

**Feature**

# Transcending transculturalism? Race, ethnicity and health-care

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CULLEY L. *Nursing Inquiry* 2006; 13: 144–153**Transcending transculturalism? Race, ethnicity and health-care**

This paper offers a critical commentary on the essentialist concept of ethnicity, which, it is argued, underpins the discourse of transcultural health-care. Following a consideration of the difficulties that ensue from the way in which ethnicity has been theorised within transcultural nursing in particular, the paper turns to a consideration of alternative ways of thinking about ethnicity, which have emerged from more recent social anthropology and postmodernism. It addresses the question of how to theorise ethnicity in a way that does not entail its reification as a set of fixed cultural properties, and makes some tentative suggestions for the possibility of a critical culturalist approach to difference and healthcare practice, which must include a consideration of racisms.

**Key words:** critical culturalism, essentialism, ethnicity, health-care, nursing, race, racism, transculturalism.

A number of recent health policy directives in the 'west', including documents from the UK (Department of Health 2003), the USA (US Department of Health and Human Services 2004), Canada (Health Canada 2001), Australia (Commonwealth of Australia 2004) and New Zealand (King 2000), emphasise the growing diversity of national populations and declare a desire to address the 'health needs' of minority ethnic communities. In the context of healthcare delivery, transcultural theory offers a widely accepted approach to engaging with social diversity. This paper argues that there are difficulties with the transcultural response to the challenge of ethnic diversity. It offers a critical commentary on the essentialist concept of ethnicity, which underpins most notions of transcultural practice and argues for the possibility of a critical, non-essentialist approach to cultural difference and healthcare practice. Transcultural theory is particularly dominant in nursing, and this is the discourse that is primarily addressed in this paper. Nevertheless, many medical texts and those relating to other 'professions allied to medicine' display a similar theoretical stance (Qureshi

1994; Hayles and Adu 2004; Bains 2005) and the critique that is advanced here can also be applied to accounts of transcultural healthcare practice more generally.

The article begins with a brief discussion of the concepts of race and racism and their relevance to health debates. It then moves on to examine ways in which an essentialist concept of ethnicity has come to dominate the debate around 'diversity'. Some of the difficulties that ensue from the way in which ethnicity has been theorised within nursing in particular are outlined. The article then turns to a consideration of alternative ways of thinking about ethnicity, which have emerged from within social anthropology and postmodernism and suggests how insights from such perspectives might assist our thinking about ethnicity, health and health-care. The article concludes with some tentative suggestions for rethinking ethnicity and health-care.

## RACE, RACISM AND ETHNICITY

There is considerable confusion in popular, political and administrative discourse around the use of the terms race and ethnic group, with the two often being used interchangeably (Bradby 1995; Fenton 1999). Things are no better in social research, where there are different usages expressing varying theoretical, epistemological, political and

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legal standpoints (Malik 1996). A key analytic distinction is usually drawn between the idea of 'race' as signifying the division of humankind into discrete groups, marked by immutable biological characteristics and the term 'ethnic', which is used to denote differences associated with culture, learning and socialisation.

Modern genetics has discredited the science of races because it proved impossible to sustain any single classificatory system, given that the degree of variation within postulated races came to be recognised as greater than the variation between them (Fenton 1999). However, the *idea* of race is clearly still of considerable social and political significance (Miles 1989; Brah 1992). Race may not be real, but *racism* is. Evidence abounds of the persistence of ideas about racial categories in everyday discourse and their very real effects in many forms of racist exclusion (Goldberg 1993). Racism should not be restricted to forms of exclusionary practices based on the notion of biological difference. Goldberg (1993) articulates racism as a set of postulates, images and practices that serve to differentiate, exclude and dominate, and which can use all kinds of signifiers or markers. In Goldberg's anti-essentialist and antireductionist approach, racism is not a homogenous phenomenon but seen as taking many forms (racisms) in different contexts.

Understanding the process of racialisation (the way in which ideas about race are mapped onto particular groups or populations in specific contexts) and the operation of many forms of racism may be crucial to understanding some of the apparent differences in the health status of minority ethnic groups. This is because racisms may adversely affect health and well-being in many ways (Karlsen and Nazroo 2002, 2004). First, there is the possibility of direct physical or psychological violence against those who are perceived as 'Other'. Second, racism may be embedded in exclusionary practices in, for example, employment, housing, education and immigration law, adversely affecting the socioeconomic circumstances of racialised groups, and thus impacting on their health. Third, there is growing evidence to suggest that there is a direct impact on health, as unhealthy symptoms such as high blood pressure may be a clinical response to racial harassment (Krieger 1990; 2003). Fourth, racism in health service delivery may adversely affect health. This effect may occur through the actions of individuals or through institutional practices, which have the effect of denying access to services or providing inadequate care (Parekh 2000).

## RACISM AND NURSING

Discussions of racism rarely feature in nursing discourse (Shaha 1998). As Porter and Barbee (2004) have argued,

while cultural diversity is accepted, racism is euphemised, denied or negated. Harrison (1994) argues that nursing discourse privileges a decontextualised individualism, which compromises the ability of nursing to address prevailing health inequalities, including those influenced by racisms. Nursing discourse constructs the nurse as a caring professional, who, in a colour-blind (and class-blind) way, treats people who are ill from various microlevel causes (Barbee 1993). There is a denial that nursing is embedded in unequal relations of power that structure interactions between nurses and their patients (and also interactions among nurses). The discursive construction 'nurse', 'assumes a magnanimity supposedly permitting nurses to transcend whatever racial and class biases constrain ordinary people's interactions with "others"' (Harrison 1994, 93). Where racism is addressed within nursing, it tends to be equated with individual acts deriving from (irrational) prejudice that, it is usually argued, can be eliminated by an appropriate dose of education (Mulholland 1995; Culley 1996).

Generally speaking, nurses are much happier in the domain of 'culture' than racism (Barbee 1993; Culley 1996, 1997). An exploration of the 'sensitive care of the culturally different client' and the research needed to realise this practice is preferred to the theorisation of individual and institutional racist practices and their effects on clients and colleagues. As culture rather than racism is the proper concern of nursing, the concept of *ethnicity* is invoked, albeit often in a form which is divested of connotations of hierarchy and dominance. In the discourse of health and nursing the notion of ethnicity has become the most common way of constructing a racialised subject. There is little recognition, however, that ethnicity is a contestable and contested concept.

## ETHNICITY: A CONTESTED CONCEPT

There is no single, universal concept of ethnicity. It is a term that appears in a variety of theoretical traditions (Jenkins 1997) and constitutes what Anthias and Yuval-Davis (1992) have called a 'contested concept'. Within nursing discourse ethnicity is conceived of in ways that are similar to the classical anthropological model of ethnicity as culture, and ethnic groups as largely static collectivities or 'tribes' characterised by common cultural attributes or shared origins (Bromley 1989). In this example of essentialist discourse, ethnic groups are constructed as essentially cultural groups, marked out by their common cultural heritage, homogeneity and distinctiveness vis-à-vis other ethnic groups (Rattansi 1992; Mulholland 1995). Essentialism in this context can be thought of as 'the process by which particular groups come to be described in terms of fundamental, immutable

characteristics, inherent within an individual or social group which determine their nature and the manner in which that nature is expressed' (May 1999, 34). As May (paraphrasing Werbner 1997) adds, in this process, 'the relational and fluid aspects of identity formation are ignored and the group itself comes to be valorised as subject, as autonomous and separate, impervious to context and to processes of internal as well as external differentiation' (34).

This essentialist notion of ethnicity can be seen to operate in two arenas of health discourse. First, cultural differences are called upon to 'explain' ethnic differences in health status and health behaviours. Second, gaining knowledge of 'other' cultures is regarded as the appropriate professional response to an ethnically diverse population. While this can be seen across all health professional disciplines (see, for example, Qureshi 1994 in relation to medical discourse), it is particularly evident in nursing, where one of the major responses to 'meeting the needs of minority ethnic groups' has been the development of cultural factfiles, checklists and guides. These play a key role in the notion of transcultural care.

## TRANSCULTURALISM

The view that there are distinct cultures which 'interact' with each other is implicit in the very notion of transculturalism (Dobson 1991). This agenda is most clearly manifested in the 'culture-care theory' advocated by Leininger (1978, 1991), although transculturalism should not be seen as a homogenous body of work. Learning about ethnic groups in the conventional (primarily American) transculturalist project means learning about cultural groups so that 'culturally sensitive' care can be provided. Transculturalism rests on liberal assumptions that stress the individual and individual rights, freedoms, responsibilities and action (Gustafson 2005). There are many critics of this approach, who highlight a failure to theorise power relations; a lack of awareness of the social context and discourses that shape social identities and representations; a depoliticisation of healthcare; a privileging of individualism, and the naive optimism and rationalism inherent in the educative project arising from the underlying assumptions of transcultural theory (Bruni 1988; Mulholland 1995; Culley 1996; Swendson and Windsor 1996, Gustafson 2005). Policy discourse based on transculturalism locates responsibility for appropriate care within the practitioner–client relationship, and assumes a pluralism in which group identities are different from, but equal to, each other (NMC 2002).

Recent contributions to transculturalist discourse in the British context have taken a more critical turn, insisting

that we need to understand how wider social, political and economic factors may affect the lives of minority ethnic groups (Le Var 1998; Papadopoulos, Tilki and Taylor 1998). While an explicit insistence on the recognition of wider social processes represents a considerable advance on conventional transculturalism, the notion of ethnicity as culture remains implicit in this project. The idea of cultural boundedness remains fundamental to transculturalism. It is still an issue of 'us' learning about 'them', but now the constituents of the 'Other' are viewed in less individualistic ways. It is still predicated on the idea of cultural groups, with a relatively stable identity and with cultural 'needs' — about which we must learn and to which we must 'respond' empathetically. There is a coexistence of the insistence on the importance of class, gender and generation, with a concept of ethnic groups as relatively fixed and uncomplicated cultural groups with defined sets of health beliefs and (consequent) sets of health behaviours. This apparent contradiction remains largely unproblematised.

The impact of such culturalist thinking on practice is manifested in the repeatedly expressed desire of a range of healthcare practitioners for information on the 'cultural needs' (for example dietary 'needs' and prayer 'needs') of clients (Narayanasamy 2003; Cortis 2004). In this quest for cultural knowledge, transculturalism can itself be seen as contributing to a racialising agenda. 'The manufactured need to know about and construct categories of difference justifies the reproduction of the white liberal imaginings about the beliefs and practices of non-dominant groups' (Gustafson 2005, 12). Concepts of culture are usually constructed as antithetical to that of race. But in transculturalism culture can become the functional equivalent of race. As Fredrickson (2002, 8) argues, 'deterministic, cultural particularism can do the work of biological racism quite effectively'. At the present time, the demand for educators to provide 'cultural knowledge' seems well entrenched. However, as Gustafson (2005) has argued, from a critical cultural stance, the key issue is dominant discourses of superiority and privilege rather than lack of knowledge.

In New Zealand the discourse of 'cultural safety' has been contrasted with the classical transcultural approach (Ramden 1992; Cooney 1994; Dyck and Kearns 1995; Culley 2001). While the concept of cultural safety usefully prompts us to consider how health policy discourses have been shaped in relation to political, social and economic structures, there are those who argue that cultural safety is still ultimately appealing to a personal attitudinal change as the main way to promote culturally safe practice. And, in some forms at least, it remains in the terrain of bounded cultural groups,

in this case Maori and the descendants of white European colonists in New Zealand. (Polaschek 1998). However, a 'rewriting' of cultural safety in a postcolonial, postnational frame is a promising contemporary development (Reimer Kirkham and Anderson 2002, Smye and Browne 2002, Anderson et al. 2003).

The negative effects of a concept of ethnicity as shared culture on theorising the relationship between ethnicity and health have been discussed at length elsewhere (Ahmad 1993, 1996). Ahmad charts the way in which professional discourses in health-care construct and reinforce cultural differences as the source of health problems. Cultures, defined in rigid and static terms, come to be classified as 'alien' and people are defined as more or less 'other'. The impact on health-care has been to perpetuate a deficit approach to cultural difference; to engender negative stereotyping of minority ethnic clients; to render 'white' ethnicity invisible; to fail to see the significance of racism and, ultimately, to encourage a limited form of professional practice (Gerrish, Husband and Mackenzie 1996, Gunaratnam 1997; Culley 2000; Culley 2001).

## RETHINKING ETHNICITY

The need to challenge this approach to ethnicity, however, does not mean we must cast aside any attempt to understand a relationship between ethnicity and health. A number of critiques of the classical notion of ethnicity within social theory have revitalised debates around ethnicity and have led to alternative formulations that are potentially helpful to healthcare practice.

### *Ethnicity as a social process*

One of the earliest challenges to the notion of ethnicity as culture came from the social anthropologist Frederik Barth, who argued that ethnicity should not be thought of as an organisational form (as if it were an object to be studied) but as a social process (Barth 1969). For Barth, ethnicity is about the relationship between groups rather than the content of those groups. 'We should understand ethnicity as a social process, as the moving boundaries and identities which people, collectively and individually, draw around themselves in their social lives (Fenton 1999, 10). Barth emphasises the social processes that produce and reproduce boundaries of identification and differentiation between ethnic collectivities, rather than the content (what he called the 'cultural stuff') of ethnicity. 'Barth emphasizes that ethnic identity is generated, confirmed or transformed in the course of interaction and transaction between decision-making strategiz-

ing individuals' (Jenkins 1997, 12). Rather than seeing ethnicity as defined by culture, and ethnic groups as cultural groups, culture and identity are part of the building blocks of ethnicity as a social construction. This is summarised in Barth's famous vessel analogy. Ethnic categories are the vessels of culture but it is the ethnic boundary that defines the group and not the 'cultural stuff' that it encloses.

Joanne Nagel has more recently reformulated Barth's vessel analogy in constructing the analogy of the shopping cart (trolley). Ethnic boundary construction determines the shape of the shopping cart (size, number of wheels), and 'ethnic culture' is composed of the things we put into the cart such as music, dress, religion, beliefs, symbols and customs. Culture is not a shopping cart that comes to us already loaded with a set of goods; rather, we construct culture by picking and choosing items from the shelves of the past and the present. Cultures change, 'they are borrowed, blended, rediscovered and reinterpreted' (Nagel 1994, 162).

Within this discourse ethnicity is rooted in social interaction and ethnic identity is mutable and situational. As the individual moves through daily life, ethnic identity can change according to variations in the audiences encountered:

Since ethnicity changes situationally, the individual carries a portfolio of ethnic identities that are more or less salient in various situations and vis-à-vis various audiences. As audiences change, the socially defined array of ethnic choices open to the individual changes (Nagel 1994, 154).

Jenkins (1994) also importantly argues that ethnicity is not *simply* a matter of personal choice. External discourses play an important part in the understanding of what it means to be a member of an ethnic group (Karlsen 2004). While there is a degree of agency, there are also external forces shaping ethnic boundaries. Boundaries are also constructed by outside agents and organisations, so that one's ethnic identity is influenced by the views held by others about one-self.

Jenkins challenges the pluralism that often accompanies the social anthropological model, stressing the importance of *categorisation* in the social construction of identity and the importance of power and authority relations in that process. External forces such as immigration policies, census and other ethnic categories, ethnically linked resource policies and legislation are very significant. Individual choices are circumscribed by the ethnic categories available at a particular time and place. Jenkins argues that some individuals and groups are in a position of power whereby they are able to impose a characterisation on others in ways that affect their social experience in significant respects (Jenkins 1997). Ethnic identities are externalised in social interaction and internalised in personal self-identification and, as such, are

subject to change, redefinition and contestation. Health discourses are themselves involved in constructing ethnic categories and racialised identities. This is perhaps most clearly seen in the role of medicine in the construction of 'scientific racism', which served to legitimate slavery in the nineteenth century, the eugenics movements of the early twentieth century and the racial policies of the Nazi state (Krieger 1987; Muller-Hill 1988).

Ethnicity is not merely symbolic; it is also materially constituted in structures of power and wealth. Ethnically defined populations have locations within the economic class structure and within political settings. The boundaries of ethnic groups are symbolically represented and materially constituted within structures of power and privilege. Minorities can be privileged elites or relatively powerless suppressed groups. This approach also argues that ethnicity has a different force in different contexts. There are some societies (and some times) in which ethnic boundaries have monumental effects and there are others where ethnic categories play a relatively minor part or where their importance varies from context to context. For some, ethnic identity is of little import. Fenton (1999) theorises this in terms of a double contextualisation of ethnicity:

Ethnicity as a social phenomenon is embedded in social, political and economic structures which form an important element of both the way ethnicity is expressed and the social importance it assumes. At the same time ethnicity as an element of individual consciousness and action varies in intensity and import depending on the context of action (21).

### *Postmodernism, identity and ethnicity*

Postmodernism also offers us some interesting insights in theorising ethnicity, radically challenging the concept of ethnic groups that underpins transcultural theory. Postmodernism sees the world as fragmentary, discontinuous and often chaotic — the neat rational models of science and progress are displaced. The monolithic and homogeneous are cast off in favour of the new cultural politics of difference, diversity and heterogeneity (Gillborn 1995). The abstract and general are substituted by the contextual, provisional, variable and shifting (West 1993). Postmodernism proposes a 'de-centring' of the subject (Rattansi 1992). Hall (1992), for example, rejects the concept of a unified 'centred' human subject, which is a product of essentialist discourses. There are, he argues, multiple forces at work on and through individuals. He argues for a de-centred subjectivity — individuals are confronted by a multiplicity of possible identities based on a number of differences — gender, class, age, religion and ethnicity, which may be more or less import-

ant in different contexts. Identifications and affiliations (ethnic or otherwise) are contextual. This undermines the stable conceptual categories commonly used in the idea of culturally sensitive care. It also articulates with a re-conceptualisation of the concept of culture. This has been most directly addressed in the British context, in a collection of articles brought together by Rattansi and Donald (1992). Rattansi argues for a non-essentialist and non-reductionist concept of culture as a social process. Culture is not seen as fixed, finished or final, which we can sum up in a body of contents, customs and traditions, but a critical concept that appropriates some of the theoretical advances of post-modernism. Culture is constantly made and re-made — ever changing, fluid and shifting.

Cultural hybridity is an important concept in post-modernist work on theorising ethnicity and centres around the work of Stuart Hall (1992), Homi Bhabha (1994) and Paul Gilroy (1993). Hybridity theory rejects the idea of ethnic rootedness or any singular ethnic or cultural identity, emphasising the contingent, complex and contested aspects of identity formation (May 1999, 22). Hybridity refers to the fact that not only do ethnicities change over time, their development cannot be understood as being separate or self-contained. 'New ethnicities' are hybrids — the ever-changing products of complex processes of social change and the continual juxtapositioning of traditions and cultural practices in a global era. Hybridity is seen to undermine essentialisms through processes of mixing and fragmentation. It is not possible here to review the extensive debate about hybridity theory in postmodernism, as hybridity theory has several formulations (see Malik 1996; Friedman 1997 and May 1999 for a critical review). Jenkins (1997) makes the point that historical and ethnographic records demonstrate that the world has always been ethnically hybrid: 'Cultural and ethnic diversity (pluralism) is nothing new. The secure hermetically bounded group is an imaginative, somewhat romanticised retrospect' (38). Ahmad (1995) has argued that while hybridity may be valorised in some postmodern texts, this is not the 'reality' of the postmodern world.

The postmodern critique of multiculturalism and transculturalism is not proposing the adoption of a counter 'antiracist' discourse. Antiracism is often posited in opposition to multiculturalism, but as Rattansi (1999) and others have argued, crude forms of antiracism are predicated on the same essentialist assumptions as multiculturalism. Crude antiracism ignores diversity and complexity; reduces complex struggles to a black—white dualism, and constructs racism as a simple determinant of identities, interests and sociopolitical unity (Gilroy 2001).



## CRITICAL CULTURALISM

Mays (1999) argues that we need to seek an alternative to the essentialism of classical anthropological concepts of ethnicity while acknowledging and explaining why, at the collective level, ethnicity remains a very durable and powerful force. At the same time we need to recognise, as Jenkins and others argue, that power relations are involved in the process of ethnic ascription. Identity choices are structured by a number of constraints and historical determinations. This leads us to a view of ethnicity, which stresses both agency and structure. As May (1999) comments, 'How can we acknowledge group-based cultural differences — which clearly exist — while at the same time holding on to a non-essentialist conception of culture?' (27).

Several authors have suggested that one way to do this is via Bourdieu's notion of habitus (Bourdieu 1990; Smaje 1997; Wicker 1997; May 1999). Bourdieu describes habitus in the context of social class, but the analysis can be equally applied to ethnicity. The habitus is a 'socially constituted system of cognitive and motivating structures', which provides individuals with predisposed ways of relating to and categorising both familiar and novel situations. The habitus is formed in the context of people's social locations and inculcates in them a 'world view' based on these positions (Shilling 1993, 129).

This set of dispositions — what Bourdieu would call "bodily hexis" — operates most often at the level of the unconscious and the mundane and might comprise in the case of ethnicity such things as attitudes to language, dress, diet and customary practices (May 1999, 28).

A key point is that Bourdieu attempts to overcome the agency/structure dichotomy in positing that habitus does not determine individual behaviour. Choice is possible, but choices are not unlimited. Habitus is a product of socialisation, but also modified by individuals' experiences of the world. It suggests that traditional cultural values and practices do exert considerable influence at the individual and collective levels and may be slower to change than post-modernism would suggest, but habitus also accommodates an ongoing and recursive process of cultural construction and reconstruction.

Ethnicity as habitus is an important component of what May has called 'critical multiculturalism'. This concept has been pioneered in education discourse but the theoretical and practical implications of the approach can be applied equally well to health-care. A critical (multi)culturalism means adopting a reflexive position that recognises cultural differences, situates these within a wider nexus of power relations and accommodates an ongoing process of cultural reconstruction (see May 1999, 28–33).

Thinking about ethnicity in more complex and critical ways than transculturalism offers, leads us to a construction of ethnicity that goes beyond the idea of bounded cultural groups. 'Ethnicity is not an immutable bundle of cultural traits which it is sufficient to enumerate in order to identify a person as an 'X' or a 'Y' or locate the boundary between ethnic collectivities' (Jenkins 1994, 197–8). Ethnic identities are subject to change, redefinition and contestation. They are not stable or permanent orderings of people. We cannot thus talk of ethnic groups as fixed and uncomplicated entities and so we cannot talk simply of interethnic or *trans-ethnic* relations. Ethnicity is contextual. At the level of the individual, its importance varies according to the context. At the same time, ethnic identity is overlaid with gender, age, socioeconomic and professional identities, each of which may be more or less significant in any specific context, at any specific moment: 'We are all ethnic, yet our ethnicity does not define us. We all need our ethnic identity to be respected, yet we cannot be adequately understood solely in terms of our ethnicity' (Gerrish, Husband and Mackenzie 1996, 19).

Yet black people in particular are often defined (by others) primarily in terms of their supposed ethnicity. Ethnicity is commonly associated with 'non-whiteness'. We rarely see 'white' people as constituted by an ethnic identity (Frankenberg 1993). For many in nursing, the 'ethnic' is still the 'Other', making the ethnicity of the dominant group so hegemonic that it is not perceived as ethnicity at all. The silence on the construction of 'white' ethnicities marks a major omission in health research (Smaje 1996). The need to deconstruct the category 'white' is especially important in understanding the potential health experiences of many less visible minorities (McLaren and Torres 1999).

## THE IMPLICATIONS FOR HEALTHCARE

There is no easy answer to the question of what might represent good healthcare practice in the context of a critical culturalist discourse. There are many models of 'cultural competence', some of which are very much in the traditional culturalist terrain discussed above (Dobson 1991; Leininger and MacFarland 2002), while others show more regard for inequalities and structural/political components (Gerrish 1997; Papadopoulos, Tilki and Taylor 1998). Nevertheless, despite claims to view the subject as simultaneously defined by multiple aspects of difference, performing 'culturally competent care' still attends to individual behaviour rather than the systemic practices (such as racism, sexism and homophobia) that organise that behaviour (Gustafson 2005).

As Gunaratnam (2001) has argued, a non-essentialist alternative to transculturalism is more uncertain, more difficult to apply and more difficult to be programmatic about. However, some tentative implications for nursing and health-care more generally can be suggested from the analysis above. There is an urgent need to develop a non-essentialist conception of cultural difference; to begin to unmask the assumptions of transculturalism and develop possibilities of practice which do not solely represent the particular habitus of dominant ethnic groups. It is argued here that a failure to understand ethnic identification as a complex and dynamic process has led, in the nursing context, to an approach that may limit professional practice rather than liberate it from ethnocentricity. Transcultural nursing has not really recognised the need to come to terms with the implications of the anti-essentialist critique of ethnicity. In contrast to a crude transculturalism there are those who (rightly) insist on the relevance of racism, of the importance of class, gender and age differences within ethnic groups — but at the same time in the very notion of *trans*-culture have in reality maintained the idea of consistent and coherent cultural groups with defined sets of beliefs and health behaviours. There are understandable reasons for this stance. We will still resort to the factfile or something like it because it is comfortable and it seems like a useful tool. It seems to offer us certainty in work which is in fact very uncertain (Gunaratnam 1997, 2001).

As Gunaratnam (1997) has argued, the factfile approach to ethnic identity is relatively simple to understand and can be programmatically applied — people can quickly learn the ‘right thing to do’. It gives us a platform to move forward — something concrete to be doing. But as Gunaratnam has shown in her excellent research on palliative care — this approach can stifle good practice. It turns the addressing of need into a task rather than a process issue — factfiles fit well into the idea of task-based competencies. As a practice, the use of cultural checklists can result in bypassing the need to engage with the knowledge that underpins the experience and the personal choice of users. It can limit professional intervention and make it more difficult for professionals to support the choices of users. It gives rise to professional anxieties about ‘getting it right’ and channels practice into safe and unimaginative areas (Gunaratnam 1997).

Rather than seeing ethnicity as defined by culture, and ethnic groups as cultural groups, Modood, Beishon and Virdee (1994) have argued that ethnic identity:

Far from being some primordial stamp upon an individual, is a plastic and changing badge of membership. Ethnic identity is a product of a number of forces: social exclusion and stigma and political resistance to them, distinctive

cultural and religious heritages as well as new forms of culture, communal and familial loyalties, marriage practices, coalition of interests and so on. Hence the boundaries of groups are unclear and shifting (Modood, Beishon and Virdee 1994, 119).

This, it has been argued, has consequences for the way in which we theorise the idea of delivering care ‘across cultural boundaries’.

However, abandoning the notion of fixed and homogeneous ‘cultures’ does not mean rejecting cultural processes as one set of influences on health and health behaviours or rejecting the importance of ethnic identification in specific contexts (Kelleher 1996; Kelleher and Leavey 2004). It means that we cannot ‘read off’ health status, health beliefs and behaviours from an individual’s designated ethnic status. While an uncritical culturalism can be an obstacle to improving health-care, it should be possible to explore in a critical way how ethnicity as structure and as identity (Karlsen and Nazroo 2002) may be significant for clients in any specific context, and how practitioners and policy makers need to respond to this (Bradby 2003). To do this nursing and other healthcare discourses need to overcome their ‘structural blindness’ and to seek ways of bringing issues of ethnicity, gender and class (and their intersections) to the forefront of the research agenda. Researchers also need to be reflexive about how their social location may influence the way in which they represent ‘Others’ and be wary of reproducing unequal social relations in their representations of meanings (Cheek and Porter 1997; Hall 1997; Donnelly 2002).

The central question is how to take ethnicity seriously in a way that does not entail its reification as a set of fixed cultural properties and how to work with this approach in practice. At the present time it is not clear that we have the conceptual tools to properly tackle this issue, although it has been suggested above that the concept of habitus may help in developing a critical cultural theory for nursing. However, to begin the process of evaluating and changing practice there are several suggestions that could be proposed as a first step. First, we need to *think in terms of complexity and fluidity*. We need to develop ways of avoiding essentialist assumptions about patients and clients from ‘minority groups’ and actively seek understandings that might be relevant to our healthcare practice. We need to ascertain rather than assume that certain preferences and practices are of significance to users (Henley and Schott 1999). At the same time we need to be aware of the power relations inherent in the social and political context in which professional–client interactions occur, which themselves organise the range of decision-making options available to patients (Gustafson

2005). We need to be in a position to respond to cultural change, hybridity and fluidity. We need to recognise that ethnicity may be important in some contexts but that we cannot define people solely in terms of their ethnicity. Ethnicity informs individual (and group) identities in culturally and historically specific ways (Bradby 2003).

Second, we need to think about difference, between 'groups' and *within* them. We need to recognise the importance of other identities or locations in structures of class, gender and generation, for example, and how these mediate encounters with health practitioners. We need an approach to educating healthcare workers that does not assume that there is a 'common cultural need' to learn about. Rather, there are heterogeneous groups with diverse social aspirations and interests and there are systemic processes that prevent fair treatment and equitable access.

Third, this paper has reiterated the untenable status of race as a biological entity. It has argued that a critical understanding of culture and ethnicity as overlapping social processes needs to be developed in healthcare discourse and that healthcare encounters are mediated by other important social signifiers. However, a desire to understand and theorise ethnicity does not require a rejection of the implications of *racisms* and *racialisation*: far from it. While rejecting the idea of race as a biological/genetic reality we need to understand the potentially devastating effects of racisms. We must develop an awareness of the ways in which racialisation can be enmeshed in health discourse and extend the research agenda to include a consideration of racisms, which might impact on clients (and colleagues). As we have seen, transculturalism tends to construct racism as interpersonal prejudice or discrimination arising from ethnocentrism, which can be erased by 're-education' (Nairn et al. 2004). In opposition to this, it is argued that we need to pay attention to the differential exclusion which is the 'deep structure' of racism, and the many forms that this can take in different historical places (Goldberg 1993). It is important to remember that when we meet clients they may well have been subjected to a variety of racisms, both individual and institutional, which may impact on their health status, their access to health-care, their feelings about using health services and their subsequent interactions with healthcare providers. As Hooks (1991) reminds us, the politics of 'difference' should not be separated from the politics of racism.

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