Othering and Being Othered in the Context of Health Care Services

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Othering is a process that identifies those that are thought to be different from oneself or the mainstream, and it can reinforce and reproduce positions of domination and subordination. Although there are theoretical and conceptual treatments of othering in the literature, researchers lack sufficient examples of othering practices that influence the interactions between patients and health care providers. The purpose of this study was to explore the interactions between health care providers and South Asian immigrant women to describe othering practices and their effects. Ethnographic methods were used involving in-depth interviews and focus group discussions. The analysis entailed identifying uses of othering and exploring the dynamics through which this process took place. Women shared stories of how discriminatory treatment was experienced. The interviews with health care professionals provided examples of how views of South Asian women shaped the way health care services were provided. Three forms of othering were found in informants’ descriptions of their...
problematic health care encounters: essentializing explanations, culturalist explanations, and racializing explanations. Women's stories illustrated ways of coping and managing othering experiences. The analysis also revealed how individual interactions are influenced by the social and institutional contexts that create conditions for othering practices. To foster safe and effective health care interactions, those in power must continue to unmask othering practices and transform health care environments to support truly equitable health care.

In the past decade researchers have begun to explore how certain practices in the dominant health care system marginalize particular ethnocultural groups. One form of this marginalization has been referred to as othering. Othering not only "serves to mark and name those thought to be different from oneself" but also is a process through which people construct their own identities in reference to others (Weis, 1995, p. 17). By talking about individuals or groups as other, one magnifies and enforces projections of apparent difference from oneself. Othering practices can, albeit sometimes unintentionally, serve to reinforce and reproduce positions of domination and subordination (Fine, 1994). Consequently, persons who are treated as other often experience marginalization, decreased opportunities, and exclusion.

Although there are theoretical and conceptual treatments of othering in the literature, researchers lack sufficient examples of othering practices that influence the interactions between patients and health care providers. Such examples can be instructive on several levels. They can help to raise awareness of how seemingly innocuous and everyday statements can distance providers from patients. These examples can also help to extend our theoretical understanding of the process and consequences of othering. Finally, in that these interactions reflect the broader structural issues influencing the health care system, they point to areas for change and transformation. The purpose of this study was to explore the interactions between health care providers and South Asian women to describe othering practices and their effects.

BACKGROUND

The concept of other has been developed and applied in feminist theory and dates back to the early 1950s with de Beauvoir's (1952) work on the nature of men and women. Griffin (1981) expanded on this idea in her discussion of how dominant members of society project negative aspects of themselves on others. Contemporary scholars have used the notion of othering to examine the issues of racism, identity, and difference (Ahmad, 1993; Fine, 1994; S. Hall, 1991; Weis, 1995). These developments have ushered in new ways to examine unequal relations in society.
In recent years, othering practices have been examined in relation to the experiences of numerous groups including African American women (Taylor, 1999), lesbians (J. M. Hall et al., 1994), immigrant groups (Anderson & Reimer Kirkham, 1998), people with disabilities (Wendell, 1996), and clerical workers (Stevens et al., 1992). Significant health consequences associated with othering have been described. Social experiences such as discrimination and othering have been associated with population health consequences such as shorter life expectancy, higher infant mortality, and hypertension (Krieger, 1999; Krieger & Sidney, 1996). Individual health effects have also been observed including depression and stress responses (Littleford & Wright O’Dougherty, 1998; Noh et al., 1999). Othering can also affect health by creating access barriers: Those who have had negative experiences in the health system and those who feel unwelcome are less likely to reenter the health system and seek appropriate health care (Bowes, 1993).

Although othering practices have not been extensively studied within the South Asian immigrant community, experiences of racism and discrimination have been documented (Bowes, 1993; George & Ramkissoon, 1998). Notions of othering, racism, and culturalism are highly related and contested concepts. We take the position that race is a socially constructed concept that has been used to create distinctions between people based on perceived biological markers or characteristics. The biological basis of racial distinctions has been refuted with the recognition that there is greater diversity within groups than across groups (Krieger & Sidney, 1996; LaVeist, 2000). Despite this, race has profound social meaning that provides the basis for unequal and unjust societal practices and structures (LaVeist, 2000). In recognition of the social construction of race, racialization has been conceptualized to recognize the process through which groups and their practices are identified by reference to visible physical characteristics, thus grounding group distinctions on biology (Cashmore, 1996; Reimer Kirkham, 2000).

Cultural definitions have also been used to account for differences and to construct groups or individuals as other. Stereotypical descriptions of the health care practices of different ethnocultural groups illustrate the tendency to essentialize or stereotype behaviors, values, and beliefs in ways that ignore individuality and diversity contexts (Anderson & Reimer Kirkham, 1998). Furthermore, in these descriptions, culture is viewed as abstracted from social, political, and economic factors. Although cultural descriptions can be useful to health providers in terms of providing guidance when working with ethnocultural groups, they can also create groups as “outsiders.” From this viewpoint, patients’ problems with access, communication, and compliance are seen as occurring because customs and traditions conflict with mainstream medical practices. The focus on cultural difference thereby masks issues of power and control in health care contexts (Allan, 1996; Anderson & Reimer Kirkham, 1998; Culley, 1996).

The ease (and eagerness) with which cultural explanations are taken up to explain differences (or similarities) between groups is referred to as culturalism. The
problem with using culturalist frameworks is that underlying issues that fundamentally affect health care provided to ethnocultural groups remain unnamed and unproblematized (Culley, 1996). These underlying issues are related primarily to matters of racism, gender, and class and are played out at both the individual and the institutional level. For example, in Canada, although it is claimed that health care is available to all citizens, some groups continue to face persistent barriers (Shah, 1998). In response to access barriers, there is a tendency to attribute the problem to the cultural beliefs and practices of the underserved group (e.g., shyness, folk beliefs about disease causality) rather than to discriminatory attitudes and practices of health care practitioners that act as barriers to health care. Culturalism, racism, and othering are thereby overlapping processes that reproduce and reinforce positions of domination and subordination, particularly when health care is provided by members of the dominant group to members of a typically subordinated or marginalized group (Razack, 1998). These overlapping processes affect a wide variety of underserved groups, including Aboriginal Canadians, visible minorities, the disabled, and gay men and lesbians (Browne & Fiske, 2001; J. M. Hall et al., 1994).

In the past few decades a large number of South Asian people from India, Pakistan, Fiji, and East Africa have immigrated to western Canada. This ethnocultural group has experienced difficulty accessing health care services, and concerns about racist practices in health care have been raised in the popular media. Our work with a large Canadian South Asian community began with an interest in describing the ways in which culture influenced health-seeking practices. It became apparent that to fully understand South Asian women’s experiences, we needed to expand our understanding of the ways in which racism and discrimination shaped these experiences with health care providers in Canada. This research serves as a case study for understanding how othering can be manifested in health care interactions with members of underserved groups.

METHOD

The analysis reported here is part of a larger ethnographic study of South Asian women’s health-seeking behavior in Canada. To begin with, we purposefully sampled South Asian women among those who responded to recruitment notices circulated in community venues. In addition, to ensure a broad range of perspectives, snowball sampling techniques were used to invite the participation of women underrepresented in the sample. The project’s advisory committee identified health care providers who should be approached to participate. The advisory committee included representatives of the South Asian community. These health care providers were known to have a large proportion of South Asian women in their practices. Although it might have been preferable to match care
providers and women, this was not feasible. In order to encourage participation, maintain confidentiality, and create open discussion, we made no attempt to recruit women who had received health care from providers who participated in this study, or vice versa.

Women were included who self-identified as South Asian and represented a variety of religions (Sikh, Hindu, Muslim, Christian) and countries of origin (India, Pakistan, Bangladesh, Fiji, and East Africa). The sample included 80 women whose ages ranged from 20 to 80 years old (mean age = 47.6) who were primarily urban dwellers and who had lived in Canada for 10 months to 32 years (mean amount of time = 11.8 years). Occupations varied greatly, with some women employed as farm workers, others employed in semiprofessional and professional positions, and some retired or working in their homes caring for children and family members. Fifty women participated in individual audio-taped, open-ended interviews. Seven of these 50 women and an additional 30 women participated in six audiotaped focus group discussions held in community centers and women's homes. The groups ranged in size from 4 to 9 participants. Some data were also obtained from the transcripts of three radio talk shows focused on the topic of health issues in the South Asian community. Data collection was completed by trained female South Asian interviewers and was conducted in the language of a woman's choice (e.g., Punjabi, Hindi, Gujarati, English). The interviewers were selected based on their language skills and their sensitivity to women's health issues. Training included detailed instruction on open-ended interviewing and practice interviews with feedback from the investigators. In the interviews and focus group discussions, women were encouraged to talk about their health, their self-care practices, and their experiences in accessing and obtaining health care services. The interview guide (see the Appendix) for the individual interviews covered the following topics: women's understanding of health, how they seek assistance in maintaining their health, experiences with illness and the health care system, and their views about the characteristics of satisfactory health care. The focus group interviews were used to discuss ideas from the individual interviews and encourage discussion about strategies that would help South Asian women to maintain their health and access the health system. Interviewers were encouraged to be flexible in their use of the interview guides, use probes when necessary, and focus on those topics that appeared to be of particular relevance to the women involved. Accordingly, there was considerable variation in the style and content of the interviews.

Individual open-ended interviews \((n = 11)\) and four focus group discussions (involving 31 participants) were conducted with health care providers who were known to have extensive experience in working with South Asian women. Names of potential participants were gathered from community contacts to represent a wide range of occupations, including family medicine, psychiatry, nursing, social services, pharmacy, and laboratory work. Invitations to participate in the study resulted in a sample of both male \((n = 9)\) and female \((n = 33)\) health care providers,
including 18 participants who were South Asian. The individual interviews were conducted by four trained health care providers (two of whom were South Asian) at a mutually agreed upon place (primarily in the provider’s workplace). Three of the interviewers were co-investigators, and the fourth was a graduate student with years of nursing experience. Although the interviewer conducting the research inevitably shapes what a respondent says, we found no evidence to suggest that the content of the interviews conducted by the South Asian interviewers differed from those conducted by the non–South Asian interviewers. Focus groups were conducted either in health care settings or at the local university. The interviewers asked health care providers to describe their experiences in providing care and services to South Asian women, their views on the difficulties women encountered in obtaining care, and their suggestions for how to work effectively with women: for example, “Tell me about ways you help South Asian women feel comfortable when they come to you for health care.”

The way in which questions are asked can influence the responses one receives. We acknowledge that the focus of the questions on “South Asian women” may have encouraged respondents to speak of South Asian women as a homogeneous cultural group. To counter the tendency, we encouraged participants to give specific examples from their own practices. It is interesting to note that even when health care providers were asked for examples, they used their experiences with an individual patient to make generalizations about South Asian women as a group. Although we probed for positive experiences, providers tended to return to negative experiences with individuals.

A careful reading of the translated transcripts revealed a major disjuncture between the accounts of women and those of health care providers. Women shared stories that made frequent reference to race, racism, and discrimination. On the other hand, health care providers’ accounts of their encounters with South Asian women were couched in a discourse of equal treatment and cultural “appropriateness.” Upon closer examination, we realized that this might be part of an othering discourse and decided to use the transcripts as a way to further our understanding of othering.

The analysis was guided by ethnographic techniques (Hammersley & Atkinson, 1995). We began by scanning the data for “rich points,” which involve conversational points representing insiders’ perspectives and in-group speech concerning others (Agar, 1994). These data were examined for recurring patterns of interactions between women and their health care providers from the point of view of women who received health care and the point of view of the health care providers. This revealed patterns of disjunctures and differences in perspectives relating to the provision of health care. Data representing the emergent patterns were compared and contrasted to identify relevant conceptual categories. These conceptual categories were refined and further developed into broad themes representing forms of othering practices.
Our analysis focused on how othering is manifested in experiences of seeking and providing health care. We also considered how the structure of the health care system shapes and supports othering practices. It was not our intention to diminish the contributions of health care providers we interviewed who work with South Asian women. Rather, we examined how everyday health care practices, accepted norms of interaction, and conventional frameworks used to understand culture can contribute to othering practices.

Although the focus of this analysis was on discriminatory treatment, there were examples of respectful encounters in the data. Women recounted positive experiences in which they felt they were listened to and treated as individuals and not treated on the basis of stereotypes. They often constructed these examples of good care as unusual or exceptional. A few of the health care providers provided examples of how they attempted to find common ground and to convey respect for individual circumstances and needs. The predominance of negative examples of health care interactions led us to examine the nature of these experiences and how practices of othering are manifested.

Although we focused on the othering practices of health care providers toward South Asian women and women’s experience of othering, we acknowledge that there are additional ways that othering is evident in health care interactions. In our data, women sometimes used othering discourses to describe their health care providers or the responses of other women in health care situations. For example, some South Asian women made generalizations about “mainstream people,” “White” doctors or nurses, and “other East Indian women.” Inevitably, this self-positioning influenced their interactions with health care providers and in subtle ways may have reinforced othering practices by providers. As a starting point for examining the complexity of health care interactions in this context, we focused our analysis on the othering practices of health care providers.

**FINDINGS**

During our analysis we identified frequent uses of othering and explored the dynamics through which this process took place. Othering was evident in the health care providers’ discussions about South Asian patients and was illustrated in women’s discussion of their encounters with the health system. In particular, terms used to distinguish “they,” from “us” and “White” from “Brown,” were markers that signaled othering discourses. Othering language appeared in descriptions of situations that health care professionals found difficult. Frustrated with some patients’ noncompliance with routine and ostensibly simple medical advice, health care providers drew on cultural characteristics and other generalizations to explain this behavior. For example, one community health nurse explained her work with South Asian women:
What I find really frustrating is that they will have a physical complaint that they should see the doctor for and you will tell them that they need to go to the doctor. They promise they will go to the doctor and then they won’t do it. They will leave it. I had this woman who had a cesarean. It was obvious that she was having an infection and it was a Friday and the whole family, they were going to take her to the doctor. No problem, they were going to go that day. Well then, of course, I phoned [her later]. She left it. She didn’t go and, of course, she did have an infection. So she left it and decided it wasn’t important and that happens a lot of times. If they are on an antibiotic and you explain to them why it is important to take it, they don’t listen to you and they don’t take it. So that’s what I find frustrating.

Underlying this explanation is an unnamed “idealized other” who is compliant, realizes what is “important,” and “listens” to the advice of experts.

Our analysis revealed that othering discourses took three forms: essentializing explanations, culturalist explanations, and racializing explanations. The alienating and marginalizing effects of these practices were evident in South Asian women’s discussions of their health care experiences. We present the findings in three sections. First, we describe the forms of othering that were reflected in the data. We then examine the ways women responded to being othered. Finally, we consider the institutional and social contexts that created conditions that reinforced othering practices.

Othering Practices

**Essentializing explanations.** Essentializing involves making overgeneralizations about things such as culture, race, location, social background, and health care practices. These overgeneralizations tend to be ahistorical and abstracted from the broader social, economic, and political issues influencing culture, health, health practices, and ways of life (Allen, 1999).

To explain why South Asian women underutilize the health care system, health care providers drew on essentialized explanations that pointed to women’s lack of ability to follow instructions, take responsibility for their health, be proactive in their use of services, and be “good” patients. As one nurse explained:

What I would like to point out is that a South Asian woman does get the same care that every other woman gets. She does not get the care where she is health responsible. And BSE [breast self-examination], for instance, is something that you have to learn yourself; you have to do it for yourself every month and then periodically go for a mammogram. And that’s how you catch an early breast cancer. They don’t know how to do it, they don’t do it themselves and that’s why they [cancers] don’t get ... caught.
The above quotation provides an example of the binaries that get created between us and them, good and bad, and appropriate and inappropriate when the needs of South Asian women are discussed. In the process, South Asian women are set apart as different. Despite health care providers’ shared belief that “you can’t generalize anything” about South Asian women, they repeatedly revealed generalizations, drawing on their cumulative clinical experiences to legitimize, rationalize, and convince others and themselves of the veracity of these claims.

The use of essentialized explanations was not limited to Caucasian health care providers. One South Asian physician explained his frustrations in serving patients from his own community, moving back and forth between “our people” and “them”:

I think again our people are sort of denying that HIV is affecting our people at all. And I think I am finding that I have more and more referrals for our Asian people who are actually HIV positive. And again it’s so frustrating you know treating them because they are the most noncompliant patients I have ever come across.

The generalizations that this physician makes about South Asians are problematic because they ignore the wider social issues related to HIV transmission, testing, and treatment. The physician appears to ignore the stigma of AIDs within the South Asian community, the ostracism a woman with a diagnosis of AIDs would face, and the complex range of economic and psychological factors influencing “compliance.”

Essentializing explanations also included sexist generalizations about South Asian women. Sexist views of women were used to create superficial distinctions about South Asian women that eliminated any appreciation of diversity and minimized the hardships of women’s everyday lives. Speaking as an expert on South Asian women’s health, a physician used his inclusion in this cultural group to legitimize his understanding of South Asian women while at the same time drawing attention to othered differences:

I must say that our women are actually healthier than the mainstream. The reason being they are very active you know, and I mean they or the majority of them are the breadwinners too. You know, their husbands have a hard time getting a job. They [the women] are working, they come home and do all the housework, and they are looking after the kids and all that. And they are very active and that’s what we promote for being healthy, you know, for being healthy and all that. So I think in general I would say they are much healthier.

By suggesting that women remain healthy when they clean, care for children, and support the family, this physician appears to downplay health risks associated with multiple demands and the subordination that some South Asian women endure.
Although there is an element of pride in this quotation, the layers of essentialism and sexism emphasize South Asian women as other. Two related forms of othering practices found in providers’ interviews focused more specifically on culture and race and are discussed in the sections that follow.

*Culturalist explanations.* To explain observations that South Asian women were not receiving optimal care, many health care providers drew upon “culture” as an explanatory model. For example, lack of participation in cervical cancer screening was attributed to cultural characteristics that supposedly prevented women from accessing screening. Rather than looking at barriers inherent in the system such as the lack of female health care providers and limited clinic hours, the health care providers used women’s personal characteristics (e.g., shyness, passivity) that they labeled as cultural to explain lack of participation in health programs. One male physician attributed women’s “resistance” to screening procedures to their culturally based viewpoints and, in doing so, offered an incomplete explanation of why women are reluctant to participate in particular screening practices, drawing attention away from other important issues (e.g., gender and the physician–patient relationship):

> I appreciate that these ladies have a viewpoint that is different, in terms of allowing me to do say, do a breast exam or papsmears or internal pelvic or rectal internal. And that is different from, and they have greater resistance to being examined in those ways compared with Caucasian Canadians.

In their discussions, health professionals often conflated issues of “culture” with lack of responsibility and lack of motivation. One South Asian physician drew on culturally based health beliefs about prevention to explain underuse of medical services:

> I think our South Asian women don’t have the concept of good health at all. They don’t like to go and see the physicians regularly at all. They only go in crisis. To them, unless you have a problem you don’t go and see your doctor at all. They do not believe in prevention at all … which is such a pity because by the time they come to the physician it is usually too late. And then they come and sort of penalize the system. The system does not work and I think it’s that they don’t take the responsibility.

Although the bulk of health care providers’ discussions focused on a lack of participation and compliance, South Asian women’s “overuse” of health care services was equally suspect. For example, one occupational health nurse explained why South Asian women appear to use the system frequently in the following way:
Well I think that it is cultural actually. What I have encountered in that particular group of people is that they are aware of the benefits and medical coverage and things that are available to them if they do have an injury. And they feel they are entitled to those things and they want to utilize them. So they are quite keen to use these services if they are available and they have no qualms about it. They feel that it’s their right. … And they have adopted the perceivable model that it’s someone else’s responsibility. And somebody else’s problem to look after my health for me. I think a lot of them have this attitude that it’s a “take care of me” situation rather then me taking care of myself or learning how to fix my own problems.

Cultural explanations in this context do not often treat culture as a dynamic and lived experience but instead reflect stereotypical and overgeneralized views.

**Racializing explanations.** Although health care providers spoke of “White” or “Caucasian” women, particularly when making reference to idealized or accepted practices, they rarely made explicit reference to “race” in their descriptions of South Asian women and their health-seeking behaviors. It may be that health care providers were aware that direct references to non-White racial categories (e.g., Brown or Black) in explaining differences in health care practices were not acceptable. Accordingly, racially based explanations were veiled in references to culture, ethnicity, and women’s personal characteristics. This was recognized by one South Asian social worker who commented on her experiences as a patient:

I find that sometimes … the attitude of the professionals in the health care system tends to have a tone of racial discrimination. It doesn’t come out very verbally so it’s hard to pinpoint it and say, “such and such a person is treating me that way.” But it is just a gut feeling that you have. … Especially in a waiting area you will find the nurse will come and be very cordial and polite to a White person when they call them in for a test or to see the specialist. And when they come out and as soon as they realize it’s an ethnic person they tend to speak slower to you, they tend to speak loudly to you, and they probably assume that you don’t understand the language.

Other health care providers drew simplistic and patronizing generalizations about South Asian women based on appearances, offering them in naive and seemingly innocuous ways. In illustrating why pregnant South Asian women were “passive” and “helpless,” one female laboratory technologist said the following:

They [South Asian women] will come in, they don’t bring a book, they don’t bring any handiwork. They often will end up laying down and sleeping. … Whereas other women will come in, and they’ll have a bag of knitting and needle crafting and reading, you know. Quite often this is the case because we get so many. So I feel I’m making a safe generalization.
What is particularly problematic about these racializing explanations is that they are used to reinforce otherness and seemingly deficient qualities.

In their discussions, health care providers often conflated issues of race (e.g., "visible minorities") with issues of language. Although language barriers are an important concern, what lies unspoken is the assumption that certain "races" have language problems. For example, by foregrounding communication problems, one health care provider minimized the impact of interacting in a racialized health system. She attempted to explain why patients perceive they "are not being treated equally" by the following questioning:

Or is it the fact that providers don't know how to react to a visible minority because they speak a different language? So the problem is the provider and not the user and the two are not talking and communicating so really it's a translation issue. It's an integration into a new culture issue.

Unlike health care providers, women spoke openly and unapologetically about their experiences in a racialized health care system, making frequent references to their "Brownness" and others' "Whiteness" and the differential treatment that was seemingly based on color. When discussing the care she received as a hospital patient, one woman gave this explanation: "I understood if it was a White person then they would insert a tube for urine, so she [the White patient] wouldn't have to get up. Why couldn't they do that for me? Because I am Indian?" This treatment decision could well have been based on this patient's health care needs, yet the decision is understood as discriminatory. Furthermore, in response to discriminatory practices, women indicated that they felt "hated," "avoided," and unfairly treated.

Surviving the Othering Experience

Women's stories revealed ways of coping with and managing the othering experience. Strategies for coping with othering experiences took several forms. In what appeared to be a protective response to feelings of vulnerability, and in reaction to discriminatory treatment, women sometimes distanced themselves from other South Asian women in order to be treated as individuals. One South Asian woman, in protesting that she was being treated "just like any other East Indian woman," described imploring her health care provider to treat her differently: "Don't put me in that category .... I am not like other East Indians, I have no experience of what East Indians will do. I'm pretty well brought up here."

To minimize the potential for being othered, some South Asian women attempted to diminish outward actions and appearances by trying to "fit in." They claimed that South Asian women should make more of an effort to fit into the mainstream health system, suggesting, for example, that it was important to learn to "be quiet" in childbirth, not demand too much, and be more assertive and ask questions in their health care encounters:
They [South Asian women] must attend prenatal classes. I don’t know if our women have more pain or just create a scene there. They are more demanding than giving. I think that Canadian people are very reasonable. If you tell them something nicely, they are willing to listen. But we ask for some very unreasonable demands.

The importance of fitting in was extended to visitors and family members. One woman commented as follows:

People have to learn how to act or behave in a hospital. When they go there they stand and form big groups and stand in the middle of the hallways, making it impossible for nurses or other people to go through. These things make the nurses and doctors mad.

Women also attempted to resist othering by invoking their rights to equitable health care services and encouraging other women to learn more about and enact these rights: “The other thing about discrimination, our people don’t know their rights. And other groups, they know all their rights. Nobody can misguide them.” In contrast, another woman recommended that rather than resist, women should lower their expectations to brace themselves against disappointments related to their health care. Although women recognized problems, they were often reluctant to “complain to the authority,” explaining “in our community we can always bear a little more.” The women simply wanted health care professionals to “be nice,” to “listen” to them, and to “be polite.” One woman’s comment is illustrative: “If they talk to you nicely that is a very big relief. You see, you feel so nice if someone even gives you a nice smile and talks to you politely. That is good enough.”

Structural and Social Influences on Othering Practices

It is important to recognize that individual interactions are embedded in a larger institutional and social context. References were made throughout the interviews with women and health care providers to values of the Canadian health care system. These values were used to justify positions, and they provide a foundation on which othering experiences have to be understood and interpreted.

The values of equality and respect for diversity are idealized by Canadians and are assumed to underlie the Canadian health care system and the interactions between patients and health care providers (Anderson & Reimer Kirkham, 1998). These idealized values were called upon in the interviews to legitimize expectations for and explain good health care. For example, one woman commented that the Canadian health care system is good because patients “don’t spend money out of your pocket, you get good care; here everyone is equal.” Similarly health care providers alluded to these values in their claims that they treated all patients “equally” regardless of their circumstances.

Although values such as equality and respect for diversity are laudable, they were sometimes used in ways that obscure the very real barriers and disadvantages that
immigrants face in accessing health care and adjusting to life in Canada. One health care provider argued that South Asian immigrants should simply assert themselves as Canadians and exercise their rights as other Canadians do. She maintained that that they should know “they’re not different, they’re Canadian. . . . Canadian culture is so flexible and absorbing that I think they wouldn’t find any problem.” The assumption of an equal “playing field” in which one simply has to exercise one’s rights removes responsibility for ensuring access from health care institutions and places it on the marginalized groups who experience difficulty in accessing services.

The women we interviewed expressed hope that the idealized values would “play out” in health care but braced themselves against anticipated discriminatory practices. Those who perceived they were not blatantly discriminated against were surprised and relieved. One woman commented, “When my daughter-in-law had a baby girl, there were White nurses, they seemed nice to me. There was no hatred from them.” Others expressed a desire for equal treatment; they wanted to be treated like the “White lady” in the next bed and to have access to the same medical treatments.

Both health care providers and women alluded to the institutional structures and practices in health care that created conditions for othering practices. Despite isolated attempts to provide services to particular ethnocultural groups, the emphasis in health care institutions was on providing uniform and efficient services. Restrictions on the number of visitors, rigid appointment or treatment schedules, lack of translation services, and limited time spent with patients compounded disadvantages experienced by South Asian women. These institutional practices created additional space for othering when South Asian women did not easily fit into routines and the culture of efficiency that characterizes the mainstream health care system. In this institutional context, health care providers often constructed women as difficult to deal with and a burden on an already resource-strapped system.

DISCUSSION

It is not our intention that the findings of this study be generalized to other groups or other contexts. The analysis is based on conversations with a limited number and variety of health care providers and South Asian women in Canada. Although we did not observe interactions directly, informants’ accounts provided interpretations and reactions that may not have been available through direct observation. The use of interviews to obtain accounts of health care interactions, therefore, provides valuable insight into the interpretive lens that informants use to understand their experiences.

Claims that contemporary racism is becoming subtle and difficult to recognize in overt ways (Henry et al., 2000) stand in direct contrast to the compelling expressions of othering found in this study. Perhaps most disturbing is that these expressions of othering are enmeshed in health care providers’ everyday discourses, reflecting their lack of critical awareness of varying manifestations of discrimination, racism, and the social context of women’s lives. In the Canadian
context, these findings are a reminder that issues of racism coexist and conflict with dominant social values related to equality and justice.

The danger in writing about othering practices is that it may unintentionally reproduce essentialized notions about how South Asian women are treated and want to be treated. We were cautious of adopting the role of "transformative intellectuals" (Lather, 1991, p. 109) who speak on behalf of less advantaged groups. At the same time, in the context of this study, South Asian women on our advisory committee and in the local community raised concerns about discrimination in health care and challenged the research team to examine this issue in the data.

It is noteworthy that othering practices were not confined to members of the dominant culture. Practitioners who identified as South Asian demonstrated similar patterns of othering and spoke of similar struggles in working with South Asian women. This observation is supported by other researchers who have argued that misunderstandings can occur even when health care providers and patients are matched on ethnicity, gender, and language (Flaskerud & Nyamathi, 2000). Middle-class values and professional socialization can preclude practitioners from critically considering how race, gender, and class play out in the provision of health care. If it is recognized that health care providers' perspectives are shaped by dominant values and ideologies of the health care system, professional education modified to include critical perspectives can be an important source of positive change.

Efforts to promote cultural competence in health professional education are necessary but not sufficient (Culley, 1996). Health care providers in this study believed that greater "cultural sensitivity" is required in health care. Understanding the ways in which people's responses to health and illness are shaped by culture can help providers to adapt their practices to be more responsive to specific groups. However, culture is only one dimension of people's experiences (Anderson & Reimer Kirkham, 1998). The problem with relying solely on enhancing cultural sensitivity to improve health care is that it wrongly assumes that one can "know" another culture—that culture is something concrete, static, and applicable to all members of the group. These assumptions about culture perpetuate stereotypes of particular ethnic-cultural groups as outsiders and as problematic (Culley, 1996). An alternative approach is to recognize culture as inextricably tied to power differences and societal inequalities. Culture represents more than the beliefs, practices, and values of particular groups; it is also located within a constantly shifting "network of meanings enmeshed within historical, social, economic and political processes" (Anderson & Reimer Kirkham, 1999, p. 63).

While we work to improve the health care system, many women continue to experience othering practices. Practitioners working with underserved groups such as South Asian women need to increase their awareness of marginalized women's health care experiences by creating safe opportunities for women to voice their concerns. These opportunities may be instrumental in addressing the disjunctions among women's expectations for good health care, the espoused ideals of the health care system, and clinical realities.
The findings of this study describe the ways in which othering practices are manifested in health care interactions. These practices include essentialism, culturalism, and racialization. Our analysis focused primarily on culture and race; further work is required to explore how race intersects with class and gender in contributing to othering practices. To foster safe and effective health care interactions, those in power—namely, health care providers, policymakers, and researchers—must continue to unmask othering practices and transform health care environments to support truly equitable health care.

There are a number of ways that, as health care providers, we can work toward creating more equitable health care environments. We can begin by attending to othering practices through the development of a critical consciousness (Henry et al., 2000). For example, we need to monitor the language we use to refer to groups of people who may be different from ourselves. Terms such as *us* and *them* may seem inoffensive but are reflective of wider social issues. Accordingly, the language we use in discussing patients can unwittingly contribute to misinformed ideas about “race” and “culture” even when health care providers subscribe to values of equality and fairness (Anderson, 1998). Despite our best efforts, patients can be treated as others even when this is unintended. Therefore, we need to pay careful attention to people’s perceptions of othering practices and discrimination: They provide clues as to how individuals, organizations, or the wider system may be creating or perpetuating othering practices in health care.

ACKNOWLEDGMENTS

This research was sponsored by a grant provided by the National Health Research and Development Program of Canada (NHRDP) and by NHRDP research career awards to Joy L. Johnson and Joan L. Bottorff, and an NHRDP studentship award to Annette J. Browne. We thank Neleena Popatia and Pauline Sumel for their valuable contributions to this research study.

REFERENCES


**APPENDIX**

**Abbreviated Interview Guides**

**Guide for Interview With South Asian Women**

I'd like to first learn about the things that you do to stay healthy. Can you tell me about that?

Where do you obtain information about staying healthy and preventing illness?

Can you tell me about what happens when you feel ill? What do you do? Who do you consult?

How do you decide to visit or consult with a health professional?

Can you tell me about a time that you were ill and needed to seek medical care? I want to learn about your experiences.

Have you ever experienced difficulties in getting the health care you desire or need? What would you have liked to see changed?

Now that you’ve told me about some of your experiences, I would like to learn more about your opinions about the health care system.

Is there anything else that we haven’t touched on that you would like to tell me about?

**Guide for Interview With Health Care Professionals**

What do you think are the major health issues facing South Asian Women?

Based on your experience of working with South Asian women—where do they obtain information about health and staying healthy?
Can you tell me about your experience in dealing with the South Asian women in your practice?

Are the health issues that South Asian women face different from the other women you see in your practice; if so how?

Is your practice with South Asian women any different than with other female clients?

In your opinion what, if any, barriers do South Asian women experience in seeking health care?

In what ways can health care be improved for South Asian women?

Is there anything else that we haven’t touched on that you would like to tell me about?
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