had not been informed about my research project. I then explained the research project to her and the purpose of tape-recording the handover. I

also offered to destroy the tape in front of her. She was reassured and confident now that she knew, that there was no problem. She stated that she had assumed that it was to do with a law suit and that was why she was interested to know why I was tape-recording the handover.

This incident made me realise the need to be constantly aware of who was involved in events and particularly in relation to incidents, whether I would require further consent. All members of staff and residents whose health state permitted knew I was taping conversations and discussions as well as other events that were occurring at the home generally. Indeed, I used to walk around with a small tape-recorder that was clearly visible. At times when staff or residents did not want me to tape record an interaction they would ask me to turn off the tape recorder or they would reach and turn it off themselves.

I wanted to tape-record and capture the flow of events in the nursing home, the noises, the tone and loudness of voices, singing, and any other sounds that frequently occurred. This I thought would capture a sense of the embodied unconscious and conscious culture and cultural context of the nursing home. So the tape-recorder was on most of the time, recording activities and sounds, such as those made by dropping utensils, turning on showers, flushing toilets and telephone ringing. Tape-recording also captured human voices that expressed care, tenderness, love, joy, pain, surprise, aggression, rudeness, anger, orders, sadness, crying, hopelessness, laughter, singing, movements, walking and communication styles.

While I found that transcribing the tapes was time-consuming, the tapes were vital in the re-creation of recreating my embodied experiences of lived moments at the home. Listening to the tapes placed me vividly back in amongst the nursing home environment and life