CHALLENGING EVERYDAY VIOLENCE TAKING RACE & GENDER INTO ACCOUNT: POLICY IMPLICATIONS

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ABSTRACT

Informed by feminist political economy, this article explores the policy implications for health reform directions, organizational capacity, and the nursing profession to more effectively prevent, address and respond to violence in nurses' practice settings. Grounded in key informant interviews, our analysis underscores the importance of understanding violence against nurses as embedded within organizational practices that, in turn, are informed by health reform directions and other social and political dynamics, including the intersections of gender and race. There are implications for a policy agenda encompassing comprehensive and multilevel strategies that foster supportive environments and equity.

SETTING THE CONTEXT

In this article we identify the policy implications arising from recent research[1] examining the risk and violence encountered by Ontario nurses. These policy recommendations are grounded in key informant (KI) reports of the dynamics of race and gender, and their role in shaping the violence nurses face. We also draw on previous analysis interrogating these dynamics and intersections (Choiniere, MacDonnell and Shamonda, 2010) to focus on policy suggestions for the health care system, health care organizations, and the nursing profession.

It is important to contextualize our analysis within the key assumptions informing our path of inquiry. First, our critical feminist political economy lens, in assuming the influence of broader social and economic structures on health care settings and nurses' work environments, increases our concern that current discourses about violence against nurses lack comprehensive racialized or gendered analyses of that violence (Armstrong 2001; Das Gupta 2009). Secondly, it is well documented that workplace violence is a serious obstacle to health and quality care, with significant implications for nurses, families and communities (Registered Nurses Association of Ontario [RNAO] 2009a; 2009b; Shields and Wilkins, 2006). Since employment and working conditions are major determinants of health, it is important to examine the historical, social, political, economic and cultural contexts shaping the work and health of diverse groups within this female-dominated health profession. A growing body of literature points to how the social organization of race, class, gender and language contributes to negative workplace dynamics for racialized[2] nurses (Das Gupta 2009; Giddings 2005; Hyman 2009; McGibbon and Etowa, 2009; Modibo 2004). Yet, little is addressed in mainstream nursing or occupational health literatures (Messing 1998). Consequently, in spite of increased levels of immigration, an increasingly racialized nursing workforce, and growing attention to diversity, access and equity in Canada, gaps remain in our understanding of these issues and their implications for nursing (e.g., Giddings 2005; Gustafson 2007; RNAO 2009a; Khanlou and Jackson 2010).

Elsewhere we have detailed the patterns of violence across settings and sectors, demonstrating its everyday nature for nurses (Choiniere et al. 2010). Here we focus on the policy recommendations, emanating from qualitative interviews with a purposeful sample of seven KIs, five with significant expertise in nursing administration, research, education, practice and policy. Two of

these KIs, while not nurses, possess broad expertise in issues of equity and violence. In this article, we address the policy recommendations relevant to: i) health system reform directions; ii) organizational programs of support; and iii) nursing profession issues, within the Canadian context.

POLICY IMPLICATIONS

i. Health system reform directions

The KIs link the capacity of the organization and the quality of organizational support to broader reforms. They note that the trend of the past two decades to apply market-based reforms to the health care sector interferes with an organization's capacity to prevent violence, or to provide adequate support when it occurs. Other research affirms similar implications of this trend in health care reform, in which care is devalued relative to measurable aspects of treatment and cure, shifting attention away from the system and organizational resources needed to support nurses in all aspects of care. This has significant implications given that nursing is a highly racialized and gendered workforce (Choiniere 2011; Varcoe and Rodney 2009).

In this business model approach (Armstrong 2001), agencies are reorganized, with each manager responsible for more units and many more staff. Efficiencies and cost-savings take priority rather than leadership in care-related activities, as one KI notes, "…you know, [we have] multiple unit responsibility… [there is a] focus on the economic model, case management, all these trends… [it's] cheaper to have one manager in charge of multiple units…cost efficiency certainly is first and foremost…" (#2). As a result, work intensity has increased, while attention to and support of nurses at the point of care has decreased. As another KI explains,"…owing in part to the nature of the work, you know, [we are] understaffed…" (#5). The KIs link the direction of reform with the intensification of nurses' work and their experiences of violence. Business or efficiency assumptions have resulted in problematic decisions, as the KIs suggest, when "…people are warehoused… with very little nursing care, um, because of chronic understaffing… (#5) or because… "there's a lot of de-skilling… [and] we certainly need to have a better skill mix" (#4). These KI recommendations identify the need to challenge the business-model norms that are contributing to inequity and violence against nurses within the health sector.

Improvements to the quality of health management leadership are suggested to facilitate a more critical response to reform trajectories and, as is noted, to "help leaders in the health care sector recognize, [and] address… racism and ethnicity and especially the intersections… it's not talked about… beyond policies and guidelines… they won't tell you how to implement [these policies]… [But it's] not just what you do but how you do it…" (#1). They also suggest that health management and leadership curricula must more effectively incorporate the current workplace complexities of race, language and gender, making it a legitimate focus rather than simply an "add-on." This will improve the organizational capacity to identify conditions contributing to increased risk and violence for diverse nurses, and to create much needed programs and tools to address these complexities.

ii. Organizational programs of support:

The KIs identify that managers and other key personnel require broader organizational backing to effectively create and enact programs of support. One KI shares how it is a problem when this is lacking. "…[T]he person who was responsible for the program… got totally burned out and… left the position…[explaining that], 'I bring these issues to the senior team and they don't even take it on.'… It's not saying 'Yes, we have a diversity coordinator' or 'We have a black person as part of our senior team or a green person as part of our senior team', it's what you do with that person and how you help them understand their roles" (#2). They identify that despite organizational resources for diversity, tokenism can too often prevail with little attention to creating space for meaningful dialogue or challenging the status quo."…you can write policies, you can write procedures but you're really changing a culture. It's having honest dialogue with people about how it impacts you, right?" (#3).

Programs such as recruitment, hiring, orientation and mentoring are identified as critically important to support nurses as they interact with patients and colleagues and also have implications for retention. Orientation and education programs are cited as necessary to create a welcoming environment and reduce isolation for all recent employees, especially those who are new to the setting, such as internationally educated nurses. One KI noted the value of these programs,"… Meeting people where they're at [is important]…. Start[ing] from the interview… [and then] giving opportunities for the individual…to feel heard and to feel that they can come and speak with you and not be judged…" (#2). It is during these programs that information about human rights and violence reporting policies, professional values, codes of conduct and other infrastructure in place to guide the relations of care, are made explicit. To facilitate the effectiveness of these programs, KIs recommend that organizations need to focus more resources on educating all of their managers and resource personnel on key legislation and information. As one KI illustrates, "[There are] different pieces of legislation to address different points on the spectrum… [such as,] violence that's directed towards a person because of their race… the continuum of harassment to violence…

anti-harassment and anti-discrimination policies" (#3). Because of this complexity, serious problems can arise because too often, "they [organizations] are not equipped to deal with violence" (#3).

The KIs advocate for expanding access to mentoring programs, which are primarily found in urban hospitals, as a means to address the particular needs of racialized and minoritized nurses and enhance their resilience and capacity to work within the system. Effective mentoring programs would build on nurses' strengths and respond in relevant ways to the interrelationships between their personal and professional lives. "Simple questions like 'what rubs you the wrong way?'...'how could we help you cope in an effective way in this environment?'...[we] need to… ask those questions… to even make it a culturally competent environment" (#2). Another key recommendation is the need to address barriers to finding jobs and going through the hiring process. "New immigrants... are telling me they can't get through the front door either through the interview or even finding out that there's jobs available…[There] is a shortage of people to provide that mentoring (#4). Also important is access to meaningful programs for diverse groups, including those with "variable linguistic ability… If you've got marginalized workers, how are they…going to make progress…if they are… not given opportunities to improve their language" (#4). Providing improved mentoring has implications for their career trajectories.

In-service training to raise awareness of diversity was frequently suggested by KIs as a strategy to foster organizational capacity. While the KIs reported on a variety of potentially helpful training and workshop initiatives, they also noted limitations linked to clinical setting challenges or power differences and uneven organizational commitment. Mandatory diversity training is recommended "for all staff based on the anti-racism, anti-oppression framework" (#1). Another KI identifies the need for opportunities for nurses and other staff to dialogue about "workforce diversity and how it impacts on people's abilities to work together as a team" (#4). Thus diversity education, along with other programs and policies that consider the processes of racialization and the dynamics of gender, would better equip health care professionals to address violence within organizations.

Skilled educators and strong organizational supports are required for effective training initiatives. Yet training challenges are found in both content and process. While several KIs suggest that knowledge of intersecting oppressions and an understanding of individual needs are critical, they observe that group members can be very uncomfortable while participating in workshops that address issues of power and privilege. These workshops may also have unexpected outcomes, such as silencing participants or shutting down dialogue. As one KI illustrates "…how [do] you teach people to cope effectively when… being abused…when… being disrespected… being not included… tokenized?… how do you deal with a particular situation to be able to respond and then to walk away feeling respected?" (#2).

iii. Nursing Profession Issues:

Throughout the KI interviews is the argument that the costs to individual nurses and the nursing profession are too high to ignore the building tensions and contradictions between professional expectations and current reform directions. KIs report that nurses are too often caught between patient needs and professional standards on the one hand and organizational demands on the other hand. Furthermore, the reply, "you know, it's part of the job…" in response to this fundamental conflict has very serious individual and professional implications.

A key policy response offered to address these ongoing tensions is for professional, regulatory and union organizations to better fulfill their mandates in ensuring healthy workplaces for nurses, especially those who are on the margins, such as internationally educated and minoritized nurses. They recommend that nursing organizations should take a stronger role in educating their members, calling on union, professional association and regulatory body collaboration to address these contradictions; "…[there] needs to be more education [and] acknowledgement…where people are feeling excluded [and]oppressed…"(#3). "…[W]ork needs to be done… from a broader analytical perspectives of gender, race [and] class…(#1). The KIs suggest that regulatory colleges should expand their focus beyond "weed[ing] out the incompetent [individuals]…" (#4). They also propose a broader regulatory role in ensuring safe work environments, including engaging in issues of violence, whether it happens "through a patient… another colleague or… the employer" (#2). "[I]f they are serious about… addressing this issue then it's got to move beyond the rhetoric" (#1). The suggestion is also made that tools such as Best Practice Guidelines (BPGs), although useful, require more attention to the organization's capacity to implement and support the changes. "That policy statement or practice guideline… has to get linked to the actions of that organization (#1). Gaps were also noted in union support regarding the need for "more rigorous education of … local representatives" (#5). The need for all nursing organizations to attend to their own organizational inequities and "…look at some of their own processes…"(#1) was also emphasized by most KIs.

The KIs call for changes in nursing curricula to better address the invisibility of racialization, gender-bias and broader issues of reform to more effectively engage with the

problem of violence in all settings. They note the invisible or marginalized course content and limited representation by racialized faculty members as very problematic, "[too often they are] elective courses… marginal to the whole curriculum" (#6). The KIs reported on the implications when diverse nurses fail to see themselves, "reflected in the curriculum or hear… [their] stories in the curriculum" (#6). The need for an anti-oppression lens to examine curricula was strongly recommended in order to more effectively address the root causes of violence and marginalization, retention, education needs and career mobility for diverse groups of nurses.

DISCUSSION

This article foregrounds the importance of a policy agenda that attends to the broader structural constraints to the wellbeing of diversely situated nurses. These KI recommendations echo other literature demonstrating that business or market-based reforms are inappropriate for the health care system (Adams and Nelson, 2009; Armstrong, 2001; Varcoe and Rodney, 2009). Our analysis of their interviews, emerging from a feminist political economy lens, underscores the costs to nurses, and consequently to care, when health system reforms and organizational practices ignore the relational aspects of nurses' work and the conditions that support them. Indeed, an unmistakable implication of this analysis in its foregrounding of structures and conditions that underpin health and equity is that organizational cultural competence cannot be achieved without this broader focus (Östlin et al. 2011).

These experts in nursing emphasize the need for policies and programs reflecting a comprehensive and multilevel approach in order to create and maintain supportive practice environments. They advocate an approach that is in concert with employing a broader social determinants of health perspective and one also consistent with the health promotion strategies reflecting primary health care principles that aim for social justice, as articulated in the Ottawa Charter for Health Promotion (World Health Organization 1986). It is a reaffirmation that to be healthy, society must pursue "…the full range of public policies that affect determinants of health, like employment relationships and conditions… or the operation of gender norms. More specifically, how… economic status, ethnicity, and gender intersect to shape health risks and outcomes" (Östlin et al. 2011, 2; See also Benach et al 2010; Sen and Östlin 2008). This is our path to achieving true health equity.

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NOTES

[1] This research initiative: Armstrong, P (PrincipaI Investigator), H. Armstrong, J. Choiniere, T. Daly, W. Giesbrecht, M. Lilly, J. MacDonnell, P. Tulloch (Co-Investigators). *Nurses at Risk: Exploring gender and race in workplace illness, injury and violence was* supported by funding from the Social Sciences and Humanities Research Council of Canada.

[2] We draw on the Canadian Research Institute for the Advancement of Women for the following definition of racialization… "racialized will refer to anyone who experiences racism because of their race, skin colour, ethnic background, accent, culture or religion. In this fact sheet, 'racialized' includes people of colour, Aboriginal peoples, and ethnic, linguistic, religious or cultural minorities who are targets of racism. When terms such as 'women of colour' are used, it refers only to that group, as Canadian statistics are often collected separately for 'visible minority', 'Aboriginal' and 'immigrant' groups. Racialized women have different cultures, histories, religions, family norms, life experiences, and are subject to different stereotypes. What they have in common is they are *racialized* – they are subject to racism and made to feel different because of their racial/ethnic background" (p. 2).

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