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In Visible Bodies: Minority Women, Nurses, Time, and the New Economy of Care

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In Visible Bodies: Minority Women, Nurses, Time, and the New Economy of Care

Health care reform in Canadian hospitals has resulted in increased workloads and bureaucratization of patient care contributing to the development of a new economy of care. Interviews with nurses and visible (non-white) minority women who have given birth in institutions undergoing health care reform revealed that nurses felt compelled to avoid interactions with patients deemed too costly in terms of time. Overwhelmingly, these patients were members of culturally marginalized populations whose bodies were read by nurses as potentially problematic and time consuming. As their calls for assistance go unanswered, visible minority women complained of feeling invisible. Taken in context of historical and contemporary interethnic relations, these women regarded such avoidance patterns as evidence of racism. Obstetrical nurses, too, understood that the new economy of care wrought by health care restructuring has altered nursing practice and patient care to the detriment of minority women. [racism, health care reform, visible minority women, nursing, Canada]

Introduction

For seven consecutive years, Canada held the premier rank in the United Nations Human Development Index (National Post 2001). According to government officials, the accolades bestowed by the global community of nations are in recognition of Canada's status as a country with a well-educated and culturally diverse populace who live in relative harmony and who have access to a world-renowned health care system. Increasing child poverty, health crises among First Nations groups, and a decline in living standards for the country's most vulnerable have contributed to Canada's slide from the number one to a number three position in 2001. Many Canadians have been aware that this prestigious rank was tenuous as they witnessed a decline in government spending for key institutions, including the well-cherished health care system, over the past decade (McQuaig 2001). The paucity of funds, an aging population, and high costs of technology and pharmaceuticals contributed to the wave of health care reform or restructuring that swept across the continent in the 1990s.

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This paper considers the ways in which health care reform has altered the work previously performed by hospital nursing staff, resulting in a new economy of care that disproportionately disadvantages culturally and economically marginalized patients. Specifically, I examine the relationships between nurses and visible (non-white) minority women giving birth in hospitals undergoing health care restructuring. The perceptions of current nurse–patient interactions were situated within the context of their previous birthing or nursing experiences prior to the implementation of health reform. Time-stressed nursing staff often deferred what they presumed to be problematic or time-consuming encounters with women marked by their visible minority status. Using Essed's (1991) concept of everyday racism, I will demonstrate how these avoidance patterns—taken in context of the historical relations between ethnocultural minorities, Euro Canadian society, and state institutions—were experienced as racism and discrimination by the women in visible minority bodies. The impact of health reform, and the new economy of care it has forged, therefore, has far-reaching implications for social relationships and equity in civil society.

To set the stage for this discussion, I first provide an overview of health care in Canada and describe the system's response to cultural diversity. Next, I illuminate the context of this study—the process of health care reform—and introduce the two main protagonists in this work: nurses and visible minority women. At this juncture, I describe the study that was undertaken to examine the hospital birthing experiences of South Asian, Vietnamese, and First Nations women and their relationships with nursing staff. Then, I share responses from nurses and new mothers about their experiences and observations of in hospital obstetrical nursing care after health care reform. I will attempt to demonstrate that health care reform has forged a new economy of care wherein nurses avoid what they presume to be time-consuming encounters, most notably with women inhabiting visible minority bodies, in favor of less costly interactions. In this context, visible minority women observe that their desires and needs are unheard—rendering them invisible. Although these avoidance behaviors are largely the product of policies and procedures that constrain nursing practice, they can readily be interpreted by visible minority women within the context of historical relations and everyday racism, contributing to their perceptions of injustice and discrimination.

Health Care in a Culturally Diverse Society

The Canadian health care system is renowned for providing high quality care to all residents, regardless of socioeconomic status. The federal government establishes the parameters of health care through the Canada Health Act that ensures that health care is universal, portable, accessible, comprehensive, and publicly administered (Wilson 1995).¹ Provincial governments administer health care resources utilizing transfer payments from the federal government. All Canadian residents are enrolled in provincial health care insurance plans that ensure accessibility to the system. Physicians are public servants who either bill the provincial government for services rendered or are employed as staff of a health care institution (Wilson 1995).

Over the past 15 years, social scientists have drawn attention to problematic interactions between biomedically informed health care institutions and staff, and

members of ethnocultural minorities. As Page and Thomas (1994) have demonstrated, the health care system works to preserve and reinforce white public space by glossing over structural inequalities and transforming Euro American (or, in this case, Euro Canadian) values and sensibilities into the "common sense" operations of the institution. Lack of access to services, linguistic barriers, culturally inappropriate diagnoses and treatments, and inflexible hours of operation have all been cited as presenting challenges to members of culturally and economically marginalized communities in North America who seek health care services (Anderson and Kirkham 1998; Bair and Cayleff 1993; Masi, Mensah, and McLeod 1993; Neufeld et al. 2001; Young and Spitzer 1999).

Although the results of such studies undertaken in the United States and Canada have been generalized to both countries, the meaning of accessibility differs with national context. In the United States, employment benefits are generally the key to health services (Bronstein 1996), whereas the Canadian health care system ensures access to all services, regardless of ability to pay (Wilson 1995). Although ostensibly eliminating economic barriers to care, the Canadian health care system, as an extension of the nation-state, is embedded with middle-class Euro Canadian values that include a focus on self-reliance and self-care and the presumption that all Canadians have the financial ability to follow through on these prescriptions (Anderson and Kirkham 1998).

In the 1990s, however, both systems underwent significant upheaval under the guise of health care reform. Health care restructuring promised to rationalize expenditures using evidence-based decision making, while concomitantly supporting a model of patient-centered care.

Health Care Reform and Nursing Staff

Health care reform in Canada has been driven by a neoliberal agenda that focuses on fiscal restraint, the pressures of the global economy, changing technology, and a shifting demographic profile (Gustafson 2000). Economic downturns from the mid-1980s to 1990s and a renewed focus on debt reduction resulted in reduced federal transfer payments to the provinces destined for the health sector. Provinces responded by embracing the new wave of health care restructuring, heralded by an array of quality and total quality management reforms that resulted in flattening management hierarchies and altering decision-making structures that involved decentralizing some while centralizing others (Casebeer and Hannah 1998). The reforms have led to a shift from institutional to community and home care, closure and demolition of facilities, and massive layoffs of predominantly female staff.

Provincial health authorities have attempted to restrain budgets in a multitude of ways; however, efforts to set limits on the earning capacity of physicians were met with great resistance (Lum 1998). As a result, nursing staff, 96 percent of whom are female (Valentine 1996), became the major target of budgetary constraints (Lum 1998). By the mid-1990s, 250,000 nurses in Canada experienced job loss or destabilization due to health care reform (Armstrong-Stassen, Cameron, and Horsburgh 1996). From 1988 to 1997, the per capita ratio of health professionals fell in some provinces by 11 percent. Loss of nursing staff comprised the largest group within this category. The per capita rate of nurses per declined by 8.2 percent for the entire nation, reflecting both job loss and increasing population size

(Buske 1999, 2000). The percentage of nurses employed part time had increased and the remaining staff was older, reflecting their seniority in the ranks (Buske 1999). In the province of Ontario alone, nearly 19,000 hospital nursing staff was displaced. In addition, some evidence suggests that visible minority nurses were most affected by the layoffs, in part due to lesser seniority status (Lum 1998).

Dissatisfaction in the ranks of surviving staff has also been reported. Nurses who retained hospital positions felt let down by their employers, whose role in the layoffs reinforced the notion that budgetary concerns had taken precedence over human ones. Moreover, increased tension between remaining staff has been reported (Armstrong-Stassen, Cameron, and Horsburgh 1996). Loss of experienced nurses has also led to shortages in critical areas forcing patient transfers across cities and provinces (Moulton 2000).

Nurses have been vociferous in their response to cutbacks, citing increasing workloads, mandatory overtime, and the increased dependence on casual labor as contributing to demoralization, stress, and compromises in patient care. The paucity of jobs and decline in working conditions has led to a 30 percent decline in nursing school enrollments in Canada in the mid- to late 1990s (Sibbald 1999).

Nurses who remain in the health care system undertake to care for a more culturally diverse populace than earlier cohorts of nurses. The relationship between nursing staff and their patients is informed by both historical and contemporary sociopolitical contexts.

Visible Minority Women and Canadian Society

From its inception, state building in Canada has focused on creating a Euro Canadian society, albeit often with the labor power of non-European migrants. Thus, despite its reputation as a harmonious multicultural society, Canadian society contends with a legacy of discriminatory immigration policies that have included direct or indirect exclusion of migrants from certain countries and a history of repressive actions toward the indigenous peoples of the territory (Jakubowski 1997). The historical context contributes to current unequal conditions such as high infant mortality rates and living conditions that rival the poorest of nations among some First Nations communities (Frideres 1998; Waldram, Herring, and Young 1995) and the reduced socioeconomic circumstances of visible minority migrants (Kazemipur and Halli 2000).

Both voluntary and involuntary migrants tend to experience a decline in socioeconomic status when settling in Canada; however, while most second-generation migrants reclaim their socioeconomic status in the subsequent generation, this is not true for visible minority migrants (Kazemipur and Halli 2000). The overall status of visible minority women is further diminished. Approximately 50,000 immigrant and refugee women enter Canada each year (Guruge, Donner, and Morrison 2000). Migrant women tend to be employed at higher rates than immigrant and refugee men (Guruge, Donner, and Morrison 2000); however, they still occupy the lowest echelons of the Canadian workforce, often in positions that offer few or no benefits and demand rigid work hours (Statistics Canada 2000).

Indigenous peoples of Canada often face daunting life circumstances. First Nations women have the lowest life expectancy in the country (Clayton 1990) and the trend toward urbanization has resulted in a concentration of female-led

households (Kastes 1993). High rates of poverty and chemical dependencies, the legacy of residential schools that disrupted cultural transmission and contributed to the dissolution of traditional social structures, have made First Nations' parenting suspect, resulting in proportionately greater numbers of child apprehension from First Nations mothers (McKenzie 1991).

Conflating immigrant, refugee, and First Nations women into the singular category of visible minority women denies the broad diversity of peoples, histories, phenotypes, and social locations contained therein. Some authors have suggested that the term *visible minority* should be regarded as a fabrication of the Canadian state designed to draw attention away from historical specificities, and from the working-class interests and economic inequalities associated with people of color (Carty and Brand 1993). The problematic nature of this category, however, is central to the issues presented in this paper; therefore, I will continue to use it for two main reasons, albeit with awareness of its contestations. First, the response of predominantly Euro Canadian nurses to the phenotypic presentation of birthing women and their subsequent categorization as visible minority or nonvisible minority women results in the rapid assessment of whether encounters with these patients will be regarded as problematic or time consuming. Second, cast together as these diverse groups may be under this rubric, all women included in these categories share in the struggle against marginalization in Canadian society and are often responded to in a singular fashion by members and institutions of Euro Canadian society. It is within the context of these realities that visible minority women and nursing staff interact in hospital obstetrical departments and labor under health reform.

The Study

This study, commissioned by a coalition of nongovernmental organizations, community health centers, and hospitals, was carried out in a large culturally diverse Canadian city.² The major objective of the project was to examine the hospital childbirth experiences of visible minority women, including their interactions with nursing staff, in light of increased dissatisfaction noted by minority women, particularly in routine patient exit surveys. Health care reform and its consequences figured prominently in informants' stories.

Coresearchers from each community who were members of a community health education organization that provided the major impetus for this project offered introductions to community members, which allowed me to participate in community activities. Furthermore, my coresearchers aided in recruitment of participants, provided linguistic interpretation where necessary, and ensured that interview questions were relevant and appropriate. A convenience sample of 19 new mothers who had given birth in one of three participating community health centers or hospitals were interviewed individually or as part of a focus group using a semistructured interview guide. The sample was comprised of five First Nations, six South Asian Canadian, five Vietnamese Canadian, and three Euro Canadian women who ranged in age from 15 to 40. Informed consent was obtained before the interviews that were taped, transcribed, and conducted in the language and location of the respondents' choice. The interviews elicited responses regarding women's experiences giving birth in hospital, their perceptions of pre- and postnatal care,

and their deployment of social networks and support. Foreign-born respondents were asked to compare their most recent birthing experience with prior births in Canada and their country of origin.

In addition, members of the coalition who worked in the hospital sector provided entry into their respective institutions for me, and I was allowed to confidentially recruit nurse respondents. Eleven obstetrical nurses from hospitals were interviewed about their experiences working with indigenous, immigrant, and refugee women. The nurses averaged 46 years of age and had an average of more than 22 years' experience in the nursing profession. Four informants were foreign born: two were from the Caribbean, one was from the Netherlands, and another the Philippines. Transcriptions of focus groups and interviews were subject to theme and content analysis initiated by me and commented on and verified by the coresearchers. The implications of health reform figured prominently in all of the stories shared by new mothers and nurses alike.

Health Care Reform, Nursing, and the New Economy of Care: Responses from Nursing Staff

Reduction in staff has been almost concomitant with changes in models of patient care and a changing patient profile. In obstetrics, the once common practice of segregating the mother from her newborn has been replaced with dyadic care that has mother and infant rooming together to encourage parental bonding (Phillips 1987). This transformation, in effect, also doubles the number of patients under a nurse's care. And the movement away from institutional to community care has limited the amount of time a new mother can recover in hospital from an average of three days to a new standard of 24 to 36 hours. Physician approval is required for hospital stays in the obstetrics ward that extend beyond 36 hours. The increase in patient load and rapid turnover of charges has been a major source of stress for obstetrical nurses. Rose, a British trained nurse-midwife with 20 years' experience, remarked:

It's frustrating when I send someone home when I feel they're not ready. Then I get frustrated when I get home and re-live the whole day, the whole evening at work and I think to myself, "Damn it, I didn't do what I should have today." And I'll say to my manager: "I don't think we're sending these patients home ready to cope." I saw those end effects when I worked in a family medicine clinic where babies come in after seven days and the mothers think it's OK that baby hasn't eaten at all and it's lost weight and it used to bother me.

In addition, nurses feared that the brevity of hospital stays reduced the likelihood of identifying problems such as postpartum depression and infant distress and impaired the nurse's ability to impart meaningful information on infant care and breastfeeding to new mothers. As Roxanne,³ a Euro Canadian nurse with 16 years' experience said:

If a person were in hospital five years ago, they would be in for longer than 24 hours or 12 hours, which would increase their exposure to different nurses on different shifts to have different little bits of wisdom imparted on them, and an opportunity to ask more questions about the baby. An opportunity to go through the first day of elation, the second day of exhaustion, and the third day of OK,

OK, now I've had this kid with me for two days, three days, what happens when I get home and this cord thing is still here?

Although a home visit program complements early discharge from the hospital for all new mothers, hospital-based nurses expressed concern about the ability of time-stressed home care nurses to provide the necessary care and support they had provided in the past. Moreover, although the home care program for new mothers had been well received by approximately two-thirds of respondents in a regional survey; a third of the participants were dissatisfied, disproportionately comprised of migrant women who lacked extensive support networks and often the material resources to cope with recovery from labor and delivery at home (Bubel and Spitzer 1996). Health care reform, with its focus on home and community care, has increased the burden of all women in their roles as family caregivers (Gustafson 2000); however, the burden on immigrant and refugee women whose family support systems have been truncated has been especially severe (Guruge, Donner, and Morrison 2000; Neufeld et al. 2001). Further, the focus on self-care, individual decision making, and health promotion activities might be unrealistic in terms of expenditures, or culturally inappropriate in terms of responsibilities for familial care (Anderson, Blue, and Lau 1991; Guruge, Donner, and Morrison 2000).

Rapid turnover and increased patient load have reshaped nurses' duties within the institution, contracting the amount of time available for intimate patient interaction. Although caring work has often been cited as the source of the nursing profession's denigrated status vis-à-vis other health professions, nurses unanimously reported this to be the most rewarding aspect of their work and the major attraction of the profession. Indeed, the most meaningful aspects of their work—caring for their patients and teaching new mothers about breastfeeding and infant care—were reduced to brief encounters with women recovering from exhausting labor and delivery. Nurses were no longer able to conduct the baby bath demonstration cited by several respondents as a favorite activity for which they no longer have time. Chelsea, a nurse for 20 years, noted:

It was a special time, a very special time. And you know, this may be just silly, when I used to do them, but I used to comb the babies' hair and make it all special and the moms used to think it was great. And now we don't even have combs to comb the babies' hair. So these kinds of things that were important, I thought, aren't important anymore because of the budget cuts.

Enacting the new economy of care, nurses felt compelled to not only discharge patients they felt were ill suited for home stay, but were bound to complete workload measurement surveys in which tasks are classified and allotted specific time. Care work is not, however, readily quantifiable as many respondents attested. As Kate, a Euro Canadian nurse with ten years' experience shared:

There is nowhere, you know, when they do that classification thing. . . . There's nowhere that says, the man is dying, needs to hold your hand. You know, like there's no spot for that and yet that really is as important as the rest of the stuff that you can do. But you don't get to do it, you don't. After a while, you have to condition yourself not to even think about those things or you cannot continue to work.

Under health reform, the values of care and compassion that grounded nursing education and practice for centuries (Ashley 1976), tempered in recent decades by efforts to broaden and create a more scientific profession (Barbee 1993; Leininger 1991), were viewed as being undermined by institutional regulations designed to create a more efficient operation. Nursing practice is disciplined by the new economy of care through the implementation of bureaucratic schedules and forms that provide an account of patient and hence, nursing movements and care (see Foucault 1979; Timmermans, Bowker, and Star 1998). The Nursing Interventions Classification system used to keep track of nursing activities is designed to detail nursing practice through a taxonomic description of duties. The resulting standardization of a nursing timetable works to make some specialized duties—including emotional labor—invisible while highlighting areas that may be subject to economic downsizing (Timmermans, Bowker, and Star 1998). Surveillance is therefore both self-administered and subject to the scrutiny of managers in patient care and administration. As the notion that “time is money” is furthered, latitude with patient care is discouraged. Spending time efficiently is necessary to accommodate the increasing number of patients under a nurse’s care, while staff is anxious to resist the push toward an increasingly factory-oriented model of reproduction (see Martin 1987).

Time compression, increased workload including patient care and paperwork, coping with an increase in patient complaints, and shortages of supplies exacerbated stress and compelled staff to budget their time with patients accordingly. As a result, patients who were perceived to be problematic—that is, demanding of greater time—were often overlooked in favor of encounters that could be executed with greater ease and swiftness. Visible minority women were often regarded as causing potentially time-consuming encounters due to presumed linguistic and cultural challenges. Roxanne observed:

I think that if I have a patient who is East Indian or if a nurse has a patient who is East Indian, who doesn’t have a good understanding of the language, I find that nurses will just avoid dealing with them. And in relation to the cuts, if the people were in hospital longer, there’s a greater chance of them to have an interpreter available or at least get those avenues checked out.

Nursing Care, Education, and Equity

Additional time was not only a commodity that nurses could ill afford to expend based on the new economy of care, but was also envisioned by nurses as a resource that needed to be allotted equally among patients under their care. The notion that equal time expenditure with each patient was indicative of fairness of treatment was commonly offered as a preemptive remark to counter any possible accusations of racism. The confusion, however, between equality—treating patients the same—and equity—spending the time needed with patients to ensure equivalent outcomes—was frequently evident.

These responses must be contextualized not only by their institutional setting, but also by the nature of nursing education. There is no standard approach to cultural issues in Canadian nursing education. Some faculties integrate an exploration of culture, personal values, and diversity throughout their curriculum, while others offer distinct units or courses on ethnicity and health or suggest students enroll in an anthropology course as an elective (Carpio and Majumdar 1991). Overall,

nurses are taught to treat everyone the same and avoid conflict. Nursing education seldom attends to structural inequities and the sociopolitical context of ill health (Barbee 1993; Carpio and Majumdar 1991; Jackson 1993; Nance 1995). Nursing practices like biomedicine presumes a uniformity and stable object of care, effectively "whiting out" class and ethnocultural difference (Jackson 1993). Although nurse informants acknowledged that costly interactions were forfeited in favor of more expedient ones, attributing their own decisions to externally enforced institutional measures, many still rationalized their behavior in terms of providing equal treatment to all. Equitable treatment, however, would have best been achieved by reversing those proportions so that marginalized women could be allotted greater, not less or even an equivalent amount of time than middle-class Euro Canadians if required.

Visible Minority Women: Laboring under Health Reform

The hospital childbirth narratives collected in this study, although joyous in their outcomes, were embroidered with expressions of pain and frustration that focused on hospital policies, experiences of personal racism, linguistic barriers, and perceived avoidance by nursing staff.

Over the past decade, many Canadian hospitals have sought to enhance their responsiveness to a culturally diverse society and contemporary social trends. These efforts have resulted in special birthing rooms, allowances for the burning of ritual substances such as sweet grass in hospital rooms, few restrictions on the number of visitors in the delivery suites, the ability for new mothers to retain their placentas for ritual purposes, and on-site, or on-call, health interpreters available to service major language groups. Numerous women, however, noted that nursing staff routinely denied them the opportunities to take advantage of these new policies. For instance, some women who repeatedly asked to take home their placentas discovered that these were disposed of by hospital staff. Another woman who sought comfort through her labor by listening to powwow music had her cassette tapes confiscated by a nurse. Others were admonished by nursing staff for having too many people in the delivery room, even though other hospital personnel stated repeatedly that the visitors were welcome.

In some instances, procedures and policies conflicted with cultural beliefs and the wishes of the new mother and her family. To enable early discharge, nurses are compelled to encourage women to begin walking and washing as soon as possible following delivery, despite cultural prescriptions that require strict bed rest or avoidance of showers. Some of the Vietnamese and South Asian migrants received verbal reprimands for hesitating to follow through on these demands and a fear of displeasing the nurses was a prevalent theme among these respondents.

Conversely, nurses scolded women for violating policies of which they were unaware. Women were admonished if they did not know they could pick up their infants from the nursery, if they brought visitors into neonatal intensive care, or if they left their infant in care of another mother while they walked down the hall. Indeed, a number of policies enacted as cost-saving measures, including reducing or eliminating free on-site snacks for women in the unit, abolishing the practice of providing free diapers to departing mothers, and no longer providing a layette for low-income mothers, placed some women in an awkward position. When women

availed themselves of supplies that had been given during their previous hospital births or when they made inquiries about them, they felt like “beggars” or even thieves when challenged by nursing staff.

These reprimands were contextualized by the circulating stereotypes of visible minority women and the historical unequal relations between the predominantly Euro Canadian staff, the institution, and the clientele. For instance, First Nations mothers who made telephone calls outside of their room were accused of abandoning their children. Vietnamese and South Asian women were admonished for being either lazy or behaving like “princesses” when they hesitated to walk or chose not to breastfeed their infants. Trinh, a newcomer from Vietnam, did not wish to cause any conflict: “In Vietnam, my mother said we should not take showers after childbirth, just a sponge bath. Here, they said take a shower and I obeyed them.”

At times, the new mothers were subject to direct racist comments, although other incidents reflected more subtle behavior. Taped interviews with nursing staff substantiated the testimonies of the new mothers. Although certainly not all informants expressed directly racist or stereotyped views, many, even those who were themselves members of visible minority groups, offered a variety of candid statements regarding the “low pain threshold” of members of certain ethnocultural groups, the tendency for others to be involved with illegal drugs, the peculiar body odors emanating from some patients attributed to strongly spiced cuisine, and the lack of attachment to children among some groups who reputedly freely “give away” their children to relatives.⁴

Linguistic problems also frustrated encounters with staff. Even foreign-born women who spoke English found it difficult to express themselves in the midst of delivery or its aftermath when—as one exhausted mother realized—her English as a Second Language classes did not teach her the term for “catheter.” Michelle, a new mother from India, is fluent in English, but during a difficult delivery, found herself struggling to express herself to the consternation of the attending hospital staff: “It’s hard, if you have your own mother tongue, you just try to speak that language instead of English. It just comes in your mind. I was just telling in my language and she [her sister] was telling them, [‘She’s] having leg cramps. . . . Why are you yelling at her?’”

While interpreter services are expanding as an on-site service in some institutions, off-site interpreters are often required for some languages or at those institutions where the service is not yet available. Moreover, the brevity of hospital stays for labor and delivery decrease the likelihood that an off-site interpreter will be requisitioned. Often multilingual staff from across the hospital is pressed into service with varying results. As Ellen, a Dutch nurse, recollected the use of a volunteer interpreter does not preclude misunderstandings:

I had a Vietnamese couple with the translator. She even wanted a circumcision, which I found really strange because Vietnamese babies aren’t usually circumcised. . . . I did ask her why she wanted her baby circumcised and she said because you have to be circumcised to be a Canadian citizen. And I said, no, that’s not true.

The new mothers interviewed were keenly aware of the impact of health care restructuring on nursing staff, and many respondents expressed sympathy

for the nurses who literally seemed to run from one demand to the next. Many, however, were often painfully aware that their demands were overlooked in favor of interactions with Euro Canadian patients. Lien, who immigrated to Canada from Vietnam in 1992, said, "I had a C-section so I didn't feel anything during delivery. I was really upset and in a lot of pain when I woke up. I ask the nurses for painkillers, but not all of them responded to me."

Melissa, a 30-year-old Vietnamese Canadian, also found that her requests for analgesics were ignored while nurses appeared to attend to Euro Canadian women. She remarked that: "Nurses think you are a liar. Vietnamese are mean." Several days after returning home, Melissa's home care nurse ensured that she received treatment for a severe postpartum infection that was not detected in hospital. Unlike her first experience in a Canadian obstetrics ward, she was discharged without an examination by a physician or nurse despite complaints of severe pain. Melissa added, "I think the doctor treated me badly because I am not Canadian . . . I think it's because of cutbacks, maybe less hours, people just do their job and rush home."

Pascale, a First Nations mother of four also observed that some women received different treatment by nursing staff: "Just as I was leaving the desk, there was a native girl walked in but I noted that she didn't get quite as much attention and she was kind of put off."

Mariah, a 15-year old aboriginal mother of one, concurred: "Like there was a white lady in there and she got everything. Everything she'd ask for, they'd get for her and you, know, she was just treated so well . . . with me, or say, any other native lady was to ask for something, it would be like 'Yeah, in a minute.'"

Carole, a Euro Canadian mother, noted similar avoidance patterns while visiting a friend in the obstetrics unit: "There was a native woman . . . calling for a nurse because she said she was in a lot of pain. . . . It seems like they were faster to take care of Dolly [my friend] than they were to take care of this woman. . . . I mentioned it to a nurse that was there . . . and she said: 'Oh, she's had six kids, you don't have to worry about her.'"

The early discharge policy was also regarded as problematic. Women generally felt that they required more bed rest before being discharged. Furthermore, those who had troublesome deliveries were concerned about their families' abilities to manage potential complications. Some women, feeling rushed by nurses to relinquish their beds, again perceived that their treatment was different from that given to Euro Canadian women. Maya, an Indo-Fijian mother of two, said:

She [nurse] was asking, "When are you going home? What time are you supposed to go home today?" she was telling me in the morning. "And why are you still over here?" Then I said, "When my husband comes, then I'll go." Then she says, "When he is coming back?" I think she was really mad at me. "When is he coming back?" she was saying, the tone of her voice was really hard, right. But she was really smiling and laughing and talking to other people and that hurt. I thought that was her way—the way she was talking to me—but when she talked to others, she was really nice.

Not all interactions with nursing staff were hostile or frustrating. The majority of informants shared memories of a particular nurse who kept bringing ice chips, whose touch or smile was particularly encouraging, who was respectful

and kind; these were nurses who spent—in the new economic language of the workplace—time. Cecilia, a member of the Nisga'a First Nations recalled: "She [the nurse] took care of me. She was worried about my needs, like if I wanted a drink or anything like that, and she explained what she was doing. She was always checking on me and giving me lots of options . . . She wasn't grouchy because there were so many people around."

Nurses, Visible Minority Women, and the New Economy of Care

According to the perceptions of many new mothers, time was spent disproportionately on the white bodies in other beds. Observing that other patients were attended to, while their own repeated calls for assistance went unheeded—these women began to sense they were invisible. Their invisibility was reaffirmed when reduced by nursing staff to elemental characteristics of their apparent visible minority status (i.e., the Chinese in Room 3); thus, individual characteristics and desires were rendered inconsequential and unseen amid the cacophony of patient and administrative demands.

Nurse respondents confirmed the observations of the visible minority mothers. The economy of care does not allow for the time-consuming interactions that may ensue when linguistic barriers or noncompliance with hospital-designated standard postpartum activities such as showering, walking, and breastfeeding are anticipated. Roxanne, a Euro Canadian nurse, said of her colleagues: "They [nurses] won't go into East Indian women's rooms because 'Oh, they're just going to do whatever they want to do anyway. Just leave them alone. They are just going to do whatever they want.'" Others admitted to avoiding interactions with women perceived to be of visible minority status, only to be surprised that the patient was fluent in English and acquiescent in terms of nursing expectations.

But Is It Racism?

Are these perceptions and interactions merely the detritus of the new regime in health care or are they more pernicious in their effect? To consider this question, we must briefly examine the key definitions of racism and discrimination. Discrimination "is a socially structured and sanctioned phenomenon, justified by ideology and expressed in interactions, among and between individuals and institutions, intended to maintain privileges for members of dominant groups at the cost of deprivation for others" (Krieger 1999:301).

Various taxonomies of racism have been proposed to make examination of the issue more sensitive. Most definitions differentiate minimally between personal racism that includes the maintenance of negative assumptions about others that may result in the devaluation of the Other or ethnocentrism (Fleras and Elliott 1999; Jones 2000) and institutionalized racism that focuses on structures that limit access to power (Jones 2000). Fleras and Elliott (1999) further differentiate institutional racism into systematic and systemic forms. The former involves implementing rules or procedures that overtly or covertly limit the participation of members of minority groups, while the latter refers to policies, procedures, and priorities that may not be inherently or intentionally racist, but whose effects are. Additionally, they cite two forms of societal racism: everyday racism that

is embedded in language and symbolism, and cultural racism that privileges the values and interests of the dominant members of society (Fleras and Elliott 1999). Essed (1991) asserts that structural forces of racism are connected and experienced in the context of quotidian existence. Systemic racism is embedded in the ethos of organizations that readily ignore gender, class, and ethnoracial inequities and underscore the failure of ethnic groups to attain the values and practices of dominant society (Essed 1991).

As the hospital environment reflects the pervasiveness of personal racism in the community at large, racist beliefs were held and expressed by nurses (and patients) and visible minority mothers were aware of being targeted by directly racist comments or subjected to circulating stereotypes. Institutional and societal forms of racism are of even greater interest. If as Jones (2000:1212) wrote, "Institutionalized racism is often evident as inaction in the face of need," then the unheard voices of visible minority mothers are an example. The perceived inaction of the nursing staff is interpreted through the ongoing lived experiences of discrimination faced by visible minority women and racist historical relationships that circumscribe interpersonal and institutional relationships (Essed 1991).

In Visible Bodies, Nurses, and the New Economy of Care

Perceived cultural and linguistic misunderstandings have acted as potential challenges and barriers to appropriate health care for culturally marginalized Canadians prior to the implementation of health care reform; however, the changes wrought by restructuring have placed a disproportionate burden on visible minority women, as evidenced by nursing staff themselves. As workloads have increased and are shared among fewer staff and as hospital services, including nursing care, are refracted through the lens of cost-benefit analysis, health care reform has forged a new economy of care. Nursing care is costed out with the use of care maps and time charts to ensure that effort and expenditures are maximized, that time is commodified and spent as economically as possible. Interactions that might be costly are overlooked, avoided, or compressed. Those interactions that appear to cost the system are those that involve women who are marginalized economically, socially, culturally, and linguistically. They include interactions with women who may not speak English or who are thought not to.

Minority women are often deemed "noncompliant" because they choose not to breastfeed their infants straightaway, as many South Asian Canadian women do, or have too many visitors, as the First Nations women were perceived to enjoy, or who may be reluctant to walk following labor, as are women from many cultures that mandate a rest period following labor and delivery. Indeed, women who may appear difficult to teach as they seem to lack educational sophistication were also perceived by nursing staff as potentially costly in terms of time expenditure. In this study, however, participants—both obstetrical nurses and new mothers—observed that quick decisions about the allocation of attention were primarily determined by reading the ethnoracial markers on the patients' bodies. As the new economy of care is promoted, therefore, minority women's voices become increasingly marginalized in favor of what are perceived to be less problematic encounters.

All women laboring in hospitals are constrained by institutional authority. Health care personnel and institutions have the power to displace the embodied boundaries of private and public, control food intake, restrict movement, or threaten one's autonomy on a prolonged basis with institutionalization. They are the gatekeepers for services and referrals and the masters of the scientific truth about the body and speak the arcane language in which it is encoded. In the equation of patient–health care encounters, patients are invariably less powerful. In the health care system, patients are expected to not only demonstrate their consensus with the values of the system with its emphasis on individual responsibility of the body, but are also assumed to possess the financial resources to follow through with these prescription.⁵ Women's powerlessness is inversely proportional to the social and cultural capital they possess; however, even the most disadvantaged women in this study found ways to resist institutional control (Spitzer 2000).

New mothers in this study were aware that nursing staff avoided interactions and that their calls for assistance and requests for analgesics or epidurals went unanswered. Their repeatedly unheeded voices suggested that a veil of invisibility had descended; this was reinforced by the nurses who hurriedly passed by without attending to their requests. Conversely, the time-stressed nurses perceived only the visible minority body, a body that from their perspective would force them to slacken their pace and could not be accommodated within the new economy of care. In visible bodies, individual desires, experiences, and contexts were conflated, reduced, and relegated to their apparent and denigrated status as women of color—a status that was perceived to serve as the basis for their in hospital care.

Conclusion

The wave of health care reform that swept Canada in the past decade drove the movement to rationalize health care resources, including time for patient–staff encounters. The focus on efficiency and economic restraints, reinforced by surveillance mechanisms and the discourses of quality management, underscore the new economy of care. Hospital nursing staff serve as the major component of the patient–practitioner interface and occupy subordinate ranks in the gendered hierarchy of the institution; moreover, they are the ones most entrusted to enact the new care regime despite their own potential opposition.⁶ Nursing education, preconceived notions of difference, administrative pressures, and an increase in duties inform nurses' responses with regard to enacting patient care under health reform, resulting in avoidance of costly encounters associated predominantly with patients whose bodies were read as members of ethnoracial minorities. Visible minority women, observing this lack of attention, are compelled to interpret this behavior within the context of history and everyday racism. Given the original purpose of this study, we made no effort to objectively record instances of differential treatment between Euro Canadian and visible minority women in hospital obstetrical units or to document the changes in nurse–patient relations over time; however, *perceptions* that health care reform has contributed to worsened and inequitable care for marginalized women were shared by both sets of informants.

The relationships between the stakeholders in obstetrical care are notably complex; however, the promulgation of health care reform may potentially heighten tensions between patients, their families, hospital and community care nurses, physicians, and administration. Nursing staff who survived the rounds of employee layoffs must contend with understaffed wards and increased duties. As a female-dominated profession traditionally viewed as subservient to physicians, nurses occupy a precarious place within the hospital hierarchy. Although many nurse respondents viewed themselves as patient advocates, they were also required to adhere to institutional policies and physicians' orders, leaving them little latitude in opposing the changes brought about by health care reform, even as the most meaningful aspects of their jobs are being diminished.

The public has yet to engage in a discussion of the consequences of health reform from multiple perspectives. Anthropologists have a role to play in explicating this situation—and in forwarding the experiences of those who are most vulnerable, among them, visible minority women. As Sarah, a nurse for 30 years remarked: "I know we are all under the gun with the health care cuts and this sort of thing, but I think that we really need to work together more than ever, because what could be more important?"

NOTES

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1. Universality, however, does not guarantee that all citizens enjoy equal access to services of equal quality. Health services on First Nations reserves are woefully inadequate, rural residents seldom have access to the range of services offered to urban dwellers, and newcomers tend to underutilize services.

2. Although identification of the province where this study was conducted would be useful in understanding the context of the data, confidentiality agreements between the researchers, the community organization who sponsored the project, and health care institutions involved prevents us from revealing this information. Perhaps most significant here is that newcomers are eligible for the same health care services available to all permanent residents and citizens, including hospitalization and physician care, after a 12-month waiting period (see Gagnon 2002).

3. All respondent names are pseudonyms.

4. Nurses themselves also reported being subject to racism by patients and their families. Often incidences where visible minority nurses were discriminated against brought the issue of racism into the forefront for Euro Canadian nurses. Individual nurses often diffused these situations by exchanging responsibility for problematic patients. Nursing managers encouraged this solution as direct confrontation was viewed as inappropriate in light of all patients' right to unhindered care. Racist commentary directed toward ward mates also occurs. One nurse manager confided that she enjoyed trumping racist patients by moving the minority patient into superior (private) accommodation without comment.

5. Eighty-five percent of the patient/respondents were economically disadvantaged.

6. In addition to the uncertainty of turning "their" patients over to community-based nurses, some nurses expressed frustration that they were seldom consulted, or had their advice ignored, by physicians whose consent was required to prolong a new mother's hospital stay beyond 36 hours.

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