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Delivering diversity: meanings of cultural competence among labor and delivery nurses in an urban hospital

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DELIVERING DIVERSITY: MEANINGS OF CULTURAL COMPETENCE
AMONG LABOR AND DELIVERY NURSES IN AN URBAN HOSPITAL

by

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DEDICATION

I would like to dedicate this work to Diane Weiner for teaching me the wonder and joy in observing and talking to people. Her memory serves as a constant reminder to be passionate about research and living the life of an anthropologist.
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DELIVERING DIVERSITY: MEANINGS OF CULTURAL COMPETENCE AMONG LABOR AND DELIVERY NURSES IN AN URBAN HOSPITAL

REBECCA GARZA

ABSTRACT

Nursing theory has contributed significantly to discussions of so-called culturally competent biomedical healthcare delivery. This study explores how Labor and Delivery nurses at a large, urban teaching hospital negotiate the care of a hyper-diverse patient population and construct working understandings of competence. Archival research, semi-structured interviews and participant observation demonstrate that “cultural competence” is not a distinct concept, but rather functions as an ambiguous symbol used to discuss a variety of challenges with advocating for patients and delivering care in communities faced with issues of racism, immigration, low socioeconomic status, and multiple comorbidities.
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LIST OF ABBREVIATIONS

CLAS .................................................. Culturally and Linguistically Appropriate Services
IMR .................................................................. Infant Mortality Rate
IOM .................................................................. Institute of Medicine
L&D .................................................................. Labor and Delivery
LBW .................................................................. Low Birth Weight
MMR .................................................................. Maternal Mortality Rate
NAPH .................................................. National Association of Public Hospitals and Health Systems
NCMEC .................................................. National Center for Missing & Exploited children
NEH .................................................................. New England Hospital
OMH .................................................................. Office of Minority Health
PSH .................................................................. People’s Specialty Hospital
RN .................................................................. Registered Nurse
INTRODUCTION

I was told from the beginning that they wouldn’t talk to me. They are too busy. They are important, work 12 hour shifts, are probably uninterested, and definitely have far too many things on their plate to talk to a young anthropologist. Their stories would definitely be amazing. But attempting to interview and collaborate with Labor and Delivery nurses would probably leave me with no participants and little data.

I received all of this advice when I dreamt up my graduate research, but stubbornly chose to pursue my interest of interviewing the Labor and Delivery nurses about their understandings of cultural competence and diversity anyway. In every interview with a Labor and Delivery nurse, I experienced an inability to schedule interviews, a hesitancy to guarantee a 20-30 minute interval dedicated to “just talking”. And, above all, I encountered nurses with a wealth of knowledge, experience, and patient theories which would often lead to a session well above the agreed interview time. I would often think of the doctors that gave me these warnings, as I did on the morning when I met Nadia\(^1\), my fifth research participant. In order to collect data and prove my naysayers wrong, I made myself available at the hospital whenever my research population might be willing to talk to me.

Nadia promised me one half hour after her 12-hour overnight shift early one August morning. I made sure to be early, mostly to arrange my interview guide and test out my recorder on the wooden picnic bench just a two minute walk from the Urban Hospital Labor and Delivery Unit. I also wanted to enjoy the crisp morning summer air.

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\(^1\) All of the people mentioned in this study were given a pseudonym in order to maintain their confidentiality.
that I rarely experience due to my personal tendency to sleep in and miss the traffic of the early commuters in my favorite coffee shops. I was quickly learning to enjoy the unpredictable appointment times my participants would choose to meet. And I much preferred to wait for an interview while watching the sun peak over the Metropolis\(^2\) skyline than in the halls of the hospital on dark Friday nights, which I had I experienced the last time that I scheduled an interview at the end of a nurse’s shift.

Nadia wandered over to me right on time, with a relaxed demeanor that I was sure I would not be able to carry after a 12-hour shift. She explained that the night had been easy – only four or five babies were born rather than the chaotic nine or ten which can lead to a “bad night.” After we took care of reading through and signing the formal IRB consent form and I had turned on my new audio recorder, Nadia began to tell me about her experiences with the “most vulnerable” patient population she had worked with as a labor and delivery nurse. Halfway into our conversation, Nadia remembered an experience with a Latin American patient whom she described as “reactionary” and seemingly “mentally unstable”.

The story featured a woman laboring alone who was angry and aggressive much to Nadia’s surprise. Nadia discovered that one reason for woman’s erratic behavior was that she did not understand the lack of female providers on the floor. After discussing the hierarchy of the teaching hospital, Nadia arranged for all female care throughout the woman’s labor until the anesthesiologist came in to provide the epidural. At this point in the story, conflict erupted with patient and provider yelling at each other and Nadia

\(^2\) “Metropolis” is used as a pseudonym for a large city in New England.
attempting to mediate both sides of the dispute. While Nadia did not condone the
patient’s behavior, she was “appalled” by the anesthesiologist who behaved so poorly to
what she would characterize as a “really vulnerable” patient. This patient story was an
example of the diversity that she encountered with every shift at Urban Hospital and the
abilities that she has acquired as a mediator and translator of hospital culture. She had
only been working at Urban Hospital a few months but already had decided that Urban
Hospital had the highest patient volume she had seen, and that the patients were the
“most vulnerable” of those she had encountered in the United States. Like most of my
participants, Nadia had her own theories about Urban Hospital and the patient population.
These theories would revolve around stories of finding a way to negotiate the best
outcome for the patients that often had little to do with training that they had received in
school or at the hospital.

When I heard Nadia’s story about her “reactionary patient”, my mind raced with
ideas for coding; the tension between group descriptions and individual anomalies, the
“rules” of being a good patient, the problems with a male-dominated obstetric world and
the tensions of teaching hospital hierarchies. On top of my interest in the intersection of
so many cultural value systems, I was horrified to hear how a doctor would treat a
laboring woman. A woman whom other cultures (Callister & Vega, 1998) and even the
L&D nurses with whom I talked would agree was in a unique and sacred state was yelled
at by this doctor.

For Nadia, this was the norm; cultural tension, teaching the patient how to deliver
in a hospital, advocating for her patient and providing female support to a woman she
hardly knows. For me, this story was the culmination of structural forces that have divided groups around the world and privileged some to be birthed into chaos while others are birthed into peace. The unfortunate incident of conflict Nadia described alludes to the tensions of cross-cultural work and the breaking point of the hospital’s acceptance of diversity. My shock only reinvigorated me to continue my research and understand these stories as windows into the American culture of birthing and healthcare at large.

Diversity is not a topic that is limited to the realms of healthcare. Popular culture is increasingly concerned with ensuring that diverse American populations are treated well and given equal opportunity to all aspects of life. Songs dedicated to overcoming difference such as Michael Jackson’s “Black or White” and Lady Gaga’s “Born This Way” urge listeners to accept their own identities as bearers of difference and spark social change particularly toward an anti-racism movement. In the very public arena of commercials featured during February’s 2014 “Big Game” two companies, Cheerios and Coca Cola, explicitly tried to showcase America’s diversity. Cheerio’s commercial with a multi-racial family, attempting to depict that Cheerios celebrates “all kinds of families,” was met with controversy in 2013 with racist comments on social media sites. Overall, the company revealed that there was a positive reception leading them to create a sequel with the original cast in 2014 (Elliott, 2014). Coca Cola created a similarly evocative minute long commercial featuring “America the Beautiful” sung in 7 different languages with footage of differing ethnic, religious, racial and familial backgrounds around the United States. The president of Coca Cola North America added that the video “is exactly
what Coca-Cola is all about: celebrating the diversity that makes this country great and the fact that anyone can thrive here and be happy (Journey Staff, 2014).”

While popular media attempts to feature a celebration of diversity and urge audiences to accept this diversity, the Institute of Medicine’s ‘Unequal Treatment’ report showed that America is not equally available to all people to thrive. This report demonstrates that racial and ethnic disparities are present not only in health, but also in healthcare. Minority populations are less likely to receive needed services even after adjusting for insurance access and lower quality healthcare results in higher mortality. The report recommends multi-level changes to eliminate health disparities through raising awareness, interventions within health systems, policy changes, and education for patients and providers. This education includes “culturally appropriate” educational programs for patients to help their understanding of the healthcare system. Provider education is deemed most important however, as they need tools to manage and understand the diversity of patients that they care for (Smedley, Stith, & Nelson, 2002).

Although the field of cultural competence, especially with its roots in medical anthropology, was established well before this report, the insistence that cultural competency among health care professionals will aid in the elimination of unequal treatment has spurred medical education to focus on this in the formation of their professionals.

Cultural competence is a well-developed field with many different approaches such as attempting to teach the health beliefs about specific communities without oversimplifying culture. Some strategies have featured teaching models of working with
difference such as Kleinman’s explanatory models, where each interaction with a patient, no matter their identity, is conceived as a transaction between cultures that must be reconciled through a dialogue between patient and physician (A Kleinman, Eisenberg, & Good, 1978). The nursing field has created its own source of cultural competency models in part because cultural competency models from medical anthropology and medical fields emphasize the relationship between physician and patient. The role of the nurse in delivering culturally competent care has been stressed through an abundant research base stemming from the well-known Transcultural Nursing theory which wedds nursing and anthropology ideas to establish that “culturally based care (caring) is essential for well-being, health, growth, survival, and in facing handicaps or death (Leininger, 2002, p. 192)”.

With the acknowledgement that America is only becoming a more diverse population, skills beyond medical knowledge and practices are quickly becoming an important part of providing effective medicine. In the words of Joseph Betancourt, “Call it what you will, the field of cultural competence aims to quite simply assure that health care providers are prepared to provide quality care to diverse populations (Betancourt, 2006).” Even as the importance of diversity becomes more apparent and institutionalized in medicine and nursing however, the frame of cultural competency is criticized for failing to critically contending with contemporary racism and structural factors that produce the difference that impedes medical care. From these critical perspectives, cultural competency frames may be used to reproduce dominant values, unequal power
differentials and ignore the failings of political policy (DeSouza, 2013; Drevdahl, Canales, & Dorcy, 2008; Hester, 2012).

I enter this dynamic field with a profound interest in birth anthropology and birth disparities in America. This thesis is a meditation on cultural competence and diversity in an urban safety-net hospital through the lens of Labor and Delivery (L&D) nurses. It explores nurses’ stories in order to understand the ways that cultural competence and diversity are constructed, at the bedside, within a patient population that is overwhelmingly characterized as vulnerable, underserved, and diverse. “Cultural competence” is often considered the solution to the problems that diversity poses. Rather than contending with one specific theoretical frame of cultural competence, I intentionally aimed to understand definitions and uses from the L&D nurses in order to identify how these theories may be influencing the practice of delivering care to minority patients. In each interview, however, I found that theories of cultural competence are embedded in a weighted history of local history and politics, healthcare culture, and health disparities unique to given contexts in the United States. Through an in-depth analysis of stories, and an examination of the context of Urban Hospital, I explore the working theories that nurses use to cross cultural divides and care for laboring women. As we look to rectify health disparities and respond to waves of immigration into the United States, an understanding of the ways nurses manage difference and tension at the critical moment of birth illuminates the strengths and weaknesses of our healthcare system.
I begin by illuminating the context in which my study takes place both geographically and academically in chapter two. Urban Hospital, the site of my study, is set within the vibrant hyperdiverse urban center of Metropolis. The history of this safety net academic medical center provides a background to understand the peculiar loyalty and dissatisfaction that nurses and the city as a whole hold for the hospital that permeates their stories of the diverse patient population. I then discuss the history of Labor and Delivery in the United States in order to understand the particular culture of birthing that is unique to this country which values medical intervention, often to an unnecessary degree. Although much of the anthropology of birth literature I discuss decidedly ignores the role of Labor and Delivery nurses, the themes provide a useful tool to understand stories of birth. Finally, I provide a brief exploration of anthropology’s engagement with the field of cultural competence before discussing nursing theories of cultural competence. While anthropology and nursing disciplines cannot be completely untangled, by discussing them separately, I hope to emphasize the ways that nursing cultural competence theories have included the particular relationship between nurse and patient.

After this introduction to the context of my study, chapter three explains the qualitative research methods that I used to identify understandings of cultural competence and diversity at Urban Hospital. The primary source of data collection was semi-structured interviews with six L&D nurses and participant observation around the hospital. Background information was collected through informal interviews, archival data and other literary research. I will highlight my own experiences gaining access to
and conducting research in the Labor and Delivery unit. The discussion of this difficult task will reaffirm the need to conduct ethnographic research in hospitals, particularly in the field of birthing as it occurs overwhelmingly (in our society) in the hospital.

In chapter four I discuss the importance of Urban Hospital as a mediating force in the conceptualizations of the patient population and nurses’ jobs. To do this, I analyze Urban Hospital as a borderland within Metropolis. With its specific mission and history of targeting and caring for the marginalized populations of Metropolis, it functions as a unique entity within Metropolis marked and reproduced as a marginal institution even after undergoing a dramatic change in funding that elevated its status. As a borderland, Urban Hospital is characterized by paradoxes and dis-ordered medicine which makes caring for marginalized patients possible, as normal medical culture and policy can be suspended.

My analysis then turns to the subject of Labor and Delivery in chapter five with a focus on birth as a border activity. In attempting to advocate for good birth outcomes among this vulnerable population, the nurses negotiate among the technocratic American hospital birth culture, their own beliefs, and the beliefs of their patients. These different cultures and belief systems were discussed in stories of mediating between patient and provider and in learning about birth beliefs and practices through observations of diverse labor performances. While these particular nurses showed a profound awareness of cultural forces shaping their patient’s lives, beliefs about which women are “good” at birth complicate the agency that nurses attempt to give their patients.
Finally in chapter six I turn to nurse’s explanations of diversity and cultural competence. While cultural competence was a contentious idea, each of the nurses created a working theory based on their personal values and upbringing as well as professional experiences working with patients at Urban Hospital. All of the nurses professed that there was no formal training in cultural competency done by Urban Hospital but suggested that informal sessions helped them learn about the different cultures of the patients they care for. Theories of cultural competence ranged from practical compliance centered theories to expectations of difference in each clinical encounter. Even though specific theories and conceptual models were not cited in our conversations of cultural competence, the nurses referenced Urban Hospital as a place that is more diverse than other hospitals in the area as something which must be attended to within clinical encounters.

I end with a final discussion of the ways that studying cultural competence in a borderland proves an opportunity to work through any number of issues pertaining to diversity and marginality. Cultural competence did not often function as a salient theory or toolset but rather as a way to consider the difficulties of mediating hyperdiversity within the Labor and Delivery unit. Although my study is limited by the number of research participants, and may not be representative of all understandings and beliefs of the unit’s nurses, I convey several specific recommendations regarding hospital policy and services in light of my findings. I hope that future research continues to complicate the ways that theories of cultural competence trickle down from or up to administration.
and policy in healthcare institutions, paying attention to the ways that the social history of a space mediates clinical interactions.
BACKGROUND

“If you want to do international health -walk across the street to [Urban Hospital]”

(Annas 2013)

In this chapter I explore both the spacial and theoretical context that sets the stage for my research with the labor and delivery nurses at Urban Hospital. As I will show in my analysis, the unique environment of Urban Hospital and Metropolis that I introduce here is a mediating factor for understanding diversity and cultural competence. Similarly, the environment of birthing in America and anthropology of birth literature create a basic understanding of current trends in labor and delivery in America which allow the nurses in my study to theorize on both the “special” state of labor. Finally, anthropology literature on cultural competency show the complex arena to which my study entered as a meditation on cultural competence. Although separated into different sections, these are each pieces of the complex story that nurses at Urban find themselves in when working through diversity and creating understandings of cultural competence.

Our Setting: Metropolis and Urban Hospital

My study took place in the city of Metropolis which is located along the North Eastern coast of the United States. Metropolis is known for being a proud a city, steeped in history that goes back to the beginnings of the United States and all too eager to display the logos of their hockey or baseball teams. Among the many things that Metropolis is known for however, the historically high volume of immigration is particularly important when discussing issues of diversity. Metropolis has seen rapid
demographic change in the last three decades which has informed the changing identities of healthcare institutions such as Urban Hospital. Similar stories of hyper-diversity can be seen in many major American cities.

Historically, various ethnic populations have been tied to specific neighborhoods in Metropolis and the healthcare institutions that they frequent were often popularly recognized through these affiliations. Although the diversity of the world has been represented for many decades in Metropolis, the last three decades have seen a shift in demographics which has dissolved many of the ethnic boundaries. Recent studies of these demographic changes have theorized that Metropolis’s increased diversity and complications of identity have created a new environment of “hyperdiversity” (Good, Willen, Hannah, Vickery, & Park, 2011, p. 2).

In the past thirty years, several demographic indicators have illustrated the drastic changes in Metropolis. As shown in Figure 1.1, Census data from 1970 show that 98 percent of the population was black or white with white being the clear. In the same year, 13 percent of the population was foreign born (Figure 2). 2010 census data (Figure 1.2) shows a drastic decrease in the white population to 49 percent while Black and Hispanic each increase to 20 percent of the population. The Asian population grew from less than 1 percent to 8 percent in the same time frame and the foreign born population increased to 25.8 percent. Although this data gives a picture of the rapidly changing landscape of Metropolis and hints at social changes such as white migration to the suburbs, the data does not describe the diversity of immigrants. The black population of Metropolis is made up of African Americans as well as people recently relocated from the Caribbean.
and Africa. Similarly, the Hispanic population consists of American citizens from Puerto Rico as well as a slew of Latin American countries. It is important to remember that Metropolis is still a city that has heavily segregated neighborhood even while the diversity is increasing. The neighborhoods directly North and South of Urban Hospital’s neighborhood stand as perfect example as the Northern neighborhood holds a population of 79% white residents while the neighborhood to the South has 21% white residents (“Demographics and Selected Socioeconomic Statistics, Boston,” 2013).

Figure 1.1. Metropolis County Census 1970

![Metropolis County Population Diversity 1970](image)

Source: Data adapted from *Shattering Culture* (Good et al., 2011, p. 11)
Figure 1.2 Metropolis County Census 2010

Metropolis County Population Diversity 2010

Source: Data adapted from *Shattering Culture* (Good et al., 2011, p. 11)

Figure 2 Foreign Born Populations in Metropolis County

Source: Data adapted from *Shattering Culture* (Good et al., 2011, p. 12)
In a study of the diversity of Metropolis, Seth Hannah suggests that a “post ethnic” direction of characterizing patients has emerged as patients and clinicians have shown a classification system much more complex than the census’ traditional pentad of ethnic and racial categories. Through discussion with clinicians and clinical staff on race, ethnic and cultural boundaries, Hannah created the concept of hyperdiversity to describe social environments similar to Metropolis in order to think more critically about diversity (Good et al., 2011, p. 41). Hannah defines racial-ethnic diversity in a clinical setting as “having a patient population composed of members of easily identifiable racial or ethnic groups as defined by the ethnic pentagon (Good et al., 2011, p. 36).” The roots of this understanding are traced back to the civil rights and pan-ethnicity movements of the 1960s where racial and ethnic categories were used to reinforce group cohesion of diverse individuals against the common enemy of racial or ethnic discrimination. The categories emerging from this time period have an important impact on clinical settings in Metropolis as residential segregation breaks down and clinicians, commonly used to their “monolithic racial-ethnic environment”, are forced to see patients from many racial and ethnic groups in their clinics (Good et al., 2011, p. 37). As clinicians are challenged with the growing diversity of their patient populations, cultural differences emerge as obstacles to delivering standard medical care. Although racial and ethnic categories are often used as a proxy for culture, Hannah’s participants focused on issues of language, immigration status, nationality, socioeconomic status and illness category as informing cultural differences. Hannah refers to this circumstance as a cultural environment of hyperdiversity. He defines this as:
... A social setting that is *highly diverse* (in terms of race and ethnicity as well as social class, immigration and religion), *dynamic* (unstable or undergoing change), and *multidimensional* (individuals may choose to identify with broad racial and ethnic categories or narrower categories such as country of origin, neighborhood, or sexual orientation). (Good et al., 2011, p. 41)

This theory, created to understand the new diversity characterizing Metropolis’ clinical environments will be helpful in understanding the discussions of diversity with my own participants and the environment of Urban Hospital. Interestingly, while Hannah suggests that this shift is generalized throughout the population of practitioners in metropolis, my participants took great care to express their opinions that Urban Hospital experiences *more* diversity (or hyperdiversity) than other institutions that cater to “monolithic” patient populations. This brief overview of Metropolis’ hyperdiversity is directly reflected in the history of Urban Hospital whose mission has been to take care of Metropolis’ underserved populations for the past century and half.

*Urban Hospital*

Much of my research is steeped in the complicated history of Urban Hospital to understand the ways in which the changing identities of this institution have reflected national discourses and nurse’s changing understandings of cultural competence and diversity. Urban Hospital was created from the merger of Metropolis Community Hospital and Metropolis University Hospital in 1996. Although histories of both hospitals are important to the current identity of Urban Hospital, after this brief introduction to the hospital, I will focus primarily on Community Hospital for my analysis.
Metropolis University Hospital is the source of Urban Hospital’s academic and research identity. This hospital went through several phases of development and name changes prior to the merger with community hospital. Metropolis University’s School of Medicine opened in 1873 and changed the name of the hospital that it was affiliated with three times in the century leading up to the merger with Community Hospital. Although this hospital was always located in the same neighborhood as Community Hospital, just a few streets away in fact, the environment of this privately funded academic institution was contrasted sharply with Community Hospital up until the merger. Although fascinating, Metropolis University Hospital did not have a L&D unit prior to the merger and none of the nurses in my sample discussed this hospital at any great length. Rather, the spirit of Community Hospital was emphasized in much of my work.

The story of Community Hospital begins in 1861 when the Metropolis City Council voted to create plans for a hospital that would serve “the worthy poor” of Metropolis (Cheever, Gay, Mason, & Blake, 1906, p. 1). A location in a new neighborhood, unfortunately near a sewage canal that drained out to the ocean, was selected and the hospital opened for patients on June 1, 1864 (Cheever et al., 1906, p. 237) with 208 beds (Cheever et al., 1906, p. 3). The hospital still stands in the same location though there have been extensive changes to the hospital buildings as well as the surrounding neighborhood. Community Hospital continued to be owned by the city until the merger with Metropolis University Hospital. As a city hospital, it was known “for treating the people in the neighborhoods” (personal communication) and, in general, for serving the poor. Being the city-owned hospital, Community adopted an endearing
reputation. Residents expressed pride and loyalty toward Community, with some patients proudly identifying themselves as being “Community Babies” (if they were born there). At the same time however, community members were quick to turn their back on this hospital for lack of adequate facilities or funding, probably due to their fundamental association with the indigent. These attitudes toward the hospital were carried over to Urban Hospital which will be explored, along with more details of Community and Urban Hospital’s developing maternity services in Chapter four.

In 1996, the mayor of Metropolis approved the creation of the single entity of Urban Hospital which would be a private, non-for-profit institution. This merger initially was not seen in a favorable light because of the differing institutional identities that were to be combined. Metropolis University Hospital had been a non-profit, private institution that delivered tertiary care while Community hospital was owned by the city and had a mission to serve the low income community of Metropolis. One attending in the current Obstetrics department at Urban Hospital explained that Community’s labor and delivery unit was a particularly lucrative incentive for the merger. The incentive comes from the idea that patients that birth at a hospital will come back for their family’s subsequent care; “families make great customers”. This attending’s opinion was echoed by several participants that discussed the loyalty that patients have toward Urban Hospital.

Urban Hospital is currently described as a “private, not-for-profit, 496-bed, academic medical center (Anonymous, 2013c).” It has the mission of delivering the best healthcare possibly to all people regardless of their social and economic circumstances which marks it as being one of the largest safety net hospitals in New England.
(Anonymous, 2013c). The National Association of Public Hospitals and Health Systems (NAPH) defines “safety net hospitals” by their commitment to providing access to healthcare for people that would otherwise have limited access due to social circumstances such as inability to pay, insurance status or health condition. This means that the hospital has the mission of maintaining an open door to all people and will serve primarily vulnerable populations (America’s Essential Hospitals, n.d.-a, n.d.-b). Although the Medicare Bill, signed into law by President Johnson in June 1965, had established the insurance program for the poor and elderly, need for safety net hospitals was not eliminated (as had been predicted). The NAPH was created in the early 1980’s to provide coordination among the safety net hospitals nationally and continues to lobby, research, and provide resources for the 200 safety net member hospitals. With 73% of patient visits coming from vulnerable populations, Urban Hospital, exemplifies the mission of safety net hospitals (Anonymous, 2013c). Urban Hospital is the primary hospital affiliated with Metropolis University Medical School which is ranked 30th for research and 39th for primary care in the US news medical school rankings (US News).

Urban Hospital’s patient population reflects the hyperdiversity of Metropolis. 30% of Metropolis’ patients do not speak English as a first language which has prompted the hospital to invest in extensive language services. On site interpreters are provided for 23 languages alongside around-the-clock video and telephonic interpreter services. Additionally, Urban Hospital has a refugee center that serves patients from over 70 countries each year (Anonymous, 2013b). Over half of Urban Hospital’s patients are
foreign born, prompting one Metropolis University professor to remark: “If you want to do international health walk across the street to [Urban Hospital]” (Annas 2013).

Other noteworthy programs and achievements, of particular interest to my research, include that Urban Hospital was the first Baby Friendly hospital in the state and established a breastfeeding center which has increased breastfeeding rates from 58% to 88%. Urban Hospital also offers unique programs such as addiction services for mothers, a community doula program, and is currently piloting Centering Pregnancy groups. The development of these programs to target birth outcome disparities in the diverse population and as cultural competence practices will provide an interesting commentary on the entanglement of Labor and Delivery culture and hyperdiversity.

**Labor and Delivery History**

My study uses Labor and Delivery as a case study of understandings of cultural competence and diversity in nursing because birth is “universally treated as a marked life crisis event (Jordan & Davis-Floyd, 1992, p. 3)” but is a non-pathological event in the hospital. Anthropology of birth is an important part of the broader anthropology of reproduction and adds theoretical depth in that childbirth practices reflect social values. While the focus of birth anthropology has expanded in the last few decades, discussion of the medicalization and cultural constructions of American childbirth are most pertinent to my study (Sargent & Gulbas, 2011).

Bridgette Jordan (Birth in Four Cultures) and Robbie Davis-Floyd (Birth as an American Rite of Passage) are key researchers in the study of birth as biosocial event whose “topic is physiological and whose language is cultural (Jordan & Davis-Floyd,
Although childbirth is a universal event, societies confront the danger or “existential uncertainty” that accompanies birth with their own set of internally consistent beliefs and practices that regulate the event in ways appropriate to the cultural context (Jordan & Davis-Floyd, 1992, p. 4).

Brigitte Jordan’s *Birth in Four Cultures* investigates childbirth as a production of both a universal biology and a particular society. Her work focuses on isolating features of the birth process that allow for cross-cultural analysis within a biosocial framework. Some of these biosocial features include: local understandings of birth, preparation for birth, birth attendants, birth territory, the use of medications, technology of birth and the source of decision-making power (Jordan & Davis-Floyd, 1992). Her work within the United States, for instance, showed that 99% of all babies are born in the United States and typically was:

“...physician attended and professionally managed with an orientation towards medical technology and pharmacological methods of pain relief. From the time she is admitted, decision-making power and responsibility for her state rest primarily with hospital personnel and the physician in charge.” (Jordan & Davis-Floyd, 1992, p. 46)

This analysis of American birth specifically does not address the various “alternative” types of childbirth that smaller segments of the population have access to. Rather, her fieldwork was representative of births routinely done in large teaching hospitals which is similar to the way most American women give birth (Jordan & Davis-Floyd, 1992, p. 46). Conveniently, the setting of my own fieldwork, Urban Hospital L&D, is a large teaching hospital and reflects this understanding of childbirth. Urban Hospital has responded to changes in American childbirth culture with the incorporation of nurse-midwifery and
private suites that which was not prominent in Jordan’s study, but these changes reflect new currents in the American culture of childbirth. Jordan’s understanding of birth as a production and socially mediated event is of particular interest in my study when I discuss the construction of the birthing environment in Urban (and Community) Hospital.

A discussion of the American birthing practices requires a quick history of the rise of hospital birth. In a 1980 article Nancy Dye suggested three major periods in American birth: birth as an exclusively female social affair attended by midwives, a transition from social birth to medically managed birth, and the consolidation of medical management of birth. The slow transition from midwifery to physician managed birth began in the late 18th century when midwifery came to be subsumed under the “medical sciences” and physicians began to learn obstetrics. Women were barred from becoming physicians who paved the way for a male dominated obstetrical field. Objections to physician-attended birth on the grounds of female modesty were countered by the interpretation of birth as a dangerous and pathological process that required medical intervention (Dye, 1980). As physician managed births were normalized social customs interpreted birth as a private event between patient and physician. Midwives attended the majority of births in America until the 1920s though there was a steady decline as medicine became increasingly professionalized. In contrast to European midwives who maintained a professional identity, American midwives at the time were depicted as having low social status, and lacking standard practices and knowledge of common medical tools (such as forceps) even though there is evidence that their birth outcomes were on par with general practitioners at the time. In the early 19th century, however,
midwifery became a scapegoat for high maternal death rates and some states outlawed the practice of midwifery. In the 1920s, the profession of “nurse-midwives” was introduced but was only an option to women in areas that did not have obstetrical services until the last several decades. Between 1920 and 1960, the number of hospital births increased from one quarter to about 96 percent of all births (Dye, 1980). The evolution of technology and cultural birthing values after birth was moved to the hospital is important to the development of the labor and delivery nursing and current birthing discussions.

Anthropological discussions of American childbirth show the way that hospital L&D departments have been constructed around values of medicine and order. Robbie Davis-Floyd’s work discusses the ritualization of childbirth in America and the ways that middle class women, who have the ability to choose birthing options are affected by “standard American hospital birth.” Her work specifically uses a white middle class sample which will not be consistent with the hyperdiverse patient population of Urban Hospital. However, the understanding of pregnancy and childbirth as a contradictory to biomedical and western ideals provides the basis for comparison that diverse populations are often subject to in cross-cultural interactions. Davis-Floyd suggests that pregnancy in itself defies major cultural concepts such as the idea that only one person can occupy one body (Davis-Floyd, 2003, p. 68). The liminality inherent in this situation marks pregnancy as a dangerous time which is why, up until the last several decades, pregnancy and childbirth was kept out of public eye, in the private, feminine domain. In the last several decades, however, women who are pregnant are seen working and in the general
public eye and childbirth has become a medical event. This medical event which is deemed “technocratic birth” use scientific and educational language to disguise their ritual purpose. The standard hospital procedures inherent to technocratic birth create the identity of mother as patient, and control the social circumstances to socialize mother and baby to their new role in American society. In this book, technology and the role of physicians are meant to disempower women since the physician is in control in order to ensure the health of mother and baby. Technocratic birthing practices provide control over the natural process that society relies on for its continued growth.

The experiences that women have within this technocratic birthing system have been shown to lead directly to birth outcomes such as when a woman perceives that she had little control over her childbirth experience and has a higher rate of post-partum depression. Davis-Floyd noted this phenomenon in 9% of her research participants and used Janis and Catano’s model of learned helplessness to understand that lack of control over childbirth that leads to mild post-partum depression is a form of learned helplessness (Davis-Floyd, 2003, p. 276).

Responses to Davis-Floyd’s work have challenged the idea of “natural” childbirth as the optimal alternative to technocratic birth by adding the complicating factor of race. Gertrude Fraser discussed the rise of hospital births in the South. In her ethnographic work, she found that this shift was a symbolic change for the community as they were included in the health bureaucracy that had often ignored their needs. Although midwifery was valued, inclusion in medical birth culture meant that the African American communities that she worked with were incorporated into the “public”. Fraser
reminds scholars that when we discuss the politics of reproduction, we must account for local experiences and the fact that race and historical injustice complicate discussions of reproduction (Ginsburg & Rapp, 1995). Bledsoe and Scherrer also respond to the idea that medical interventions performed by obstetricians are particularly disruptive to the natural course of childbirth by showing that contemporary women have the new worry of achieving the perfect birth and motherhood rather than the fear of death in childbirth that riddled previous generations. They suggest that the obstetrician’s behaviors in themselves are not the disruption, but the disruption of control that this causes to the woman. Contemporary attempts in control of childbirth have created a new type of patient that are identified by their birth plans and authority on knowledge of medical birthing procedures (Bledsoe & Scherrer, 2009). Other studies have attempted to deconstruct the current volatile atmosphere of American birthing practices by exploring the turf wars between midwives, general practitioners and obstetricians, issues of litigation (obstetrics has one of the highest rates of litigation), how evidence based medicine have recreated the body of the mother, and complicating issues of control with race and class (Good, 1998; Lazarus, 1994; Wendland, 2007).

Discussions of American childbirth practices have also invaded popular culture popular documentaries, newspaper articles, and TV shows reporting on the “birth wars.” I am using the term “birth wars” to describe the conflict between technocratic birth and so-called “natural” birth. Popular documentaries such as The Business of Being Born attempt to address problems in the American birthing culture such as the reasons for the United States’ alarmingly high cesarean section rate (32.8% in 2011 (CDC, n.d.)) the lack of
options that women have in delivery mode, and the standardization of medical procedures
that disempower women. The documentary addresses the fall and rise of midwifery,
waves of pain management techniques, and the introduction of Pitocin, and other
technologies that are meant to ease suffering and speed along labor which the
documentary illustrates as intervention cascades that lead to the high Cesarean rates of
the United States. This is all complicated by medical norms that portray birth as a
dangerous situation, with potential for complications at every stage, and insurance
companies that refuse to cover alternative birthing centers or midwifery practice (Epstein
2008). This documentary, although clearly advocating on the side of midwives, has
sparked dialogue across the United States. Other media sources including news shows,
magazines, and newspapers continue to report on the persistently high infant mortality
rate and cesarean rates in the United States when compared to other developed nations
(Kluger, 2009; Kotz, 2011). These rates are particularly troublesome because the United
States also holds the title of being one of the most expensive places in the world to give

Although this complicated birthing environment is what initially lead me to
consider using labor and delivery as the site of my research on cultural competence, my
focus is not on the experiences of women that deliver at Urban Hospital but rather of the
women that are helping women deliver. The labor and delivery nurses are sometimes an
invisible part of the birth process in a hospital because they mediate between the family
and laboring women and the practitioner that facilitates the actual delivery. As I will
explore in chapter five, Labor and Delivery nursing has been significantly altered by the
changing discourses of American birthing culture not only because they must deliver care according to evolving medical practice, but because the American birthing woman creates one more culture that nurses must be competent to work with. As public health institutions and hospitals become increasingly concerned with birth outcomes and disparities in birth outcomes, L&D nurses emerge as an important site of social change.

**Health Disparities**

Health Disparities, or differences in health outcomes in different groups of people, are an important aspect of national health discourses. The Healthy People (10-year objectives for national health improvements) objectives have including reducing health disparities in America for the past two decades defines a health disparity as

“…a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion (“Disparities,” 2010).”

The federal government commissioned the Institute of Medicine (IOM) to create a report on US health disparities in 1999. This report, titled “Unequal Treatments” was released in 2002 and documented that large bodies of literature have proven the existence of health disparities and that minority peoples consistently receive a lower quality healthcare. This report documents that the institutions of medicine themselves are consistently recreating disparities in health. Examples of this include minority patients being less likely to receive kidney transplants or dialysis but more likely to receive less desirable procedures such as amputations (Smedley et al., 2002).
Birth outcomes, particularly infant mortality rate (IMR), maternal mortality rate (MMR), and low birth rate (LBW) are used as general markers of the countries health which can be used to assess health disparities internally and to compare the health of populations internationally. Birth outcomes are important indicators because they are seen as sentinel events; the health of the population at large can be determined by considering how well we take care of our mothers and children. In 2010, the state that Metropolis resides in had an IMR of 4.4 infant deaths per 1000 live births (Anonymous, 2012) which is lower than the United States as a whole which hit a record low at 6.14 infant deaths per 1000 live births in the same year (CDC, 2012). However, within the state, health disparities are prominent. The black IMR is 2.5 times higher than the white IMR. Additionally, women with high school degrees (or less education) had more LBW and less prenatal care than college degree (or more education) (Anonymous, 2012, p. 11).

In reaction to the documentation of health disparities, the mayor of Metropolis proclaimed that the city should work to address healthcare disparities (Good et al., 2011, p. 15). Additionally, the public health commission for Metropolis became the first in the country to specifically address racial and ethnic disparities in 2006 which lead to the founding of their center for health equity in 2008 (BPHC, n.d.) to continue to improve health outcomes for minority populations. The IOM and other research have identified increasing the cultural competence of healthcare providers and institutions as a way to alleviate health disparities.
Cultural Competence

The community and civil rights movements of the 1960s brought awareness to cultural differences in health beliefs in America. Since this period, the field of cultural competence has grown tremendously and theories have been created specializing in almost every healthcare specialty. The institutionalization of cultural competence in healthcare was highlighted when the U.S. Congress mandated that the Office of Minority Health (OMH) work with health care professionals to address cultural and linguistic obstacles to health care. In 1997 the OMH began to develop national standards for Culturally and Linguistically Appropriate Services (CLAS) in order to articulate more consistent health care delivery across the nation. These standards, published in 2000 and update in 2010, ultimately aim to eliminate racial and ethnic health disparities to improve the American population’s health (U.S. Department of Health and Human Services, OPHS Office of Minority Health, 2001). The newly updated CLAS standards and the accompanying Blueprint (a document that describes the standards in more detail and outlines strategies for implementation) were launched in the spring of 2013. This launch event outlined the current state of national discourses on cultural competence. Emphasis was placed on the necessity of employing the CLAS standards because the country is becoming more diverse by the day and highlighted how this is economically beneficial. Connections were made to civil rights and equity because issues of discrimination are often barriers to culturally and linguistically appropriate care. There is a need for change in many healthcare settings because culturally appropriate services must be made available at every point of contact with health institutions. Importantly, even though this
discussion is at the national level, culturally and linguistically appropriate services cannot be regulated or mandated, therefore it is up to individual institution to hold itself accountable to the standards and promote them.

Medical Anthropology has been particularly important in developing the field of cultural competence in general and influenced much of the literature on cultural competence in nursing. Medical Anthropology has established that culture is an important factor in diagnosis, treatment, and general care of patients. Scholars such as Arthur Kleinman helped to popularize the notion that culture, does in fact matter “in the clinic” (Arthur Kleinman, 1981). Academic medicine has increasingly recognized that it must provide cross-cultural education to its students in an effort to take part in social justice work of alleviating health disparities (Betancourt, 2006; Hester, 2012). The field of cultural competence however continues to struggle with issues including lack of consistency or focus in intervention programs and evaluations (Price et al., 2005). While there are many models for cultural competency trainings many focus on the interaction between doctor and patient. For example, Kleinman discusses one approach where actual “cultural competency” practices for medicine are not stressed as a list of ‘dos or don’ts” even though it is often interpreted as such to medical professionals. Rather, he suggests that practitioners bring principles and understandings of anthropology into clinical encounters to create effective cross-cultural interactions between the culture of the patient and the culture of the physician. Kleinman introduced the “explanatory models” approach as a way for practitioners to work with patients to understand how the social world effects and is effected by illness through the use of “mini ethnographies” (Arthur
Kleinman & Benson, 2006). Anthropological concepts are adapted to counter major health care problems that have been highlighted above such as disparities in access to care, high costs and patient dissatisfaction (A Kleinman et al., 1978). In general, Joseph Betancourt suggests,” call it what you will, the field of cultural competence aims quite simply to assure that health care providers are prepared to provide quality care to diverse populations (Betancourt, 2006, p. 499).”

Other scholars have addressed the need for cultural competency efforts to take into account the historical linking of cultural and race. Seth Hannah suggested that environments of hyperdiversity require that culturally competent healthcare needs to take into account the variations in racial and ethnic boundaries. Hannah found that practitioners used an individualized formulation of culture rather than broad identity characteristics. Hannah suggests that work should be done to determine when group-based characteristics are salient for a client (Good et al., 2011, p. 62). Some cultural competency initiatives have suggested matching patients with clinicians of the same culture, however much research has shown that culture matching is not effective due to intra-cultural diversity (Good et al., 2011). Others have suggested linking cultural competency concepts more closely with evidence based practices in order to make it more clinically applicable (Engebretson, Mahoney, & Carlson, 2008). More critical forms of cultural competence are also prevalent which suggest that culturally competent practices often do not address issues of unequal power in the culture of health and will therefore not succeed in eliminating health disparities (DeSouza, 2013; Hester, 2012). These criticisms of cultural competence practices is particularly important to childbirth
discussions in America when “culture” is deemed as an inappropriate excuse from pregnant women for refusing medical attention and action is taken to save the baby in circumstances of court-ordered cesarean sections (Irwin & Jordan, 1987).

Nursing Contributions to Cultural Competence

Although nursing theories of cultural competence often employ anthropological theories, I separated the literature that specifically attends to nursing in cross-cultural situations. Medical anthropology often emphasizes medicine over nursing and I feel the need to highlight how the discipline of nursing has contributed a significant amount of literature in its own right.

There has been a great deal of literature that discusses the importance of culture to nursing as well as its impact on childbearing. Lewallan suggests that in the current American environment of increased diversity, maternity nurses need to help the client understand the hospital birthing culture while embracing the client’s culture (Lewallen, 2011). Population specific studies of nursing patients show that patient satisfaction is increased with higher degrees of cultural and linguistic confidence and that understandings of the culture can help alleviate health disparities (Castro & Ruiz, 2009; Yosef, 2008). Studies have gone as far as to articulate that nurses have the ethical obligation to address the culture of populations that have multiple ethnic and racial identities such as that of veterans (Hobbs, 2008).

Several major theories of cross-cultural nursing care have emerged that go beyond general studies of the importance of culture to nursing care to suggest models of practice. One of the most influential theories in the United States is Transcultural nursing.
Madeleine Leininger established the discipline of transcultural nursing in the early 1970s which has the goal of establishing culturally congruent care. She created the theory because nurses needed to understand the anthropological view of culture. Further, she valued care as the “essence of nursing” which had meaning within the contexts of culture (Leininger, 2002, p. 189). The goals of transcultural nursing are:

“The central purpose of the theory is to discover and explain diverse and universal culturally based care factors influencing the health, well-being, illness, or death of individuals or groups. The purpose and goal of the theory is to use research findings to provide culturally congruent, safe, and meaningful care to clients of diverse or similar cultures. The three modes for congruent care, decisions, and actions proposed in the theory are predicted to lead to health and wellbeing, or to face illness and death (Leininger 2002:190).”

Clearly, transcultural nursing seeks to incorporate concepts of anthropology into nursing practice, though whether or not transcultural nursing has always been effective in translating concepts of culture to practitioners has been disputed (DeSantis, 1994). Transcultural nursing has been useful in allowing understandings groups of people, such as the homeless to be viewed as a culture and therefore, enhance nurse’s abilities to work with these populations (Law & John, 2012). Some authors have even suggested that transcultural nursing is necessary in the multicultural context of the United States because culturally competent nursing creates higher patient satisfaction and better outcomes (Maier-Lorentz, 2008).

Even though transcultural nursing is, perhaps, the most popular theory in the United States about nursing and cultural competence, other theories, particularly cultural safety have emerged, often critique transcultural nursing’s approach. Cultural Safety is a theory developed by nurses in New Zealand that specifically addresses a decolonizing
agenda. This theory confronts power structures that lead to health disparities and that seek to regulate culturally different patients (particularly the native population in New Zealand). This is done by acknowledging the self as the bearer of culture rather than perceiving others as carrying the difference. Significant scholarship has discussed the ways that maternity nursing as well as birth outcomes can be enhanced through the use of cultural safety (DeSouza, 2013; Kruske, Kildea, & Barclay, 2006; Woods, 2010).

Though I have identified specific nursing cultural competence theories, there is a body of literature which suggests the use of phrases such as “cultural sensitivity” or “cultural humility” to portray understandings and critiques of “cultural competence.” The ways in which people distinguish between cultural humility, sensitivity, and competence are important in academic and popular discussions and have even been discussed in relation to ethics (Bourque Bearskin, 2011; Callister, 2001; Ottani, 2002; Sperstad & Werner, 2005; Zoucha & Husted, 2000). In my own study however, I used “cultural competence” as the phrase to identify the discussion around cross-cultural care because was easily identified and allowed sufficient ambiguity to leave room for conversation.

Following the engagement with health disparities and vulnerable populations, theories of social justice in nursing have also emerged that engage understandings of cultural competence. These studies show that nurses’ should look beyond individual patients to the contexts in which health disparities are produced as well as advocacy for vulnerable populations (Buettner-Schmidt & Lobo, 2012; Kirkham & Browne, n.d.; Pacquiao, 2008)
A more recent conversation on cultural competence and nursing has emerged through the use of critical theory that attempts to go beyond the concept of cultural competence. Several nursing theorists have suggested that, as a discipline which is mandated to practice evidence based medicine, nursing cannot continue to use cultural competence to reduce health disparities because it has not been proven to improve health status and distracts from causes of health disparities that exist at broad levels of society (Drevdahl et al., 2008). Critical reviews of Transcultural Nursing theory emerged suggesting that performing cultural competence in a clinical setting focuses on individual behavior while ignoring the institutionalized practices which contribute to racism. This is done by reinforcing “dominant liberal discourse” which influence dominant social practices and hierarchies in social practices. Critical understandings of social structures, race, and ethnicity lie at the heart of these studies (Culley, 2006; Gustafson, 2005; Nairn, Hardy, Parumal, & Williams, 2004).

As I have briefly introduced, the field of cultural competence is abundant with different models for practices as well as critiques of whether these theories truly address the health disparities that plague the United States. Using the study design that I describe in my next chapter, I attempt to construct the ways that nurses have engaged with this theoretical arena in their professional lives.
METHODS

Hospitals in general – and safety net hospitals in particular – provide a unique space for anthropological research. My research used qualitative data collection and analysis to study the experiences of Labor and Delivery nurses at “Urban Hospital”, located in a large city of New England, in order to identify multiple understandings of diversity and cultural competence. The primary sources of data collection were individual semi-structured interviews and participant observation around the hospital. Background information was collected through informal interviews, archival data and reviewing related literature. My own experiences gaining access to and conducting research in the Labor and Delivery unit has reconfirmed the need to conduct ethnographic research in hospitals, particularly in the field of birthing, which occurs overwhelmingly (in our society) in the hospital.

Research Question

My original research question developed out of an interest in theories of cultural competence seen in nursing and medical anthropology literature. As I have discussed in my background section, there are currently numerous theories at play considering how to practice cultural competence in order to give better care to “diverse populations” as well as to help alleviate health disparities. I wanted to understand how these theories worked “on the ground” between nurses and patients and how nurses gravitated toward different uses of cultural competence theories.

My own interest in Labor and Delivery practices pointed my study toward that department of the hospital. This is a timely study as current practices are being hotly
debated in medical and political arenas. Furthermore, public health departments and lay people are focusing their efforts on making less medicalized birth an option, partially in an effort to alleviate the birth disparities I described in the background chapter. The intersection of labor and delivery nursing and a hospital that caters to diverse populations seemed to provide a space to observe how culturally competent practices and policies would affect birth outcomes. I hoped that findings would be a key starting point to assess the role of culture in Urban Hospital’s birthing practices and would help nurses gain understandings of their own cultural positions in relation to the care they are delivering.

Yet, as I began my research, I found that “cultural competence” was not necessarily the subject that people wanted to discuss. Rather, due to the frequency of “diversity” conversations it became more important to understand what “diversity” meant for both patient and employee populations. I also found that understanding the medical institution and what it means to the community, to current employees and to the hospital historically, was an important focus. Throughout my research period, I shifted my attention from cultural competence theories to the actual meanings of diversity that nurses had developed and to how the institution portrayed diversity. The uniqueness of the Urban Hospital population became a focal point for many stories and colored nurse’s experiences with laboring women.

Recruitment

My recruitment focused on labor and delivery nursing staff, though I had been warned by advisers early on that this would be a difficult population to track down. Early in my recruitment period, after being advised by nursing staff to include both current and
previously employed labor and delivery nurses, I amended my Institutional Review Board (IRB) application to broaden the population. This revision allowed me to document a longer period of experience with the labor and delivery department from the late 1960s to the present.

Recruitment for this study began when the nurse manager placed flyers in the nurses’ break room in Labor and Delivery. One nurse contacted me through this recruitment method and subsequently became a part of my study. Additionally, the nurse manager sent out an email with the information on my flyer to all labor and delivery nurses. This method provided no responses. The director and nurse manager additionally suggested that I attend a staff meeting to introduce myself and the study. I did so, and passed around a sign-up sheet, which enabled me to obtain contact information for three nurses. One scheduled the interview right away, but scheduling proved unsuccessful with the remaining two. The final four participants I had previously met through interactions with the department, where they had heard about my study.

I believe that my initial recruitment methods through flyers and emails was not successful because I was a “stranger,” a foreign entity, asking busy nurses to take the time to pursue research methods with which they were unfamiliar or for which they saw no need. In-person recruitment allowed me to explain the flexible and trustworthy nature of my study and that it posed no cost to the participant. I learned that it was necessary to introduce myself and the way that interviewing would “work” because, although nurses are often asked to participate in (survey) research, they were unfamiliar with ethnographic work. Conversations and introductions allowed me to distinguish my
research from other studies going on in the department and to legitimate my position as a researcher through the support of the nurse manager, my volunteer badge, and the assurances of other participants.

**Participants**

A total of six nurses participated in the formal interviews. All were women and had worked for Urban Hospital from less than one year to over 40 years. Their level of education varied, including nurses who held a Registered Nurse degree (RN) degree from a hospital nursing program, a four-year Bachelor of Nursing degree and a Master-level degree. Even though the degrees varied, all nurses had, at one point, been bedside labor and delivery nurses. The sample also included with a range of ethnic and religious backgrounds that reflect the diversity of larger staff.

**Interviews**

Prior to the interviews, I created a semi-structured interview guide that included questions on four broad areas: nursing background, diversity, cultural competence, and working in this particular hospital. The guide allowed me to stay focused on a core set of topics for comparison across interviews but also gave participants the flexibility to tell the stories they felt were important. After the initial interviews, I was able to modify some questions to confirm and delve more deeply into my understanding of emerging themes.

All of the interviews were scheduled at the convenience of the staff’s schedule, which meant that they were scheduled at the end of twelve-hour shifts, during lunch, and once as a formal appointment during the workday. Each interview began with the consent
form, which I discussed briefly. All participants read the form thoroughly, were assured of confidentiality and signed the form, after which I added my own signature. I conducted each interview at the participant’s place of choice, which coincidentally was in or around the hospital, though never in the same location. I recorded all of the interviews digitally, stopping the recording if the participant expressed any discomfort discussing a particular story on tape.

My initial proposal had included two focus groups to be held at the labor and delivery floor at appropriate times for day and night shift staff. I had hoped to gather the important issues and concerns of the staff as a whole in order to focus my question guide. Unfortunately, I was unable to coordinate a time to hold these focus groups with the Nurse Manager. Interestingly, all of my participants and several nurses who did not want to participate in individual interviews expressed interest in attending a focus group, should it happen.

I transcribed four interviews fully, using Express Scribe, free software that allowed me to use the computer keyboard to control the speed of the recording audio to slow down passages and save time. Unfortunately, most passages of the fifth interview’s audio proved too difficult to hear and therefore to transcribe. For this interview, I transcribed the passages I could hear clearly and relied on field notes I had taken after the interview. Transcribing interviews throughout the fieldwork process, allowed me to reflect and revise several questions, as well as to improve my interviewing skills. All interviews and field notes were coded with the data analysis software, NVIVO 10.
During the coding process, I used a variety of different strategies, including thematic\(^3\), versus\(^4\), in vivo\(^5\), and value coding\(^6\).

**Participant Observation**

The research site itself became thematically central in my study; therefore participant observation included any interactions I had with the actual institution and interactions with the surrounding space. I attended a staff meeting, spent time in several cafeterias and waiting rooms, read signs, and received a TB test through occupational health. I was unable to do shadowing, as I had initially hoped, due to scheduling difficulties as well as hardship on nurses who already had students.

Interviews themselves often became opportunities for participant observation because they all took place in or around the hospital. Most often this was simply for the convenience of scheduling. However, each interview portrayed the ways in which the nurses interacted with the space of Urban Hospital. For example, Margaret who retired from Urban Hospital several years ago, chose to meet at a diner that she would frequent with her fellow nursing students several decades ago. She cheerfully walked me through the neighborhood pointing out the differences in the buildings and helped me imagine what the neighborhood was like when the sewage canal ran next to the hospital. While I

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\(^3\) Thematic coding involves using a sentence or extended phrase to identify what the particular unit of data is about. This process is most useful for interviews and allows categories to emerge from the data (Saldaña, 2013, p. 175).

\(^4\) Versus coding shows the dichotomous entities that are struggling for power against each other. This coding is useful for identifying competing goals within the data and focuses on patterns that reveal injustice. It is important to remember that conflicts are contextual and often have multiple sides (Saldaña, 2013, pp. 115–118).

\(^5\) In Vivo coding draws on the participant’s words and is helpful in grounded theory. This type of coding is helpful when prioritizing the participant’s voice (Saldaña, 2013, pp. 91–95).

\(^6\) Value coding is useful when assessing the participant’s values, attitudes, and beliefs. These values are not always directly stated by the participant. (Saldaña, 2013, pp. 110–115)
did not see the nurses interacting with patients, their discussion of the space were punctuated by these opportunities for observation and became helpful in analysis.

**Hospital Ethnography**

Although difficulties in accessing data are not frequently discussed as part of analysis, my experiences attempting to do research at the hospital and my own feelings of discomfort forced me to consider the hospital not only as a research site, but also as a constructed space. The hospital as a space for ethnographic research is a fairly recent phenomenon in the anthropological field. Although the understanding of the hospital as a space rich with meaning had been previously well established, it was not until postcolonial critiques shifted the focus to “the exotic self” that anthropologists took a more active interest (Long, Hunter, & Van der Geest, 2008). Van der Geest and Finkler cite several reasons for the lack of hospital ethnographies, including “defensive” hospital authorities who tend to be disinclined to welcome an observer (van der Geest & Finkler, 2004). In my own study there were both real obstacles to gathering data as well as perceived obstacles to conducting an ethnographic study.

As noted earlier, physicians in our home department had suggested that nurses in labor and delivery would not have the time to participate in an anthropological study; instead, they encouraged me to work with the outpatient clinics. I stubbornly refused to change my population of interest, especially after receiving support and interest from the nursing department of Urban Hospital, specifically the Maternal-Child Nursing administrator. Although she herself was interested to learn about nurses’ understandings of cultural competence, she could not connect me with the Nurse Manager until my IRB
protocol had been approved and I had obtained a volunteer badge. (Ironically, it took longer to secure the volunteer badge than to get my IRB proposal confirmed, because it required additional paperwork, vaccinations, and an orientation.) At that point, I met with the Nurse Manager who, I was told, would help me organize focus group scheduling and recruitment. Unfortunately, at the time she was managing both the post-partum and L&D units and was not available to schedule focus groups. She was, however extremely helpful in recruitment by sending out my flyer in an email, placing flyers in the break-room, and supporting my research in a staff meeting.

In the month between my initial meeting with the Nurse Manager and the email she eventually sent out to the Labor and Delivery nurses, I took steps to gather other hospital information to supplement my study—hospital demographics (to understand the documented “diversity” of patients), history of the departments, and information on cultural competence policy. Each of these endeavors ran into its own obstacles: in trying to gain hospital information prior to 2006, one email chain went through six people before it reached someone who had the ability to access the data and who agreed to help me. Yet even this chain of communication did not last long, and the individual did not follow through in delivering the information.

My advisers and I had assumed that a more detailed history of the hospital would be easily found “somewhere.” I began my research at the Metropolis University School of Medicine’s library where I received some pictures of Community Hospital’s Labor and Delivery unit. While they carried extensive information on the school of medicine’s history, it was outside the scope of my study. After this, I was directed to a local historian
as well as the archives of Metropolis University. These archives held an abundance of information on the nursing school that had been a part of Community Hospital until 1975 and held some information on the hospital during that time that the nursing school existed. At this point, I was told that other data on the Labor and Delivery unit might have been placed somewhere else, such as the City Library as the archives and historical information were moved after the merger, though I was unable to locate those other sources. While each of the places that I accumulated information on Urban Hospital’s history provided valuable information, the actual history of Labor and Delivery Nursing at Urban Hospital was most readily available to me through my participants’ oral histories. It is unclear whether I simply had not reached the right people with access to Urban Hospital’s nursing history, or whether no one has recognized its having a differentiated history from the rest of the hospital. I speculate that it is a combination of the two.

Finally, as I will discuss in Chapter 6, understanding cultural competency policies or training proved to be an interesting endeavor not only because most nurses agreed that they had not received formal training, but also because most administration-level and some bedside-nursing staff agreed that there had to have been something. Nevertheless, this “something” was difficult to track down, mostly because no one knew what “it” was or who would know about it.

Some of my early difficulties may be chalked up to my being an ignorant young researcher both without a nuanced understanding of the hospital structure and without the social status to engage hospital employees. The remarkable thing about these difficulties
however, was that most staff—particularly nursing administration—were interested in my study and in seeing the results. In contrast with the “defensive” hospital authorities cited by Van der Geest and Finkler as making ethnography difficult, the barriers I encountered were not people, but rather the bureaucratic organization of the hospital itself. There was not necessarily a lack of will to have research done; it was the actual act of facilitating of it that didn’t seem possible.

My own position as a researcher was not recognized. Once I had a volunteer badge, however, I became a legitimate, recognized body on the floor, able to get past guards and inquiring looks from other staff. The bureaucratic organization of the hospital with specialized jobs complicated finding the right person from whom to obtain specific information. I was often told that even if one person could not provide information, there was “somebody” who could, if only I could find them. Yet even after locating and meeting with these gatekeepers, the number of tasks and responsibilities related to working in a safety-net hospital meant that my emails and calls often went unanswered.

The difficulties I experienced resulting from the hospital’s organization are clearly not unique to my study or to Urban Hospital’s organization. At the same time, such challenges are not always a major problem for hospital ethnography. Sociologist Charles Bosk suggests that, in doing hospital ethnography, there are “invited guests” and “uninvited intruders”. He did not experience many of the difficulties that other sociologists and anthropologists often do in his ethnography of a pediatric hospital. Because he had been invited by hospital staff to conduct his research on genetic counseling, he entered as a guest (Bosk, 1992).
Uninvited intruders, however, often have difficulties and will attempt to gain access through permission or invitations from medical and high-status hospital staff to facilitate research. In an extensive appendix on research methods in *Paging God*, sociologist Wendy Cadge discusses her attempts to gain access to her research sites. As she was an “uninvited intruder”, gaining permission to study the way religion and spirituality are present in one institution was difficult. After several months of discussing her project with hospital employees that she knew, Cadge found a Chaplaincy director who was interested in her project and who suggested writing an IRB proposal together.

One month into the project, it was disbanded because the chaplain’s supervisors did not want their previous treatment of religion exposed. This is a clear case of Van der Geest’s and Finkler’s defensive hospital authorities creating barriers to ethnographic research. After this setback, Cadge decided to conduct her research at multiple hospital sites, rather than through an in-depth look at just one. She was also unable to access data about patients or conduct interviews with patients due to HIPPA regulations (Cadge, 2013). The experiences she outlines show that although many individuals were interested in discussing the research subject, the process of gaining access to a hospital as an uninvited guest was complicated by hospital authorities, hospital regulations, and the search for an advocate with appropriate status to grant her access.

Ethnographies more closely linked to my research population, and that address questions about birthing or pregnancy, also show that gaining access to hospital birthing staff is difficult, because it is one of the most protected cultures of birthing and often rests on the invitation from a key individual (Bridges, 2011; Jordan & Davis-Floyd, 1992). Yet
whether the “defensive” characteristic of hospitals expresses itself through hospital authorities, bureaucratic regulations, or simple disinterest in ethnographic research, the barriers to doing hospital ethnography are important to our understanding of the hospital as a space. They show not only that ethnographic work there is difficult; they also reveal hospitals to be other than the neutral spaces of healing that may be advertised. The very fact that hospital authorities are nervous to have someone researching how medicine is practiced in their space is not only because of the possible exposure of harmful practices, but also the potential damage to the hospital’s public image. Moreover, I discovered that certain types of research—especially evidence-based “objective” testing and research with doctors—are weighted over ethnographic work, particularly among nurses, making further exploration of such obstacles necessary. One nurse in my study alluded to the problem that nurses at Urban Hospital have in gaining access to research. As an example, she explained that discussions of current research occur in Maternal and Child Health among physicians and residents, as part of an ongoing journal club, but that the nurse’s journal club is not active. She actually speculated that low recruitment for my study might be due in part to a lack of interest in research by nurses, some of whom may view it as something “doctors do”.

Beyond the practical barriers to conducting research in the hospital, Van der Geest and Finkler also suggest that the historical lack of ethnographic research may be due to the image of the hospital as a “deceptively familiar” space, because they are (seemingly) divided by similar ward and bureaucratic organizational structure the world over. They propose, however, that biomedical hospital culture varies by country and,
more importantly, that “biomedicine, and the hospital as its foremost institution, is a
domain where the core values and beliefs of a culture come into view…. hospitals both
reflect and reinforce dominant social and cultural processes of a given society (van der
Geest & Finkler, 2004, p. 1996).” Discussions of the hospital therefore should not be
considered in comparison with, or “other” than, life outside the hospital, but actually as a
continuation of and window into the society in which it is situated.

This assertion actually challenges the idea from one of the first hospital
ethnographies (Rose Laub Coser’s Life in the Ward) which describes hospitals as an
“island” removed from the “reality” taking place outside its walls (Long et al., 2008).
Finkler and Hunter likewise characterize hospitals as distinctive institutions, which are

...among the most fascinating spaces in contemporary society: they are
complex; they are constantly changing; they harbor some of the most miraculous
achievements as well some of the most worrying risks, and they are most likely to
be the place where we are born and where we die (Finkler, Hunter, & Iedema,

They go on to argue that fascination with the hospital, in itself, is not necessarily enough
to merit an ethnographer’s presence. Rather, ethnographers may find a place in revealing
the esoteric work of the hospital, which is characterized by complex bureaucratic policies
and ever increasing specializations, each of which moves understanding of the hospital
further away from public grasp (Finkler et al., 2008).

My participants presented Urban Hospital as a window into the culture of our
society, a distillation of trends and problems prevalent in America’s current healthcare
atmosphere and society at large. However, I would suggest that they advanced Van der
Geest and Finkler’s acknowledgement that hospital culture varies by not only country,
but also local culture and circumstances different from other hospitals in the area—a contrast I will detail in the next chapter. The semi-structured interviews and participant observation data along with historical research illuminated the contentious identity of Urban Hospital which I will suggest marks it as borderland within Metropolis.
CHAPTER 4: Constructing a Borderland

“When you live near [Community Hospital] you can’t be deluded about what’s going on in America.” (Personal Communication)

“It’s interesting that white women usually don’t come to birth here except as heroin addicts.” (Mary)

I walked into the lobby of one of Urban Hospital’s main buildings with my stack of recruitment flyers and headed toward the L&D nurse manager’s office. Every time I made this trip I walked quickly through the light jazz, past the potted succulents toward the guarded entrance to the stairs and elevators. Getting past the security guard was infinitely easier once I began wearing my volunteer badge; rather than the usual skeptical search for my student ID, I was now cheerfully greeted as I made my way toward my research population. After a confusing attempt to use the stairs to reach the cafeteria, I learned my lesson and always used the elevator. On this particular day, I was pleasantly surprised to hear a faint hum of voices as I stepped off the elevator and onto the beige hallway lined with neutral pictures of flowers. I quickly walked down past a couple talking in the small waiting room, and stopped at the clear reception window that served as a final test for entrance onto the unit. The nurse on the other side partially opened the glass, briefly greeted me, than quickly returned to her task at the computer as I explained my message for the Nurse Manager. After our short interaction she sent me to the office, located just off the hallway, which meant there was no need to grant me access to the protected world beyond the locked doors that separated the long hallway from the nurses and laboring women. I knocked lightly on the office door, feeling that I clearly did not belong in this deserted hallway, left the flyers in her box, and walked to the elevator. I was always surprised at how different this Labor and Delivery Unit was from others where I had volunteered. The facilities were nice enough, always clean and uncluttered, but the locked hospital doors and small waiting room often gave me the impression that anyone not on the floor for a specific reason should leave. As I contemplated this “feeling” on the walk home, I wondered how to gain access to the mysterious world beyond the doors. (June 2013)

When I began constructing my interview questions I expected for the hospital itself to be an interesting aspect of the research but not a major focus of my analysis of
cultural competence. However, when I began to do interviews and discuss my data further with advisers, it became apparent that the space of Urban Hospital was a central mediating theme in my participant’s narratives. I was astounded with the ways the institution was presented to me and I quickly realized that attempting to separate the space from issues of cultural competence and diversity was useless.

This chapter will continue to explore the story of Urban Hospital as it was presented to me by the Labor and Delivery nurses. I will introduce the “cast” of my study throughout this chapter in an effort to establish the importance of this theme and portray the many colorful stories I was privileged to record. Mary, Esperanza, Agatha, Margaret, Nadia, and Isabelle identified Urban Hospital as a unique borderland that actively honors the marginality of Metropolis and whose specific history continues to differentiate itself from other hospitals in the area and takes on a unique tension in the community and amongst workers.

**Constructing a Borderland**

Gupta and Ferguson’s article “Beyond Culture” suggests that in the social sciences, space often functions as a “neutral grid on which cultural difference, historical memory, and societal organization are inscribed (Gupta & Ferguson, 1992, p. 7).” As such, researchers were able to create products such as ethnographic maps which show the spatial distribution of cultures, essentially using space as an organizing principal without analytical appreciation (Gupta & Ferguson, 1992). Social science now places an important focus on this use of space that essentially equates space, place, and culture which has inherent problems. For example, for people that inhabit borders (such as
between nations), who live lives of border crossing (migrant workers, international business), or even permanent immigrants, the idea of “discrete” cultures that occupy discrete spaces is implausible. In rethinking the notions of separate cultures we might consider how spaces have always been interconnected and therefore how cultural change is a function of rethinking difference through connection (rather than through cultural contact) (Gupta & Ferguson, 1992, p. 8). Gupta and Ferguson would have us focus on borderlands - “Rather than dismiss them as insignificant, as marginal zones, thin slivers of land between stable places…” (Gupta & Ferguson, 1992, p. 18).” In fact, they call on researchers to continue a critical study of space:

“We need to theorize how space is being reterritorialized in the contemporary world. We need to account sociologically for the fact that the “distance” between the rich in Bombay and the rich in London may be much shorter than that between different classes “in the same” city. Physical location and physical territory, for so long the lonely grid on which cultural difference could be mapped, need to be replaced by multiple grids that enable us to see that connection and contiguity – more generally the representation of territory – vary considerably by factors such as class, gender, race, and sexuality, and are differentially available to those in different locations in the field of power (Gupta & Ferguson, 1992, p. 20).”

I aim to complicate the idea of hospitals as territories that passively inhabit the landscape of metropolis through my analysis of Urban Hospital. The specific mission of Metropolis Community Hospital and Urban Hospital - to give high quality care to the poor inhabitants of Metropolis - transforms the physical location of the hospital. The hospital is transformed into a space that is located through its connection to the marginalized peoples of Metropolis and even the world as refugees and immigrants come
to inhabit the services that the hospital offers. In order to understand how the space of the hospital is transformed, I consider it as a borderland.

Urban Hospital’s identity, as it was presented to me by nurses, essentially illustrates the way a borderland is constructed and functions in the larger space of Metropolis. The narratives that nurses shared about cultural competence and diversity revolved around this unique hospital identity. For the nurses, patients, and city, Urban Hospital is both a point of pride – that it belongs to the people of the city and is a place where anyone can get care—while simultaneously being a source of resentment as it struggles to maintain competitive facilities and services in light of a struggling budget. This hospital identity is simultaneously created by staff, patients, journalists, hospital promotional material and Metropolis City at large.

The hospital identity, although specific in reflecting the particular history of Metropolis, can be compared to many city hospitals located in multicultural metropolitan areas and reflects the great interest in the anthropological study of borderlands. In a study of hope in African American families with children diagnosed with chronic disease, Cheryl Mattingly (Mattingly, 2010) discusses the confusions and difficulties that city hospitals in Los Angeles experience due to the variety of classes, races, languages, and cultures in the context of clinical encounters through the idea of “border crossing.” In using this concept – that patients, families, and hospital staff are constantly and often not successfully crossing borders in their interactions and attempts to find healing Mattingly ascribes the hospital and clinical interactions in general as a borderland. Through this Mattingly calls to our attention that the boundaries between social worlds are fluid and
porous and are not always defined geographically. Gupta and Ferguson used the example of borderlands as literal geographical spaces between nations and much literature has been dedicated to this concept however, scholarship has also moved toward understanding these borders as “marginal spaces of governmentality, global economics, biopower, and moral politics” (Good, 2008, p. 22). Often – these discussions of borderlands show the ways in which people have re-formulated spaces in terms of power and difference that are altogether separate from the physical location. Mattingly’s ethnography, suggests a practice-based understanding of borderlands as spaces, like urban hospitals, that are defined by “practices that bind people together who otherwise wouldn’t belong together (Mattingly 2010:20).”

This understanding of borderland is particularly helpful in understanding urban safety-net hospitals whose identities are bound up in economic and political policies as well as societal norms that act on the impoverished populations for whom these hospitals are created. The study of city hospitals as border zones characterizes them as “spaces of contradictions and disorder, as well as sites of cultural fluidity, identity making, and diverse and marginal forms of citizenship (Good 2008:22).” Urban Hospital is a borderland that is not defined necessarily as being on the “edge” or between two things, but rather because it is a space that actively gathers the marginal of Metropolis and places them as the central focus of the institution. In doing this, it becomes a place of contradiction and disorder while allowing the people that “do not belong together” to practice a unique form of healing.
Dis-ordered Medicine

Community Hospital, which was created and funded by the city since its opening in 1864, has always been an institution that held a marginal status in terms of physical appearance as well as association within Metropolis. In general this is due to the inadequate funding that causes safety net hospitals around the country to fall below their private counterparts. A Metropolis newspaper article about Community Hospital in 1968, illustrated that although the medical care was appropriate, mothers were not being given baths or allowed to see their newborns for very long. The patients that were interviewed in this article depicted the issue as being a lack of resources and appropriate funding. The article suggested that even though these issues were not specifically medical, this can be seen as providing second-class medicine because the patients could not afford to go to the private hospitals that would provide these services (Cobb, 1968).

My participants highlighted this portrayal of Community Hospital as a hospital that was lacking, due to the paucity of resources. Isabelle, an immigrant from the Caribbean, met with me for two very cheerful lunches in an Urban Hospital cafeteria which currently stands at the site of the old maternity building (which became quite useful when she explained the various layouts of the old building). She began working with Community Hospital in the 70’s and described it as being “antiquated,” due to a lack of supplies that forced nurses to improvise in their care for patients:

So it was [a] very antiquated system in many ways. We didn’t have a lot of resources and stuff. And you know, you had to be very creative in... working and improvising or working fast...with whatever you had...As simple as linen. You didn’t have a lot of linen. So you had to make sure you conserve, you know, so you had a patient who soiled the bed you’re not gonna change the whole bed you may just change the underpad. You made sure you had a pad so you could put
underneath. You made sure to conserve linens. Um, lots of stuff.... When you didn’t have towels what do you do when you want to give patients a shower or you want to give them a bed bath? What do you do without towels? So you use Johnny’s as towels. A hot pack to put on a patient’s arm, yet you don’t have hot packs. How do you make a hot pack? You take a towel, you take boil water, and you dip it in there, wring it out, and wrap it around your patient’s arm. You know things like that. I mean you had a lot of improvising to do. But, you know we didn’t have a lot of resources to work with. And so, there weren’t too many people who wanted to work at {Metropolis Community Hospital}. (Isabelle)

Esperanza, also described Community Hospital’s reputation in the city in her description of choosing to work there. Esperanza came to Community Hospital more than 20 years ago after obtaining her Master’s degree and working at the nationally ranked People’s Specialty Hospital (PSH). She met with me after 13 hours as the charge nurse on a Friday night in the beginning of July. As we sat down in a corner of the Labor and Delivery floor (almost an hour after our original meeting time at the end of her shift) she confirmed my assessment of the unusually busy day they were having. I had gathered as much from the numerous patients and families I had witnessed in the halls. Esperanza explained the contradictions and disorder inherent in the identity of the hospital:

E: I was a nurse at {People’s Specialty Hospital}. And I was doing some agency nursing ... And one of the places they sent me was here, {Community Hospital}. But I stayed away for a long time because they said it was a “dump and it was messy and...” Finally, there was no work so I came and I loved it and I loved the diversity. And I knew right away, to me right away, it didn’t seem quite as professional as {PSH} was but...

R: What do you mean by that?

E: “Yes Doctor No Doctor. Have a seat Doctor. “And everybody on good behavior. The floor nurses said “Listen, I’m not giving that med until you write the order ‘cuz you never... you never sign your verbal orders” And just talking in a different way to the doctors. And I’m thinking “Ooo!” But anyways, I thought it looked like a fun place to work so I quit. Um it was in August that I first came here and by November I quit {PSH} and joined the staff....
Even though Esperanza eventually chose to work at Community Hospital and even rejoined the staff after a short stint as an independent practitioner, she acknowledged that the poor reputation of the hospital initially kept her away. Later we discussed how, even though the hospital has improved exponentially since the merger with Metropolis University School of Medicine, the physical appearance may still not match others in Metropolis. When she admitted this, she said that some women might choose to labor at a different hospital with their second pregnancy.

The other nurses in study generally agreed that the physical environment and resources in Urban Hospital would never be on par with other hospitals in the area. However, Esperanza and other participants emphasized that women would often come back with subsequent pregnancies because of the institutional atmosphere and caring that they receive from the staff. This tension between a “shabby” reputation and quality of care or “heart” of the hospital was present throughout all of my interviews and is present throughout news coverage in Metropolis.

Metropolis news articles during and after the merger of Metropolis Community Hospital and Metropolis University Hospital, reflect the persistent marginal status of Urban Hospital within Metropolis, despite the considerable boost to resources that the academic institution provided. Some articles around the time of the merger, and even several years later, showed the difficulties of merging the two hospitals that had different, even opposing missions within the community. A 1998 article portrayed skepticism about whether the two hospitals would be able to merge the vastly different cultures held at each institution even though the two had a history of working together prior to the
merger. Two years after the official creation of Urban Hospital, the article used the argument over which hospital’s buildings would house inpatient services to suggest that: “The issue has provoked an intense debate, and not just about bricks and mortar, some participants say: This is a battle for the hospital’s soul (Kong, 1998).” In response, the chairman of Urban Hospital wrote to the editor of the newspaper suggesting that this portrayal assumes that there is an assumption that it is impossible to merge academic medical centers and city hospitals to deliver high-quality care to the needy, should be a belief of the past (Ferris, 1998). However, three years later, a 2001 article continued to showcase the two sides of Urban Hospital separately by describing the pride the medical director takes in the “state-of-the-art cardiac catheterization lab,” as a “symbol of the medical center’s academic aspirations” while showing the pride he takes in the first floor bathroom, which is where homeless people are welcome to change their clothes or wash up – a symbol of their care for the poor. Surprisingly, the academic medical center was able to thrive as a safety net hospital with over half of its patients being uninsured or on Medicaid, three-quarters being black, Hispanic, or Asian, and about 30 percent needing interpreters. The success was credited to the attempt to avoid a culture clash between the two distinct hospital cultures. Part of this was resolved by hospital departments complementing each other like Community Hospital being the only one to have a maternity ward while other departments that were present at both hospitals had to choose one department head prior to the merger. An executive cited the coherent mission of urban health helped create a cause that the two distinct hospital cultures could rally around and keeping the hospital “tightly focused” while teaching doctors about health
disparities (Barnard, 2001). The lack of resources and legacy of Community Hospital is present as a concern five years later in an editorial piece about the opening of a new hospital building. The article remarked that while nurses and doctors are often impressed at the improvement in working conditions when moving to a new building, what was different about the move to Urban hospital’s new building was “the location - on land once part of {Metropolis Community Hospital}, for many years the city's public hospital for the poor, where the facilities were often considered sub-par.” The author predicted that people of all incomes “might” start looking to Urban Hospital for treatment from the look of the facilities and enthusiasm of staff (Credit: Boston Globe, 2006).

Just four years ago, two pediatric residents wrote an opinion peace urging the national and state governments to ensure equitable funding for the work that they do on the poor, emphasizing that no hospital can expect to survive on the 64 cents that Urban Hospital is reimbursed for every dollar spent on treating low – income patients. As the patients are from neighborhoods of Metropolis with some of the highest disparities in health (low birth weight, high asthma rates, high infant death etc.), using similar language to the medical director eight years earlier, they emphasized that Urban Hospital especially needs to supply the high quality medicine that these patients need (Preer & Chen, 2009).

This is a small snapshot of the articles published about Urban Hospital by the Metropolis Newspaper, showcases the very unique and inconsistent reputation the hospital holds in the community. The articles emphasize the positive work that the hospital does for the community, in fact, the work that it was established for – to take
care of the poor; essentially, the work that no one else can or is willing to do. However, the hospital has always had funding trouble and a lack of resources which is why Isabelle had to be “creative” in her nursing practice and Esperanza was warned to stay away from this “dump.” Further, they acquired an even more unique identity with the merger by becoming an academic medical center that successfully treats the poor while still attempting to keep up with medical progress inherent to academia.

Community hospital’s marginal identity allowed for nursing practices that were unlike the hospital’s socially acceptable counterparts. In this marginal space of Metropolis, the common “white coat culture” of hierarchical roles in the hospital broke down to the extent that nurses were able to break the “professional” barrier and interact, even contradict, with doctors in new ways. Additionally, the realities of working in this marginal space, lack of resources, contributed to a different type of independent and creative nursing practice not found in other hospitals. The breakdown of medical norms intrigued nurses such as Esperanza while deterring other. I consider this breakdown as dis-ordered medicine.

The nurses understood that there is a way medicine is usually and possibly even should be practiced. They were aware that doctors are usually higher in the hierarchy than nurses and that nursing practice should have certain tools and physical surroundings that allow for a proper way of conducting their work. But Urban Hospital did not have the resources, ability or even will to create an environment of properly ordered medicine.
Rather a dis-ordered medicine is created and celebrated. Even while dis-ordered medicine is bound to the lack of resources that marks it as a marginal institution, dis-ordered medicine is what makes the institution successful in treating the marginal population of Metropolis. Dis-ordered medicine is not necessarily a bad form of medicine, though not acceptable by common medical standards, but rather a necessary and different form of practice.

What is clear in these portrayals of Urban Hospital’s place in the community is the inherent problem that the hospital poses: that there is inequality and need in Metropolis that is not only being ignored, but continuously replicated. One doctor that transferred to Urban Hospital as a surgical oncologist was described as having learned a “lesson in the health disparities that arise from poor people’s lack of access to timely care” because at Urban Hospital, just a mile away, he saw cancers twice the size of those at his previous workplace (Barnard, 2001). Rather than discussing this as an issue that any of the hospitals within a mile radius should take greater involvement with - it seems that we need a place to put the people that have disparities, and Urban Hospital is that place. There is a continuous tension between the dis-ordered medicine that is inherent in Urban Hospital’s mission and the importance of the medicine. This dis-ordered medicine and tension is part of what classifies Metropolis as a borderland. The hospital in itself is a marginal space in the society: even after a boost in resources and reputation it is “tainted” by the reputation of being a hospital for the poor. The reality of marginality in Metropolis

7 “Dis-ordered” can only be understood in relation to standardized practice models taken to represent “order.” In an environment like Urban Hospital, where such “order” is not always possible to implement, the alternative becomes, by contrast, a case of “dis-order,” deviating by necessity from the standard model. And yet, this very dis-order is characterized by creative improvisation and a capacity for flexibility and adaptiveness in the face of challenging circumstances.
is something that Urban Hospital must confront every day because it is a place where the marginal is at the focus.

**Specializing in the Marginal**

Khiara Bridges’, *Reproducing Race*, provides another study of city hospitals through her ethnographic investigation of pregnancy at Alpha Hospital in New York City. Her study revealed that Alpha hospital, and public hospitals in general, create racialized bodies through the welfare programs that were imposed on poor pregnant mothers due to their dependency on government money (often not-enough government money). Although I have no data from the prenatal care clinic at Urban Hospital her assessment of social class as a mediating factor in type of bodies that frequent the institution rings true at Urban Hospital (Bridges, 2011). While Bridges ultimately found issues of racialization inherent in the disempowering treatment of poor women’s “unruly” bodies, I found that the nurses in my study showed a profound understanding of general marginality and social class, essentially putting the blame of “marginality” on the society which has showed little respect for patients outside of the institution. That is – the programs that the labor and delivery nurses proudly portrayed as being those that were adapted for the particular marginal population with which they are concerned attempt to invert marginality so that the marginal become a targeted population.

Several specific programs stood out to the nurses that make the hospital so unique in the Metropolis healthcare industry and show the ways they have specialized in treating different forms of marginalization. These programs emerged out of the need to care for the marginalized population that no other hospital is marketed toward. Four nurses cited
the population of addicted mothers that they serve who are unable to get treatment in other institutions even in cities outside of Metropolis. Esperanza suggested that New England Hospital simply did not treat addicted mothers well, making them feel uncomfortable despite being known as a “better facility”:

Our addicts especially will say “they put me in a corner, they acted like I had germs or something as soon as they heard I was on methadone” so - and here we want to - whenever we think, and everybody thinks something about somebody, “oh she’s ten abortions” (...) But do we dislike her because of it? No. Are we gonna treat her differently? No. Are we gonna not be nice to her? Heavens no. And these patients - we want them to be honest so we can treat them better. ‘Cuz if you lie about your drugs then we’re not going to do the best we can for you, won’t be able to. So, they say “Oh I’ve used all of these bags of drugs” and they look at your face for the judgment and you just, keep your poker face and you keep moving. “Ok” and you write that down and moving on. And you want them to be able to feel comfortable being honest. So you can treat them. You know? (Esperanza)

Mary and Isabelle on the other hand note that, practically, mothers in recovery for opiate addiction can only be treated by certain providers and facilities that are licensed for these types of treatments which is why so many addicted mothers deliver at Urban Hospital from all over and outside the city. Even with this practical reason for coming to Urban Hospital, the program that it offers for addicted women is often the first time that they are respected. Often, addiction recovery patients, particularly mothers on methadone, experience prejudice and discrimination from friends, family, employers, healthcare works and others in their life. This stigma is often coupled with a lack of knowledge on the proper addiction recover treatment for pregnant women in healthcare providers (Earnshaw, Smith, & Copenhaver, 2013). The fact that mothers may be treated without stigma at this labor and delivery unit marks it unique among healthcare settings, making it a place where marginal identities are suspended. Even though Urban Hospital
is uniquely identified by this population and the nurses appreciate that this is the only place that addicted mothers may be welcome, Isabelle did discuss the hassle that these special patients caused on an already over-worked floor. Even with the compassion and appreciation of working for an institution that allows this stigmatized population to birth in a respectful environment, the patient that poses problems (not taking medication on time, not obeying medical advice) causes frustration for some nurses. As I was unable to do shadowing with the nurses, I did not gather data on how much this frustration shows in practice but it seems that with the frequency of interactions that Isabelle alluded to, that frustration was not uncommon on the floor in general.

Interestingly, Mary, a former doula who came to Urban Hospital within the last decade did acknowledge the possible racial disparities in the population that Urban Hospital serves thoughtfully as we discussed into her experiences. She said, “It’s interesting that white women usually don’t come to birth here except as heroin addicts (Mary). “

The racial tension that clearly pervades cities in the United States – shown in “racial geography” of hospitals who overwhelmingly serve minority women- becomes apparent in small realizations when nurses see a lack of white women in comparison to the vast other types of people that they serve. The diversity of patients that are seen at Urban Hospital does not translate into the diversity of Metropolis. That is, even though the diversity of Urban Hospital is partially a reflection of the hub of diverse populations that settle in this major city of New England, the people that are seen here are the poor and marginal within that diversity. It seems that that Mary and other nurses saw the city
and atmosphere of America in general, as well as the differing missions of various other hospitals in the city as the “sites of racialization” rather than seeing the racialization happening within the confines of their hospital. Therefore, the racial injustice that might be the reality of some patients, is the result of things outside of the hospital, and after people become marginalized, and then they are targeted by Urban Hospital. Which is how white women, which is assumed to be a population that has less chance of being marginalized, only finds themselves at Urban Hospital when they are ascribed a marginal status. The racialization may even be seen to be reversed at Urban Hospital where any poor and marginal person may receive appropriate care.

Agatha, one of two former nurse managers in my study, provided thoughtful answers that were engaging and deliberate, showing that she had thought of many of these issues in earnest before I discussed them with her. Agatha points out that the hospital’s marginality is actively and continuously recreated by the patient population and that the type of medicine that is practiced at Urban Hospital has to be different than at other hospitals. The most important mediator of the services that Urban Hospital is able to offer is the social class that patients inhabit, not necessarily their racial or ethnic identity:

So, our institution, obviously, is, has a mission of, you know, indigent care. And you know its “exceptional care without exception.” And it’s exactly that. Whoever comes to our doors, we provide care. And this isn’t disparaging to any other institution out there, but they don’t have that mission. So they’re able to take care of individuals who take care of themselves. Who are card carriers of their own health insurance, who, you know, are, you know, professionals and-and we take care of folks who don’t have their own health insurance although now under Obama care everyone has their- but it’s still free care, it’s just not... it’s channeled differently but it’s the same thing. and they come with a higher level of comorbidities. So there are sicker women, there are women with- with BMIs that
you wouldn’t see in other institutions because of their- their disparities. And so, we are challenged by a number of things-a number of variables that other institutions aren’t. Just by the-the women that come into our organization. (Agatha)

Unlike the structure of prenatal or labor and delivery care that Bridges suggests has come from the creation of a prenatal program by the welfare system (from an image of poor women put together by politicians, lawyers and epidemiologists) Agatha suggests that the programs in place at Urban Hospital are a function of the experience of treating women that other institutions are not focused on treating. Community Hospital was created in order to provide a place to care for the poor and through their experiences of the needs of the poor and knowledge of services that hospitals quite literally will not provide, Urban Hospital created programs that would benefit those specific challenges that come from their population. The poor and sick have changed Urban Hospital purely because the hospital has fulfilled a need in society to focus on their care rather than of those who “can take care of themselves.” What is fascinating is that the hospital itself is characterized by the patients who seek care at the institution, not only by their willingness to treat all people. Unlike historically when women would be turned away from other hospitals, Agatha acknowledges that women have the ability to go to other hospitals for care but that those hospitals do not actively take on the identity of the vulnerable patients they serve even though Urban Hospital does.

Clearly, the hospital specializes in treating the marginal of Metropolis. By targeting the marginal and creating services that treat the specific medical and social issues that marginal peoples tend to have, Urban Hospital is able to invert the structural
inequities inherent in American society. Urban Hospital seeks the patients that no other hospital would like to treat, treats them well, and enjoys them as patients. In fact, many nurses asserted that vulnerable patients were in fact the patient population that they most enjoyed working with.

**A Marginally Acceptable Patient… And Employee**

Although certain medical practices that evolved from specializing in marginal care were cited along with caring for mothers with addiction, the nurses portrayed that the ultimate reason that their patient population and institution were unique was because of the marginal identity that they continue to hold, as a whole, due to social circumstances in Metropolis. Interestingly, this marginality or vulnerability is what the nurses look for in a patient. This is also what nurses looked for in a workplace - a place for many different types of people that would not normally be found together – work together.

Margaret, an Irish Catholic nurse who grew up in the suburbs of Metropolis, called her work at Urban Hospital a “calling” because she was doing “God’s work.” To her, Urban Hospital felt like a Catholic institution. She explained that this was partially because it had a “catholic feel” and many of the patients and employees would attend the Catholic Church across the street throughout the day. However, she also emphasized that she only ever wanted to work with “this patient population.” One way we can consider Margaret and other nurse’s urge to care for the poor is through the lens of Gustavo Gutierrez’s notion of a “preferential option for the poor” which is taken from Liberation Theology. Gutierrez defines poverty by saying that
The poverty to which the option refers is material poverty. Material poverty means premature and unjust death. The poor person is someone who is treated as a non-person, someone who is considered insignificant from an economic, political and cultural point of view. The poor count as statistics; they are the nameless (Remembering the Poor: An Interview with Gustavo Gutierrez n.d.).”

This striking definition describes the target patient population of Urban Hospital – the insignificant patients in Metropolis. The idea of allowing the poor and marginalized populations a true opportunity to flourish in terms of healthcare was also made famous by Paul Farmer who used Gutierrez’s idea when he created Partners in Health. He acknowledges that disease and microbes have a preferential option for the poor – citing the higher burden of disease among lower socioeconomic classes which nurses are all too familiar with. However, medicine and practitioners often do not make a preferential option to treat the poor. Paul Farmer and Gutierrez call for society to understand and end poverty (“Dr. Paul Farmer,” n.d.). Margaret clearly associated the mission of Urban Hospital to the theology that she had learned through her religion.

I met Nadia on a crisp sunny August morning outside of Urban Hospital, just as she was getting off her night shift at Labor and Delivery. She had been working with Urban Hospital for less than a year and was ready to offer thoughtful comparisons between Urban Hospital and the others she had experienced. Nadia acknowledged patients who hold any number of vulnerable statuses were her preferred population

...the ones that actually need someone to support them ‘cause they don’t have anyone and need you to be nice to them ‘cause nobody’s nice to them. ‘cause of whatever they have going on, either they’re undocumented or they have mental health issues or they’re drug addicted or whatever (Nadia).
All of the nurses in my sample made similar remarks to Nadia’s desire to work with patients that needed them because of a “vulnerable” identity and willingness to rely on nurses for support. For Nadia, this vulnerability meant that patients did not have as much support as other patient populations:

...when I think of someone who is vulnerable they don’t have a lot of support, they don’t have a lot of physical or financial reserves. And they may have multiple issues going on for them that complicate their hospital stay (Nadia).

Interestingly, Nadia, the nurse in my sample who had been working with Urban Hospital for the least amount of time, was the only nurse who told a story of being recruited to work at Labor and Delivery rather than choosing this workplace over others.

Some nurses, however, not only enjoyed working with marginal patients because of their choice to care for the poor, but because the patients willingly accepted the nurses as caregivers. For Isabelle, the difference between Urban Hospital and others lies in the fact that at other institutions such as New England Hospital women might refuse to work with you:

You know, they never, in all my years that I worked here the patient never would say to me “I don’t want you taking care of me.” But it’s happen to me elsewhere. (Isabelle)

Isabelle acknowledged that patients who refuse care are often more affluent and more educated. Because other hospitals in Metropolis do not have the mission of delivering care to the poor and underserved, they are often portrayed as serving middle and upper-class women who are not the “best” patients to have. Nadia put it this way:

I mean, to be totally honest, I kind of prefer those {vulnerable} patients because they actually seem like they need your support and need you to be nice not that-not everyone would but like, someone say, for example, upper middle class whose
entitled and wanted their epidural yesterday, when they weren’t even in labor, they’re not my favorite patients. (Nadia)

The nurse’s preference of working with Urban Hospital’s particular patient population transfers to creating a work environment that is a more accepting, rewarding, and interesting place to work within. Some nurses took the stories of patient populations further by suggesting that the patients of other hospitals who do not present the multitude of problems that Urban Hospital’s patients do actually makes for a much more mechanical (and uninteresting) form of Labor and Delivery. Agatha echoed what another participant called a “baby factory” when discussing the type of Labor and Delivery that is done at other hospitals such as New England Hospital:

Where, you know, if you go to another institution, I’ve practiced as a labor and delivery nurse in other institutions, it’s pretty templated. It’s like every patient gets pretty much the same care, you do individualize it for the individual, of course, because everyone’s different but it’s pretty much the same type of care for that same patient population. (Agatha)

Agatha describes the way that the patient population not only makes for interesting patients that need the nurses to respect and care for them but, actually determines the type of care that the institution is able to put in place. As the patient population is not only vulnerable, but highly variable and diverse, the institution is unable to create a type of templated care that you might find among the other institutions that are “baby factories” in the area. Here, we see again that the dis-ordered medicine that challenges common medical practice is actually preferable to the nurses that choose to work at Urban Hospital.
The acceptance of diversity that creates this atmosphere of non-templated care extends, for some nurses, into an escape from discrimination. Not only does Urban Hospital pose as a unique and safe haven for stigmatized mothers such as the drug addicts I mentioned earlier but it acts as a welcoming work environment for employees based on its tolerance of patients and staff alike. In her story of coming to Urban Hospital, Esperanza established the attitudes surrounding the hospital in the 80s as previously noted but emphasized the importance of removing herself from an environment laden with racism that, in her opinion, was a result of the lack of diversity at PSH.

Well {PSH} in the 1980s, there was not a lot of diversity at all. Probably, maybe 6 black nurses two of us are here now. I know one who was in Pediatrics there, so I knew of 3, so the patients would sometimes give me their diet menu, the little kids would stare. I’d have green contact lenses and braids in my hair so they would stare at me. And I had been called the “N” word by one classmate who kind of had a dream with an “N” in it she said it in my presence intentionally at the school. And my patient, a guy from Texas, was on the phone” I’m here, my N-Gal is here taking care of me” and it was part of his conversation so I waited until he finished and I told him that wasn’t very nice that I wasn’t very comfortable with that and would he please refrain and he said “Oh sure” but I knew I could finish my shift and never have to see him again so… and the last straw was when my patient walked by, my Jewish patient, and the nurse said to me “aren’t Jewish people ugly?” And I thought to myself “well what is she saying about me?” ‘cuz the woman was just a normal woman walking by, and I said “well Mrs…. whatever her name was… isn’t ugly, that was my patient” and I just thought “Oh my gosh” that’s the way the atmosphere was in 1989 when I left {PSH} (Esperanza)

In fact, for Esperanza, this was the first time in which she encountered racial and ethnic diversity in the hospital staff:

E: … and there was a black nurse manager {at Community Hospital}. Which I had never seen ever.
R: When you came here?
E: When I came here. The floor I was on. And there were black nurses. Plural. And white nurses and black patients and white patients and it was just a mix. The
whole hospital. And the doctors were different ethnic groups. Black, White, Indian. Just different. And... that’s the difference here. ....

All of the nurses sought out a workplace where they could work with a population that would not normally be available to them. Either in caring for patients that held a vulnerable identity or in being allowed to practice without fear of discrimination, Urban Hospital’s marginality allowed nurses to practice in an environment that they found to be unique among the hospitals within the city and state. This was not only ascribed to the mission of the hospital or the services it provided but by the actual accumulation of marginal and diverse people.

**Urban Hospital as a dangerous place**

Urban Hospital was not always portrayed as a safe place because the vulnerable population is also perceived as being dangerous to the Urban Hospital staff. As I previously discussed, my conception of the mysterious nature of Labor and Delivery was partly created by the seemingly impenetrable unit complete with security measures and uniforms that made outsiders stand out. Everyone had designated roles: scrubs, white coats and name tags on staff; pregnant bellies, gowns, IV poles and tired partners with patients and no obvious place for an observing anthropologist to … observe. Beyond the uniformed roles, the unit was hidden beyond locked doors, half-opened glass windows and a maze of hallways and hidden staircases that even the nurses agreed were a bit confusing. One reason for this might be obvious to mothers and the general public, is the fear of what most hospitals call a “Code Pink” or Infant Abduction. In a report by the National Center for Missing & Exploited children (NCMEC) they acknowledge that
Infant Abduction from healthcare facilities is not a common crime, they acknowledge that this is a concern for “parents, maternal-child-care nurses, healthcare security and risk management administrators, law-enforcement officials and the NCMEC. In the United States, the incidence of infant abduction by nonfamily members is around 0-10 per year (in 2007 there were more than 4 million births in the United States) and from 1983 to 2008 the total number of infants abducted from a healthcare facility was 124 with 118 found at the time the report was published in 2009. Luckily, the odds of this devastating crime are obviously extremely small and have only decreased as the NCMEC has created security guidelines to “harden the target” within hospitals. While the guidelines outline a number of strategies for both protection of infants and recovery should an abduction be attempted (including drills, multi-disciplinary communication, and electronic security systems), the manual takes particular care to explain the reason why nurses are the “front line of defense in preventing abductions and documenting any incidents that occur” (NCMEC manual). They suggest that “given the nature” of their care, nurse’s close working relationships help to facilitate these policies as well as put the nurse in a “surrogate parent” relationship while the child is in the healthcare facility which places them in a key role for the prevention of abduction.

While my assumption had been that fear of a Code Pink was the reason for the increased security due to my training as a volunteer (when you learn the different public safety codes) and because of the emphasis on infant safety that I saw on the websites of nearby hospitals, these were not the reasons for increased security that the nurses
suggested. The Metropolis population itself has the reputation for being “dangerous” which is most obviously displayed in the changing visitor policy.

As Mary and I walked out of the cafeteria she asked me about my experience on L&D and I expressed my surprise at how difficult it was to gain access compared to the ward I had worked with on the West Coast. Mary quickly agreed and attributed it to a “security issue”. Apparently at NEH it is even more strict. She remembered just a few years ago, as a student, that they needed to sign in and out to get on the ward rather than just flash a badge. She went on to say that she believes that showing a photo ID to get onto the floor could create issues for immigrants that fear deportation which she believes might deter families from visiting. Security around L&D and Mother-Baby units seems to be a feature of Metropolis hospitals in general, marking one burden of the urban population that the medical community shares. Although I was unable to gauge whether the patients that go to Urban Hospital are seen as “more dangerous” than others the issue of violent visitors was an important conversation going on in the unit.

Coincidently, throughout my time with L&D the visitor policy was undergoing some changes. One thing that hastened this change was a violent incident on the floor where a family member was behaving inappropriately and security had to intervene. Part of the discussion around this incident was directed toward how to handle a situation where the behavior of a visitor escalates while a policy level change was also being instituted that would limit and screen visitors prior to labor by having mothers name the two people that are allowed to visit during prenatal care or intake. These visitors would then be identified and all other people would not be allowed onto the floor. Mary and
Agatha talked to me about this change and the visitor policy in general as a function of making the process of labor and delivery easier for nurses – creating a more streamlined process during the hospital stay. They both voiced their misgivings about this new policy however, believing that the policy would not work for the diverse patient population.

**M:** ... Actually one of the bumpy things is around the visitor policy-(...) it can be difficult sometimes when you have a lot of visitors coming in and out and (...) with the visitors who feel like their family members aren’t being well respected) and kind of lash out at the staff. Or you have the conflicts within the family and two family members will lash out at each other or whatever. But then there’s also cultures where like childbirth is this family event and you have lots of relatives there and – for patient safety we’re only supposed to have 3 people in the room at one time anyway and then – a couple of the conflicts were like “no we don’t want people switching in and out” and that’s hard for those families when they feel like, “But we are supposed to be having our family here and we’re not allowed to have family “

**R:** How do you work through those situations? Like explaining the visitor policy...

**M:** I haven’t had that [situation] but I’m just saying that I get the feel- I think it’s hard for some families because some of the cultures are like – there’s supposed to be lots of family there and what do you mean – I’ll explain- the patient safety, 3 at one time, is easier to explain because it’s kind of like, “look this is a small room, for patient safety we just want to make sure we can get to the bed”(...) so we’re trying to actually work out something with security (...) where there- where [you] have 3 people, you’re gonna get 3 ID bracelets and nobody else is going to be able to come up...

Agatha was similarly worried that the patient population would not respond well to this policy but actually suggested that this type of policy would work in other patient populations that are similar to the “affluent mothers” that I previously discussed. In her example, she suggests that having two or three designated support people during labor would be difficult because the families that come to Urban Hospital are not able to follow the significant birth plans that more affluent mothers might due to their vulnerable identities. Additionally, it seems that she suggests that the more affluent mothers would
more likely have support people that are able to take off work or childcare duties in order to dedicate the significant amount of time that is needed for labor support.

So, you know, you’ll have – you’ll have a nurse saying ok so, you know, “Nancy and John can be your support people” and then Nancy has to leave ‘cause she has to take care of her kids at home and so Susan will come in. And, you know, so it’s always two in a room but it’s very disjointed and that’s tough, in other places they have, you know, significant birth plans,(...) they probably had dinners with their support people to say “we’re giving you, you’re gonna be our support people.” And then they all come in together and they stay together because everyone kind of understands it. Here, it’s not that organized, do you know what I mean? So, so, things change constantly and it becomes more of a challenge.  

(Agatha)

From these nurse’s perspectives, two different realities of the patient population pose problems for a more stringent visitor policy during a woman’s labor and delivery: the fact that diverse people have diverse birth customs and expectations of who should be present at a birth as well as the practical realities of working with a low socioeconomic population pose problems. The realities of dis-ordered medicine in this hospital do not easily translate into policies that the hospital can enact, even when the dis-ordered medicine in itself becomes problematic. No matter the family’s situation at Urban Hospital, there is the possibility of “lashing out” which implies violent incidences like that which prompted the changes to the visitor policy due to interpersonal conflict – between nurse and patient/family or amongst family members. The sheer number of visitors then seems to only become a problem because of the hospital setting of labor and delivery – with small rooms and constant supervision which is made more difficult with more people in the room. By limiting visitors in the first place, nurses are taken out of the situation that may quickly heighten of asking someone to keep out of the way of medical
care. Unlike Agatha who worried about the practicality of expecting only two people to support the woman throughout labor, Mary worried simply that if, in the face of the realities of labor, if the designated visitor was not able to handle the situation, the mother would be left with no alternatives.

No matter how it is conceptualized, this change to the visitor policy was used as an example of the ways that the patient population affects the actual policy of the hospital. The change in the policy reflects the more unpleasant realities of this population – that they seem dangerous, could possibly act violent or inappropriate on the unit. This characteristic seems to be attributed to the dangerous understanding of Metropolis as a city center. In a 2010 article from the Metropolis newspaper, the Urban Hospital ER announced that they were creating a designated grieving area for homicide victim’s families. Urban Hospital cares for about half of Metropolis homicide victims, which shows that it is not the only hospital in the city that shares the burden of violence, but that it is a significant enough of an occurrence to necessitate a particular change to the hospital to treat those victims appropriately (Ryan, 2010). Obviously, however, there is an undercurrent of tension between hospital policy and patient population. The particular population that creates a more satisfying and safe work environment for employees also may disrupt the biomedical establishment if their behavior cannot be controlled.

**Pride**

Within a five mile radius of Urban Hospital are two world renowned hospitals ranked first and second by US News in a state that takes pride in its cutting edge medical institutions. Urban Hospital, at number 10, is not insulated from the competitive
atmosphere of medical progress. This is clear in the proud culture within the hospital even though it has an altogether distinctive approach to pride. One of the most elusive and important themes that I enjoyed finding was that despite Urban Hospital’s marginal status within the city, remarkably, affection and loyalty to the hospital itself is pervasive in many employees and community members. Even though Esperanza acknowledged that she had stayed away from the hospital for many years, in the end, the spirit of the hospital won her over. Beyond the urge to care for the marginal of Metropolis, Esperanza and other nurses carried a loyalty to Urban Hospital as an institution set apart from the others in the city.

In talking to one nurse outside of L&D casually about this loyalty, he described the immense pride he had to have been working for the hospital since the late 70s. He chose to work at Community Hospital because this hospital took care of the community; the people in the neighborhoods. The fact that no one has to worry about paying to get healthcare in the hospital is a point of pride for him and the staff at large and actually makes his nursing practice more humanistic. In the end, he said that this “pride” was one of the most important things about working at the hospital because “Let’s face it, this is {Metropolis}. There are choices. You can move around.” And people do move around, particularly to try out working at a “better” institution. But the people that stay do so because of the connection with the community, legacy, and tradition of community hospital. (Personal Communication).

In fact, one newspaper reporter wrote a series of articles in the late 1950’s discussing why Metropolis needed Community Hospital in response to discussions
around the decision to close the hospital and divert funding to other municipal projects began. In one article devoted to the Labor and Delivery facilities, Burns suggests that the 3000+ babies that were born at Community Hospital each year would have no other place to get the care they needed. At the time, many hospitals would not accept women who had had no prenatal care because of the many complications that the patient might present. Not only did Community Hospital accept every patient that came to the hospital, but they offered free prenatal services making this hospital literally the only place where poor pregnant women would get medical care in the area. Burns also emphasized the excellent care that mother and baby received citing the death rate as being lower than the national average for infants and the 90 applications received for only four vacant residency spots in the OB/GYN department which was affiliated with three major universities at the time. Finally, Burns addresses the unique diversity of patients by writing that “the babies are born to all races, colors, and creeds” and that nearly half of the babies were “colored” (Burns, 1958). Interestingly, although the importance of Community hospital to Metropolis is emphasized, the author describes the conditions as “antiquated”, using the descriptor similarly to the way, Isabelle, would use the word even though she encountered the hospital more than a decade later. These “antiquated” surroundings, however, are said to have been transformed into as good of a nursery and place to deliver as anywhere in the country and although the hospital was in dire need of updating (the nursery, new air conditioners, more lecture space etc.) the devotion of the staff made this a place where even hospital employees would choose to give birth over the better furnished hospitals in the area (Burns, 1958). More than half a century later and
under new administration, funding, and political atmospheres, and this dialogue of being a hospital that is devoted to the community is alive and well. The current L&D page on Urban Hospital’s website actually features a story of a hospital employee as well as other moms choosing to deliver at Urban Hospital because of the supportive and compassionate staff. The message changes however in this modern affirmation of the community values when the modern, clean and exceptional facilities are emphasized throughout the media, possibly redeeming the “antiquated” image of Community Hospital (Anonymous, 2013a).

One of the ways that nurses showed their loyalty by suggesting that it takes a special person to work at the hospital. Not everyone would have been capable of working at a hospital like Community Hospital that functioned in a certain element of chaos or with the patient population that teaches nurses to respect the poor. Isabelle said that, “there weren’t too many people who wanted to work at {Metropolis Community hospital}. And it took a special kind of person to deal with this.” In fact, it took a very short amount of time to weed out who was not that type of a person:

“In when you come here, you know in the first week or two that you’re here, that you’ll never be a nurse here. And that’s ok because not everybody can function in a chaos that we did. It was literally chaos(Isabelle).”

Even when Esperanza referenced the diversity as a part of the reason she loves working for Urban Hospital, she ultimately credited the hospital’s mission as the heart of her affection:
I would say, that the cultural diversity at this hospital is probably one of the best things about being here. And the other thing is the mission that we have, you know, to care for any and everyone no matter what their socioeconomic situation in life is, to still give them the best that we have to offer, and we do do that. And I’m very proud of the hospital for that. Yeah, that’s like a really good thing. I know our mission, and I’m very proud of our mission. And we succeed at that every day. (Esperanza)

Even Agatha echoed Isabelle’s idea that it takes special people to work at Urban Hospital and that these “special people” often do not leave, or would leave and come back (her, Isabelle, and Esperanza left for 2 years or less before returning to the hospital). She highlighted the longevity of employment at Urban Hospital which I had realized after talking to two nurses that had worked at the Hospital for over 40 years.

This employee satisfaction that they discussed seemed to counter the level of burnout that one would expect among a nursing population that has to constantly deal with a lack of resources and difficult patient population (coupled with a work environment that holds an unstable relationship in the city). Rather, the nurses that chose to work at Community and Urban Hospital, are proud of the mission and not only enjoy working with the marginal, but are actively trying to alleviate the health disparities that they experience amongst their patients. By being one of the special people that gives quality care to marginalized populations, understanding that marginalization is a product of society’s structure, and treating patients well the nurses recognize their work as going beyond medical L&D care.
Concluding Thoughts

Urban Hospital functions as an island within the city; a borderland that does not lie in between, but rather at the heart of the city, gathering all of the marginal – disregarded by society and medicine – into its institution. The reputation in the community vacillates between an ongoing appearance of being physically lacking – the sort of shabby sibling to private hospitals’ seemingly endless resources and luxurious appearances – and being a necessary institution that “picks up the slack” of the private institutions that continue to ignore major segments of the population. Whether or not the vast difference in facilities is actually a fair representation of the differences among hospitals, the reputation of Urban Hospital lingers despite ongoing renovations. The hospital struggles to redeem the historically poor reputation through their improvements in patient care and technology that resulted from the merger, pulling the hospital into the ranks of “modern” hospital that patients would choose to attend. But the ongoing mission of serving the marginal lies in tension with this call to modernity as marginality changes the services that the hospital can provide.

Urban Hospital continues its role as a borderland in Metropolis by confronting the parts of society that don’t fit in anywhere else. In order to do this, the nurses that work within the borderland must practice a dis-ordered medicine that is inherently different than at other institutions due to the constraints of physical resources and the types of conditions that must be treated in marginalized patients. By specializing in treating the marginal both in institutional programs and dis-ordered medicine nurses suggested that the hospital is able to recognize the impact of structural violence while suspending the
stigma that is associated with marginalization. The hospital borderland is a necessary institution in society where nurses enjoy a ‘fun’ and problematic work environment that they are proud of even as it presents danger to their well-being.

In many ways, Urban Hospital is defined by its geographic location - in a state with a uniquely well-funded and well executed public health system – in Metropolis, a city bursting with academic medical institutions, and in close proximity to the city’s poorest neighborhoods. However, the space of Urban Hospital is a borderland because of the proximity of different types of marginality in the same space and in the ways that the marginal are able to invert their identity in order to attain care. People that traverse spaces such as Urban Hospital or the hospitals that Mattingly discusses on the opposite side of the country are bound up in similar practices of traversing unstable spaces that cause confusion.

This borderland is created as a function of power differentials in the city – due to the realities of health disparities and a lack of attention to marginal populations by other institutions, marginal people in need of healthcare pervade Metropolis and the state in general. This borderland is constructed through historical relations and power differentials among the medical institutions of Metropolis which suggests that it is a well-defined social field where actors must play by very different rules. Wacquant describes Bourdieu’s notion of a social field: "A field consists of a set of objective, historical relations between positions anchored in certain forms of power…(Wacquant, 1992, p. 16)." While societal structures recreate systems of inequality and racism that are at the heart of health disparities, the healthcare system responded in creating a marginal place
where marginalized people may receive healthcare. Urban Hospital represents a particular way of doing medicine which does not play by the ‘rules’ of other hospital fields – rather, staff are able to bend and suspend traditional hospital rules in order to welcome marginalized peoples as employees and patients. While the public in general, and the staff in particular, is highly aware of the rules of private hospitals and the social structures that work against marginalized people, they neither abolish those rules nor adopt them completely.

The borderland is a field that attracts marginalized and “special” players. While not all nurses are able to play by these altered hospital rules, the nurses use the instability and dis-order of the field to their advantage in practicing their border work – helping women through their labor and delivery. In the next chapter I will attend to Labor and Delivery as a border practice and the ways that the labor and Delivery unit functions as a special place within the larger borderland of Urban Hospital.
CHAPTER 5: Loving Business and a Business that I Love

I think we really give love to the patients. It’s a surprising job, nursing. It’s like I told somebody: you love people you don’t know. You don’t know these people but your heart swells for them it breaks for them seriously, you cry you just… and so… it’s just because they’re a person and they’re hurting so those things come out. How can you - they’re skin color or culture block that? That would be sad for me, you know? How I would miss out. ...(Esperanza)

Once I was called into a birth (of a preemie) and after the baby was settled in the NICU the woman said to me “Can I still go to my dental appointment on Thursday?” And I realized that she must be on Healthy Start which is the health insurance that [the state] extends to everybody regardless of their immigration status. And so she must have been ineligible for health insurance because of her- you know- she was Salvadoran. …[Healthy Start] covers you until you are 60 days post-partum. So she wanted to know because the baby was born early was she gonna be penalized And lose her access for dental coverage And I just thought – what a thing to be carrying around in your head – and then the other thing that really got me irked is, the studies are a little inconclusive, but there’re some studies that show the association with dental infection or gum infection and premature labor and so if she had gotten good healthcare before she got pregnant she might have been able to carry that baby to term. “(Mary)

My original research question involved understanding “cultural competence” as it is used and understood by nurses on the floor of Labor and Delivery at Urban Hospital, which as I have demonstrated, serves a hyperdiverse population. As I described in Chapter 3 (Methods), it turned out that nurses did not necessarily want to discuss cultural competence on its own, but rather described their perceptions of difference and diversity through the context of their experiences of working at Urban Hospital. My previous chapter illustrates the discourses nurses used to conceptually construct Urban Hospital as a unique space in Metropolis. Urban Hospital is a borderland and social field within Metropolis; a marginal space that reflects the society of Metropolis, specifically the parts of society that other hospitals tend to ignore. As participant stories so far illustrate, Urban
Hospital is defined by the culturally diverse actors that work within it to provide and receive care. But, of course, borderlands are not simply places where people that ‘should not be together’ find themselves; it is a place where things are done to and by individuals. In this chapter, I will be addressing the specific work done by nurses in this borderland, specifically within Urban Hospital’s Labor and Delivery unit. In other words, this chapter focuses on the practices and cultures of birthing at Urban Hospital, as it was presented to me by the nurses who work there.

This focus on practice is essential to understand Urban Hospital’s Labor and Delivery unit as a borderland, as borderlands, “designate spaces defined by practices that bind people together who otherwise wouldn’t belong together (Mattingly 2010:20).” The practices within borderlands are what create them, because these are the things that bring people together in contested or unexpected ways. Border zones are actively cultivated, and birthing is a border activity.

I consider birth as a border activity partially to understand how birthing practices are changed when located within borderlands such as Urban Hospital. As I showed in the background chapter, the fact that most births in America occur in the hospital is a product of deliberate processes within our society. As I showed in the last chapter, the women that birth at Urban Hospital are overwhelmingly characterized as vulnerable and unique within hospital settings. This means that the marginalized patient must rely on and work with non-marginalized providers within the hospital in order to have a successful birth; an unlikely partnership. The essential liminality that is associated with childbirth – one person transitioning into two people – with the women in the process of being
transformed into her new role as a mother (Davis-Floyd, 2003) is complicated by this rare partnership. Most importantly, “reproduction also provides a terrain for imagining new cultural futures and transformations…(Ginsburg & Rapp, 1995, p. 2).” Childbirth is a transformative encounter with a hospital institution that allows patients and staff to imagine possible futures and attempt to change the way culture and society is reproduced. In a borderland characterized by dis-ordered medicine and marginality, birthing is a unique activity that requires all parties involved to rely on each other to successfully separate mother and child – even as they attempt to reproduce their own hope for the cultural future.

The borderland was co-created by L &D nurses through the birthing stories they told to me, in which structural forces mediating American birthing interacted with the patient’s circumstances and understandings of labor, and are responded to by and with the agency of individual nurses. The work of labor and delivery nursing is done with the shared goal of producing the healthy baby; but in nurses’ stories the babies are not the focus of the labor and delivery borderland, they are, perhaps, beside the point. Once the work is done (the laboring and delivering), the now separated (and transformed) baby and mother are moved to other spaces in the hospital. The borderland of Labor and Delivery is created within a marginal context, and exists only ephemerally for the temporary work of producing a baby.

Doing Labor

One of the privileges of working with Labor and Delivery nurses, rather than the “providers” (doctors or midwives) on the unit (which is where much birthing research is
focused) is that the nurses in my study were able to speak about a full spectrum of births. From the natural, joyous, ‘normal’ physiologic birth (Davis-Floyd, 2003; Jordan & Davis-Floyd, 1992) to the highly dramatic (even traumatic) high-risk birth – the nurses are able to provide a picture of the many different types of birth that happen at Urban Hospital. Nurses portrayed all birth at Urban Hospital as something that is different within the hospital, and that therefore changes the nature of, and need for, cultural competence and diversity practice. Many stories that I heard served to locate cultural competence within the Urban Hospital as a place that is unique, within a unique city, and in a unique historical time. However, even within this unique location the labor and delivery unit stands alone as a unique place because of the essential nature of labor.

One of the ways that the nurses described labor was by emphasizing the significant time that it is for a woman, and the unique way that nurses can interact with their L & D patients. As I highlighted above, Nadia suggests that it is a different “state” altogether:

_I feel like - that when a woman is in labor, that it's just a completely different state than any other time in your life and I dunno, I just try not to bring any judgment to the table and no matter what they have going on for them or what their background is, just give them the support that any woman would deserve in labor._(Nadia)

From Nadia’s point of view, when women are going through the “state” of labor, no matter who they are, they deserve support. In the context of Urban Hospital, where marginality is the common and unifying attribute amongst the population of patients, an L & D nurse may attempt to bring laboring women a level or type of support that they should receive by virtue of simply being in labor. This orientation towards patient care
was echoed by Esperanza’s similar notion of treating patients differently on the basis of them being Labor and Delivery patients, but described it as “loveliness;” specifically locating it as something that happens in the space of the labor and delivery floor, within Urban Hospital. As Esperanza and I were discussing the experience of working with a diverse patient population, she suggested that some people at Urban Hospital may still harbor racist tendencies but that they don’t show them externally. Although that is a disappointing reality she said that those tendencies were not ever shown on Labor and Delivery:

E: But I don’t see anything. I see loveliness towards the patients on this floor. It’s a kind of a loving business here. I don’t hear nasty things. I used to hear a few nasty things on Med Surge. When I first came here.  
R: So that’s kind of the culture of L&D too, to be a loving unit ...?  
E: It is. Yeah I think that’s what we’re about. I think I-we really give love to the patients. “(Esperanza)

The “business” that Esperanza’s floor does – working with laboring women and delivering babies – is one of love. Esperanza suggests that by the very nature of the work that is done on L&D, the “nastiness” in other parts of the hospital can be suspended or buffered because part of the work of labor and delivery is to give “loveliness” to their patients. The acknowledgement that the nurses give something more than medicine, in this case love, and share some sort of emotional connection to their patients further defines the nurse that works at Urban Hospital. In general, the nurses must be a “special person” to work in an environment of dis-ordered medicine. To work on L&D however, they must contribute to the special environment that is created due to the nature of labor. Both Nadia and Esperanza suggested that the nature of Labor and Delivery separates it not only from other hospital specialties – but from other times in a woman’s life. That is,
they are not only lovely toward their patients because they are marginal and deserve respect as I discussed in the previous chapter, but because they are women who are laboring.

**Doing American Labor**

Esperanza also discussed the Labor and Delivery unit specifically as the reason that she returned to Urban Hospital from a stint as an independent nurse practitioner. She articulated this return as being due to the dramatic nature of labor:

E: And [I] did that, worked as a N[urse] P[ractitioner] for about 4 years and realized that I was missing being here.
R: What did you miss?
E: I missed the drama. I missed the nurses, being a part of a group of nurses. Missed the alarms and the patients and the ups and downs.
R: ... So, what is the drama?
E: The Drama.... It’s life or death every day [here]. It’s... mom and her fetus. And heart rates that go down and the interventions that you have to do to bring it back up to normal. And when it’s not working you hit a button on the wall and ten people are in your room and everyone is doing something for that mom and baby. You know, not even words need to be spoken, everyone is doing something. Sometimes the final word is “open up the room we’re going to the back and then we have a crash C-Section. So it’s a lot of drama here. I mean in a single day you cry, you laugh... all the emotions.

Interestingly, none of the other nurses in my sample described Labor and Delivery as “dramatic:” which might reflect both a difference in personality and the difference in the perception of birth which is often pervasive in American society. The “dramatic” birth suggested here by one nurse, in which labor is a dangerous unpredictable state that can be controlled through biomedical intervention –and necessitates that birthing take place in a hospital, is only one model of birth currently available to American society.
Robbie Davis-Floyd asserts that in our society, “the spectrum of possible beliefs about pregnancy and birth is encompassed by two basic opposing models …– the technocratic and holistic models (Davis-Floyd, 2003, p. 193).” Davis-Floyd also mentions that a third model, of “natural” childbirth, is an attempt to merge the other two models. The technocratic model of birth is said to be a distillation of the major beliefs of American society, where the human body is a machine, and the female body is an imperfect version of this machine because it is inconsistent, more subject to “nature” and more likely to break down. Davis-Floyd adapted this model from Rothman’s (Rothman, 1982) earlier comparison of “medical” and “midwifery” models of birth. The use of “technocracy” over “medical” was adopted in order to highlight the management of all of society by technological experts. The resulting technocratic model of birth gives rise to ideas within the field of obstetrics that suggest or reinforce that the women’s body may ‘malfunction’ at any time.

While a medical specialty that can save women and babies should a complication arise is not seen, in this theoretical model, as problematic in and of itself – lives are saved – the inseparability of technology and birthing is where so-called technocratic birthing deviates from other models. What is respected and emphasized in this field is a reliance on machines so much so that an “assembly line” production of mothers and children in a hospital where the amount of technology directly correlates to its prestige which illustrates that the institution is the important social unit in birth. The marriage of birth and technology assumes or conveys to women that, to some degree, intervention is necessary in all births. As the baby is the end goal of this technocratic process, the perfect
baby is expected to result as the product, with a socialized mother as a secondary outcome.

In the holistic model of birth, birth reaffirms the unity of the family, the female body is normal, and birth is a safe and healthy function of this normal body. The mother and child are not in conflict – their mutual needs will be met without having to choose between the wants or needs of the mother (ex. “to have an empowering birth”) and the baby (ex. “to be born safely”). In general, Davis-Floyd characterizes this model as being more flexible and actively placing the needs of the mother and family unit above those of the institution, or social expectation (Davis-Floyd, 2003). From the 1960s through the 1980s, Davis-Floyd outlines the emergence of another model of birth which became important for many women: “natural” birth. This model of birth does not necessarily suggest a presence or absence of medical procedures, but rather the conscious participation of the mother in her birth and often also the father/partner.

As I discussed in Chapter 2’s short description of the history of an Anthropology of Birth, Robbie Davis-Floyd’s assertions about the prevailing models of birth available to American women is not whole-heartedly accepted by all sectors. She does qualify her research with the acknowledgement that her study was meant to be one of middle-class women in America (Davis-Floyd, 2003, p. 47). Although this makes her study sample one with an almost- opposite experience to that of women who birth at Urban Hospital, these birth models are pervasive throughout American society and were important to the nurses I interviewed, and to their patients, for a number of reasons. First, several of the nurses in my sample would be included in the sample of “middle class” women that
Davis-Floyd might suggest would be indoctrinated into, or choose to ascribe to, one of the models above. All of these models were well-known and alluded to by nurses in their discussions of what makes other hospitals “better” than Urban Hospital, and in their categorizations of the types of labor that they facilitate and see women experience at Urban Hospital.

Second, even though middle class women may be the exception rather than the norm in the patient population at Urban Hospital, that is not to say that poor women do not know of the different models of birth that they may experience, or do not feel the pressure of the hospital to learn and participate in American birthing models. In fact, the nurses discuss as one of their duties helping women understand the ways that birthing happens in the hospital. Ultimately, whether or not the patients themselves, or the hospital, consistently ascribe to these precise models of birth, an examination of them is helpful in understanding the wider context of birthing in the United States, which undoubtedly influences the ways that the work of labor and delivery plays out in Urban Hospital. As with many institutionalized ideals about behavior in medical settings, and perhaps even more so for women’s behavior, even in this marginal context, the norms of American society pervade.

One nurse, Esperanza, was thrilled by the ‘excitement’ that the technocratic model of birth creates in the labor and delivery room. From her narrative, one gets the image of a scene playing out from a televised birthing show or a birth scene in a movie, in which birth is distilled into a 1-minute sequence of uniformed technical medical personnel working on the mother and baby because the two lives hang in danger of the
mother’s ever-failing body. In reality, Esperanza and other nurses described many more and varied scenes of labor as a long process focused on the mother, and the ways in which ‘American Society’ in itself limits the ways that women can ‘do’ birth. That labor in itself was described much more frequently as “delivery,” the production of the baby, illustrates what a short part of the nurse’s time is spent with the patient and, how the culmination of the birth is a signal of the end of the nurses’ work.

However, the emotional side of labor and delivery which Esperanza highlighted seems to be pervasive throughout all the stories, whether in Mary showing her frustration over always “leaving in the middle of the story” as a nurse and not being able to stay with a woman throughout her entire labor, or the suggestion of fear and tragedy over babies that are born too soon, experience complications, or when there is some harm that the nurses perceive may come to their patients; whether by family members, doctors, or structural forces beyond their control. The amount of emotional investment that these women working on L & D showed toward their patients cannot be questioned.

While Esperanza portrayed her clear enjoyment of the drama of technocratic birth specifically in this quote, several of the stories she and other nurses shared convey an understanding of larger structural forces that have changed, and are changing, the ways American women birth. Many of these reflected nurses’ views on the technology that has changed over the last several decades, and which continues to shape the way women can be and are allowed to labor.

In describing Urban Hospital’s doula program, Mary went into detail about the role of a doula in American societies.
The doula role is kind of an invented role because in traditional societies women, a lot of traditional societies, women give birth in the company of other women so it’s either women you know from your village or family members and it’s- so they’re not strangers and so it kind of got invented partly because when birth got medicalized, the families got pushed out of the birthing room. And-and then women were also heavily drugged with Scopolamine so they weren’t really aware of what was happening. So we lost that knowledge of how to do labor support...because we got separated from our families who were giving birth and then also a lot of women that give birth in the medical center aren’t with their families because they’re immigrants so they might come from societies where that’s still practiced but then they come here and they’ve left their family support ... (Mary)

With this quote, Mary illustrates that technocratic birth as we know it in America is not the only way to give birth, but rather that it is the outcome of a particular historical process which has allowed us to create a model of “modern birth” that has evolved past “traditional birth” but which lost valuable knowledge in the process. That is, because of the historical and technological advancements such as moving delivery to hospitals, and offering or even imposing different forms of pain relief, “we” lost the benefit of knowing how to give labor support. To compensate for that loss of knowledge, Urban Hospital, certain sectors of the ‘natural’ birthing movement, and increasingly, and society at large, created doula programs where women can train to be labor attendants and support laboring women who may or may not be from their “family” or “village” through the process of pregnancy and/or birth.

But Mary also brings into her description an issue largely particular to Urban Hospital, within the setting of Metropolis. In Mary’s summary of doula care what is important is that many of the women that labor at Urban Hospital are immigrants from “traditional societies” (that may still have knowledge of ‘traditional’ family or
community-based labor support) but that these immigrants have left their prospective sources of labor support behind in their home country. Citing this modern challenge of migration, Mary suggests that this too is why the role of the doula is both important and yet artificial at Urban Hospital – again, a nearly unique response to a unique context and unique needs.

Margaret and Isabelle, as the two nurses that began their nursing careers at Community Hospital several decades ago, described the massive changes in L & D care that technology such as fetal monitors and even birthing tubs presented for them. For Margaret, the introduction of fetal monitors was profound because it became an “addiction” by creating “two patients.” Adding another layer of worry is whether the machines work correctly and the fact of monitoring the fetus’s readout (as a proxy for well-being) separately from the mother’s condition. Margaret did view this as a profoundly important change – that you could ‘know what was happening with the baby in case there was danger,’ yet she viewed it as a layer of authority and knowledge that profoundly changed the work of nurses on labor and delivery. The introduction of fetal monitors as the source of authoritative knowledge\(^8\) for L&D nurses and obstetrics in general illustrates the trend toward technocratic birth in American society as a whole(Davis-Floyd, 2003).

Technological changes, for nurses with more years of experience, illustrated the profound fluidity of the obstetric field in America. The nurses who gave testament to

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\(^8\) “Authoritative Knowledge” is the notion that within any given circumstance, many different types of knowledge are present but, often, there is one type of knowledge that is more legitimate. This authoritative knowledge marks all other systems as illegitimate and ignorant. Authoritative knowledge reflects power relationships and can be used to understand the current social order at work(Jordan, 1997).
these changes portrayed both the way that technology shapes American birth culture, and the way that nurses are able to give labor support and do their jobs as nurses. These L & D nurses knew that American ways of doing labor and delivery work are constantly evolving, out of particular historical time periods, that are characterized by technological developments and the evolving needs (and wants) of American women and other women who birth in America. That is, the idea of “American Childbirth” is not a fixed or easily contained idea, for several of the nurses, which in turn influenced their notion of “diversity” in birth practices.

Other nurses, rather than simply referencing the historical time periods, in which they have practiced, suggested that larger structural forces are responsible for the ways that women can labor in a hospital. Nadia in particular verbalized that, “for whatever reason, obstetrics is a male-dominated field” -- which she tied to the practice of having women deliver on their backs with legs spread, for the ease of the provider (a common though not “standard” practice in L&D). Nadia contrasts this with the way the midwives handle labor:

*And the midwives are great because they, I’m kind of on the same page as them, that they want the woman to be laboring in whatever position she’s gonna be comfortable and then the more different positions she labors in the more success she’s gonna have with her labor versus being tied to the monitors and the bed and just (...) the whole time. And is it easier to monitor the baby when the woman’s lying flat on her back? Yes. Is that a good position for her to labor in? No. And so if, you know, just through conversations with the woman if she wants to have natural childbirth it’s basically, you’re one on one with them. So you’re in there the whole time supporting them when they’re in active labor, helping them change positions and even if it means they’re difficult to monitor, being committed to their goal even if it’s difficult for me or hurts my back, you know, cause I have to be like under her belly holding the monitor on the whole time that she sways. It’s worth it! And they see, you know, that you care about their goals… (Nadia)*
For Nadia, the superior model of childbirth would be what Davis-Floyd characterized as “natural” childbirth – where women are in control of what is happening to their bodies and childbirth is allowed to progress free of unnecessary intervention. Delivering while lying down is obviously not optimal in Nadia’s opinion, but it is a continued practice because the comfort of the provider is more important than the benefit of the woman. Nadia clearly disregards technocratic birth as the optimal birthing model, as she verbally sides with midwives who allow women to labor in whatever position is necessary or comfortable. However, she shows that she does not completely disregard technological intervention, as women can opt to get an epidural as long as her other goals are honored. While Nadia showed a clear understanding that structural forces and institutionalized expectations are at work in promoting the technocratic model of birth, her ultimate concern is that power be placed in the hands of the woman who is doing the birthing, rather than left up to her providers. Interestingly, as a nurse, according to Nadia the power over what birthing model is utilized for any given patient is not necessarily up to her which was a theme among several of the other nurses. Nadia may not encourage intervention or lying down during delivery, but the provider is the person who ultimately makes this decision, while Nadia is able to assert some control over the situation by helping women achieve whatever labor they wish. I will return to the agency of nurses in changing birth outcomes, at the end of this chapter.

Structural changes that limit the ways women can labor at Urban Hospital, though suggestive of a vastly ‘American’ story of birth, are nonetheless forces that can work upon all women in labor. Along with the structural changes that have shaped the ways
women are able to, encouraged to, or believe they should, labor in America, the women and families themselves that come to Urban Hospital also change the ways that labor happens. As several of my participant said, “every woman labors differently.” Thus, every labor and birth may require a different set of skills, competencies, and different kind of nurse – another example of the broad diversity of L & D at Urban Hospital.

The topic of different types of labor was prevalent in my interviews on cultural competence and diversity with L & D, and other, nurses. These labors were boiled down to two distinctly different categories: American types of labor and foreign labor. Among the American ways of laboring, nurses described patients that occupy categories of affluence (as compared to poor women), different age ranges (young vs. old), and even “American diversity” (people that were born in and ascribe to American culture, specifically from Metropolis). As I began to discuss in previous chapters, the “affluent mother” became a common theme to identify the middle or upper class women that most of the nurses in my sample would not want to have as patients. For Nadia, this characterization meant that the ‘privileged’ mother would demand ‘her’ epidural whenever she pleased (rather than waiting for it to be indicated in the throes of labor, if appropriate). Isabelle detailed one ‘affluent mother’ story from her time working per diem in a different, suburban hospital for a more affluent population. Isabelle’s example of a patient that refused her care featured a professor from an infamous private university, with a (private, well-funded) birth plan. Isabelle predicted this mother’s labor and delivery would not go as planned, and actually ended the story in the operating room where the patient eventually ended up ‘needing’ a cesarean section. The control over
birth that Nadia suggested was important, in the previous quote, was in fact a source of contention for the nurses when the people that demand them are affluent. The affluent woman, an unexpectedly problematic patient, might be seen to represent a patient that is “other” to the patient you would find at Urban Hospital. The affluent woman also represents the types of women in Davis-Floyd’s study who have more flexibility of choice in their birthing practices. Even though this model of birth is what might be preferred for the “normal” patient by most providers and nurses in the nation, and therefore reflects an evolving dominant birth culture, the nurses in my study actively portrayed these patients as their least favorite.

Other categories of “American” patient groups include young age, exclusive of any association of coming from a particular ethnic or even neighborhood background; for example the “16 year olds” who nurses mention labor at Urban Hospital. Esperanza described this group as having a culture of their own:

“You could have the culture of our 16 year olds. Who are so strong. It’s the older women who want the epidural and the 16 year olds just go through it and have their babies. It’s amazing, they’re so strong. “(Esperanza)

According to the nurses, these 16 year olds labor differently than their older counterparts – despite their young age, they are able to handle the pains of labor more easily than their older counterparts. Any of the categories of American childbirth presented tie the behaviors and ways of laboring to the distinctly American identity of the patient. When the nurses discuss the “foreign patient,” many of them display an implicit understanding and acceptance of the characteristics of “American” types of labor inherent in the various
dominant theoretical models but, these behaviors are understood to be a product of patients’ culture(s), as I describe at length in the next section.

**Foreign Labor**

Although there were many examples mentioned of diverse labor within America, based on affluence, age, or even drug use and neighborhood affiliation, the idea of “foreign labor” to describe childbirth practices stemming from distinct religions or cultures created or adopted from outside of the United States was the focus of many nurses’ stories. The idea of “foreign labor” was illustrated through the description of several specific patient profiles.

One profile was that of the religious patient with particular beliefs which necessitate certain religious practices be done with the permission of the staff. This patient was sometimes the “Muslim patient”;

> So the, where people come from and their expectations of – is very diverse. So of course those countries all have their own birth customs so like a Muslim family ...I’ve now come to know that a male relative or if they, usually it’s done by a relative I think because they don’t have a chaplain nearby, but to-they whisper a prayer in the baby’s ear – the call to – the call to prayer that “God is Great” is supposed to be the first words that the baby hears so they whisper it in the baby’s ear. That’s the prayer that you say five times a day. And I’ve learned to know where East is because I had a family ask me once. Because he didn’t – I guess some of the prayer rugs now have compasses in them but one of the families didn’t have one so they asked me “Which direction is East?” because he was gonna pray at the like- at the regular set time. (Mary)

More often, nurses described patients with particular cultural beliefs that were a result of the country that they immigrated from, and/or the beliefs of their families. These patients were sometimes categorized by entire contents or regions of the world “Hispanic”, “African” and “Asian,” or described with particular countries or an ethnic specificity
such as “Brazilian,” “Nigerian,” “Haitian,” or “Chinese.” According to L & D nurses, all of these cultures either brought a certain amount of cultural baggage that create something that nurses must learn to do in addition to their “normal” labor duties (such as knowing which way is East), or create a very physical, bodily difference in the way that women experienced labor.

For example, Nadia explained that Brazilian women ask for cesarean sections and epidurals in almost the same ways as the affluent American women discussed above – unnecessarily and before/without being medically indicated. However, she describes this as a function of Brazilian culture where C-Sections are elective:

And Brazil has a really high C-Section rate because- and you can have elective C-Sections there. And when people come here they don’t understand that it’s not safe [sic]. And so, if you have someone being induced for labor, it doesn’t matter how many times you explain to them that this is a multi-day process and that this first medicine we’re giving you is just to thin and ripen your cervix, it’s not to start labor. Guaranteed by the second day, the family throws a fit and [says] ‘it isn’t working, should we do a C-Section?’ And then you explain to them, the interpreter, that she doesn’t need a C-Section, that this is fine, but they get themselves so convinced that she needs a C-Section that she does actually wind up with a C-Section. But three days down the road and she’s totally exhausted and so, knowing that that’s how it goes almost every single time that they walk in, not in labor, and say “Hi I want my epidural.” And you’re like “Ok you can have a seat.” ‘Cause you are clearly not in labor and you’re not gonna get an epidural if you’re not in labor! It’s helpful to know them ahead of time so that you can just bend over backwards to remind them that-that this is the deal. That, you know, this is how it’s gonna go. And if more people keep reminding them of the same thing, maybe they will have a better experience and won’t be totally, you know, disappointed. (Nadia)

Interestingly, Nadia discussed Latin American women in general very differently:

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9 The Cesarean Section rate in Brazil has been estimated at 50% in 2011 and is associated with affluence (Goldani et al., 2013).
So...99% of people from Latin America are incredibly stoic. They show up, usually about 10 centimeters dilated. They don’t say a peep and they may have a tiny bit of sweat on their brow and that’s your sign that that baby’s about to come. And if you—if they, you may see them just make a tiny grimace but they don’t scream, they don’t breath, they’re just tough as nails, and then if you say “Is the baby coming?” and they say “yes” you have to listen to them because it’s probably right there. And they just are amazing at having babies and I think that they’re from a culture where lots of babies are born at home and this is just what you do, you just — its part of life and you toughen up and you don’t scream and throw a fit. But I can tell with the—the residents who are new; it’s really interesting to be like “well look at her, she’s not in labor.” And I’m like, “She is a Hispanic multip. She’s totally in labor, you know, and she’s gonna deliver in the next 10 minutes.” And they’re like “you’re crazy she’s only 4 centimeters.” So I’m like, “Fine, I wouldn’t go too far.” And then, you know, and it’s not like I’m right and they’re wrong, it’s more just having that experience, that you have to watch them more closely because they’re really good at having babies really quickly. You know. Not every time but a huge percentage of the time, and so I feel like instead of it being chaotic and rushed, and the baby’s born in the toilet, if you know that, you can stay in the room and have a nice controlled birth.

Although these particular stories focus on one part of the world, Latin America, they illustrate some of the many ways that nurses categorize labor through both their ‘knowledge’ of the world and personal experiences. Nadia suggests that a “controlled birth” is preferable over one that is overly dramatic and chaotic. This fits within the “natural childbirth” paradigm. Because birth is a normal process of the body, we can know it and manage it in a calm way. Nadia alluded to a birth model that she had said was preferable before, but she also suggested this is complicated by the ways that birth happens with the (in her view) naturalistic, essential differences embodied within Brazilian or Hispanic women. Perhaps they will expect a cesarean section if that is their ‘culture,’ and that expectation will change the way labor progresses so that the Cesarean Section eventually is indicated, but not in the scenario of controlled decision making when patient and provider arrive at that decision at the same time.
In Hispanic women, Nadia sees them as “good” at birth, because of the way birth is conceptualized in their “home” (country). In this approach, since birthing is a “normal” thing and these populations may have been exposed to home births or received care from ‘traditional birth attendants’ in their countries of origin, the women’s physiological and emotional response to childbirth is seen as likely to be different from a U.S.-born woman’s. ‘These’ women are assumed to be able to withstand the pain and work of the birth without the “fuss” that an American woman might make. As a nurse, you must be prepared to see different indications of pain and progression.

In describing what “culture” is and how it is in childbirth, Esperanza similarly suggested that foreign women have different ways of expressing the pain and work involved in childbirth, but grouped these tendencies in with other “cultural practices.”

But then you see another person from that country and another person from their country want those same things. No they don’t want ice cubes in their ginger ale; they would want some tea after the birth. They want something warm; they don’t want the American way of an ice cold glass of Cola, that’s not what they want. They want something warm and soothing, they want tea, they want soup... they want the mother-in-law to sort of take care of them and dad goes and that’s ok. So you just see little things. They have their hair covered and that’s important to them, they prefer not to have males, they let it [out] all loose and get dramatic. (mimicking a woman moaning/wailing) “oo-oo-oo-wee” all over the room and just express themselves in their pain a certain way. But the same – same dialogue, same sounds, same clicking. Clicking of the tongue. Same words “Mezanme, Mezanme,” click click click click. Same culture. These are cultural things. I think it’s fabulous. And so, you can embrace this lady in this, this is who she is, this is what she wants to do. And you, then you might find the quiet, stoic Vietnamese patient who doesn’t say a word, she’s stoic [sic], she doesn’t really want anything for pain, or you might find one that does, where every person’s not the same. But no hooting and

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10 Haitian Creole
no hollering. Just quiet and then she’s fully dilated and gonna push her baby out. (Esperanza)

In describing different cultures, Esperanza too describes different expressions of pain such as noises or a lack thereof. It is well established that pain perceptions and behaviors are influenced by culture which implies that pain assessment is an aspect of culturally competent care (Callister, Khalaf, Semenic, Kartchner, & Vehvilainen-Julkunen, 2003). She also expresses her perceptions of the different needs that women have based on their ‘culture,’ such as different types of fluid or labor support. This idea of a “stoic” Vietnamese woman is an interesting comparison to that of a Hispanic woman that is quiet because she is “good” at birthing as in Nadia’s explanation of the Hispanic patient. Notions of “good” and “bad” birthers based on performances of pain and healthcare worker’s perceptions of labor progression have been found to be problematic. Attributing a patient’s behavior to their cultural identity as a good birther echoes old anthropological notions of primitive pelvises where “primitive” peoples are conceptualized as having a particular obstetrical hardiness (Bridges, 2011). I will problematize these ideas that tend to conflate cultural differences in labor progression with race later in the chapter.

Finally, several of the nurses like Mary brought up vast inter-ethnic/national-group differences with her examples of Nigerian patients:

And then sometimes (...) so that within a group you can’t assume that they’re homogenous. There’s certainly economic diversity so like the – Nigerian women who come to birth with us generally pay their own way and so they must be the crème de la crème because they seem to all have visas. They pay their own way they come here have their baby so their baby has a US passport and can go anywhere and get a head start in life and then they go home. Then there’s also socioeconomic diversity and that could be within a particular country too (...) I haven’t seen as much of that but there is some of that. (Mary)
Here, Mary quickly qualifies her statement of the socioeconomic diversity of foreign patients by saying she has not seen it as often, while acknowledging that it does exist.

Beyond illustrating their perceptions with examples of “foreign labor,” the nurses further acknowledged the existence of different ways of managing labor around the world. This not only encompasses the idea that women have different ways of embodying the pain of childbirth, but also that they may engage in certain ‘rituals’ or practices that are culture-bound or culturally transmitted to them. For example, Mary described a Somali patient that she found a squatting beside [the patient’s] bed after the epidural because “that’s how you have... babies: you squat” [in Somalia]. This particular patient, according to Mary, was eager to receive pain relief but expected to continue to actually birth her baby as she was accustomed to women doing in her home country. The nurses are highly aware that ways of birthing, along with pain-management or pain-response behaviors and other rituals surrounding birth, are highly variable among countries and cultures.

While some, like Nadia, are highly critical of some of the practices of American birth culture, other nurses simply acknowledged that other cultures handle labor differently. For the latter, the information about child birthing practices in women’s home countries are relevant in that the nurses see themselves as taking on the role of teaching patients how to ‘correctly’ birth in America, and appoint themselves to negotiate between typical American birthing structures and patients unfamiliar with them.
“Agency” nursing

Issues of cultural competence have become particularly important in the past decade[s] due to the overwhelming body of medical and social science literature on disparities in birth outcomes for different minority or disadvantaged populations. Because of my original focus on cultural competence in this study, I asked nurses whether they believed cultural competence was important in Urban Hospital birth outcomes, and how so. These nurses often suggested that improving women’s birthing experiences and communication were the primary things that would lead to better birth outcomes, through the use of cultural competence. I will focus more on what these understandings of cultural competence and diversity mean, to nurses, and in relation to theories and practices of cultural competence, in the next chapter. Here, I am specifically interested in presenting what their understandings of cultural competence and its relevance to their work suggest about the role Urban Hospital nurses play in managing labor, and their perceptions of the nature of labor and delivery itself.

Nadia explained that her cultural competence training allows her to build a relationship with the patient. This in turn allows the patient to rely on Nadia for labor support and causes the patient to take the nursing staff’s advice on how to handle labor:

I feel like with that [cultural] competency comes a level of mutual respect between you and the patient... they acknowledge that you’re trying to take their needs and their belief system into account versus just being like “well you’re in America and this is how we do it here.” So it improves your relationship with them and I find that once you have that... opens [a] door to them they’re a lot more likely to rely on you for labor support and if you make a suggestion they’re more likely to take your suggestion versus decline it. For example, like, position changes; they may want to lie flat on their back but if that isn’t working for the baby, or they’re in labor and they’re having lots of back [pain] for example, if I
just say “you need to turn on your side” and I don’t-haven’t really developed a relationship that is kind of engendering support, they might say, “No I’m fine like this.” They might not move. Whereas if I have that relationship, and say, and give them reasons why it would be good for them to move, then they’re a lot more likely to take my recommendation. Give it a try. So I think that... from...my experience as a nurse, we have tips and things that we know that can be helpful in managing labor, no matter what your culture is and I think that in itself can improve birth outcomes. So, I think that, that you can have a lower C-Section rate, you know, if you connect with the patient and you know, you can get them to change positions and what not. I think that it probably has a bigger impact on the patient experience as a whole more than birth outcomes. Just because they feel like they were listened to and supported and that you cared to ask. You know. Either what their belief system is or what they wanted or didn’t want. (Nadia)

Cultural competence, ideally, allows the nurse-patient or nurse-patient-family relationships to become more stable in order to complete the shared birthing work.

Nadia’s ideas about cultural competence allude to the fact that a woman’s birth experience is taken for granted as a measurable outcome, at Urban Hospital at least. Even though the woman’s goals should be respected, the outcome of birth of a healthy baby takes priority. Further, even though a vast amount of ‘foreign’ labors were described insofar as nurses discussed how women not born in the U.S. go into labor with ideas from home shaping and guiding their approaches to birth, within the cultural competence paradigm for improving birth outcomes, physiological differences in labor were not accounted for.

Nadia was certainly correct that nurses have a key role in birth outcomes on the floor. Individual L & D nurses generally have been found to have significant effects on birth outcomes, so much so that different nurses within the same department can have widely varying ranges of cesarean rates among their patients, even when controlling for complicated cases (Radin, Harmon, & Hanson, 1993). Edmonds and Jones’ study
(Edmonds & Jones, 2013) showed that nurses, who have an expert knowledge of labor, negotiate with physicians in order to “buy time” for patients to ultimately deliver vaginally. Within the hospital, such researchers acknowledge that medicalized (and technocratic) birth is the dominant model. In an ever-greater push toward efficiency, nurses use their communication skills, knowledge, and professional rapport to referee with physicians in order to give theirs patient a chance to have a better birth outcome.

Through suggesting options such as position changes, hydrotherapy, and by offering overall encouragement, nurses reassure the patient that a vaginal delivery is possible. This demonstrates the importance of a nurse-patient-physician decision making model in the context of nurse-managed labor (Edmonds and Jones 2013). Nurses at Urban Hospital create agency for their patients by supporting the patient and managing their relationship with the rest of the hospital (mainly providers and other physicians such as anesthesiologists or residents). Nadia showcased this relationship in the quote above but suggested that negotiation for better outcomes happens between patient and nurse as well as patient and physician or physician and nurse. Nadia exemplifies that nurses resist inequities in health systems and advocate for patients which she vocalizes within the framework of cultural competence, even if this advocacy is practiced regardless of culture.

In the case of Urban Hospital then, nurses must work to mediate between the dominant birth model, as well as their own priorities for labor, and, of course, the patients’ priorities and preferences. At one level, nurses claim there is something about labor that is innate. That position changes or other ‘tips’ are simply a part of doing the
‘work of labor,’ and that these tips work for all patients and help to improve birth outcomes. Possibly, since there is clearly diversity in the types of labor nurses witness and advocate for, managing these is not always about “cultural competence” as much as it is about being a savvy nurse that knows the work of labor, and understands how to “get the job done.” But that still begs the question of whether patient experiences are or are not birth outcomes in and of themselves? Or of whether patient experiences can be seen to change “real” (measurable) birth outcomes.

In fact, birth experiences are increasingly acknowledged as a large factor in birth outcomes, regardless of whether they are seen as a birth outcome in their own right. Women who report negative birth experiences have been shown to have higher [secondary] infertility rates, and more post-partum depression, to name just a few post-birth outcomes (Davis-Floyd, 2003; Gottvall & Waldenström, 2002). Given the importance that L & D nurses in my study placed on understanding and aiding in rituals associated with ‘foreign’ birthing practices, as well as allowing patients to labor in the ways they choose (to the extent possible), I argue that these nurses attempted to create better birthing experiences for their laboring patients, in order to achieve desired, better, birth outcomes for both mother and child.

Isabelle likewise held similar views to Nadia’s, though she was much more direct about them. Suggesting that educating the patient about American birthing is key, she proposed that certain cultural understandings are benign; giving the example that privileging a preference for “hot” or “cold” beverages for patients in the “Asian culture” does not seem to be harmful. On the other hand, if a patient’s culture was opposed to
something Isabelle views as critical or positive like breastfeeding, then in her view, the nurse has an important role to play in teaching the patient and her family the greater good that breastfeeding does for the health of the child. For nurses like Isabelle, the value of the ‘best’ care or practice outweighs the value of respecting cultural differences.

Isabelle most obviously reflects the ways in which L & D nurses at Urban Hospital ‘teach’ their patients how best to labor. However, as I explained above, L&D nurses also acknowledge that the ‘American’ model of birth is not the only, or even preferable, model of childbirth.

A single story from Nadia about, “a woman from Latin America who, she didn’t have a diagnosed mental health condition but she definitely had something going on” illuminates this point:

[S]he just was really reactionary when anyone would go in the room and seemed really angry and if you sort of asked her what she was angry about...she would give you this whole list of things going back to how ugly she is now compared to how she used to be and would show you pictures of what she used to look like. [She was] all over the map [with her] thoughts, no kind of focus, she couldn’t really stay focused on the conversation but a lot of it came out as... aggressive and angry, which is not common in that culture at all [sic]. And so, I felt like, I didn’t really have any warning; nobody told me that, you know, so I was like “whoa” ok. And I just took my energy down like 27 notches and was just like, “tell me what you need, you know, what is it that you’re looking for?” She’s basically like “where are all the women?” and I said “what women?” and she said “the women doctors.” I said “well I’m a woman” and she’s like “yeah, well you don’t count you’re the nurse, all the nurses are women. I want women doctors.” and I said “ok” She’s like, “I’m tired of all these men comin’ in here staring at me, you know, with my legs open” And I was like “great,” you know, and so I took that seriously, kind of explored, you know, it doesn’t really matter why she’s feeling that way, but, you know, just kind of, this is the hierarchy of this teaching hospital and are you trying to say that you don’t want any men in the room or you would just prefer women [?] We kind of got that sorted out and we were able to provide her with care only by women all night long until it was time for her to get an epidural. When she did, the attending [physician] for anesthesia had to come in the room and he came in with an attitude and she [the patient]
snapped and lost [her temper]. And he was yelling at her for no good reason and she just yelled back at him, which he, apparently had never had anyone do before and was very surprising to him and [I was] just trying to manage and advocate for her because she really didn’t do anything wrong while this doctor is yelling at her... [It] was a pretty challenging situation because she was inappropriate in her own way but he started it, you know, and I was appalled by his behavior and she is probably one of the people I would consider really vulnerable because she had no family support... she actually had friends and coworkers but she refused to let anyone come and visit her she almost wanted to be totally alone... [h]er husband came to visit her and she kicked him out and then was mad that he wasn’t there and it, you know, and so, she just- she really needed support from us. And whether she admitted it or not, you know, she did... I don’t know, I felt like... it’s easy to just go in and... do your job because you have so many patients all the time... With her I had to completely... put on the breaks... ok, this one is special. She needs like, really, special, individualized attention. (Nadia)

Nadia’s story here showcases her own ideals about birth, and the ways in which she negotiates with and advocates for patients, in order to manage their labors in ways that Nadia believes are best for them. First, this patient’s behavior was erratic and not what Nadia felt is normal for the patient’s “culture”. As a Latina, Nadia thought this patient should have a fairly simple birthing experience. Interestingly, in discussing what the patient wanted, Nadia learned that the patient did not understand all the dynamics of what even Nadia had previously called a “male-dominated” birthing system. As nurses are clearly in a different role, ranked lower in the hierarchy than physicians or midwives as providers, their presence in the room did not satisfy this patient’s need for women to care for her. When Nadia understood this predicament she took the opportunity to explain the structure of the hospital – that as a teaching hospital, there is a pecking order of medical professionals able to deliver certain types of care L & D care. By teaching the patient about the type of labor that would play out during the rest of her stay, Nadia was
able to negotiate with and for her a plan that allowed them both to focus on the ultimately successful labor work then at hand.

The story takes a turn with the entrance of the male anesthesiologist. In this heated moment in which the doctor treated a “really vulnerable” patient poorly, Nadia became a mediator and advocate for the patient who yelled back. Interestingly, even though Nadia lays fault with the anesthesiologist for starting the situation, the patient was also clearly “inappropriate” in Nadia’s view. The patient relied on nurses for labor support, as she was alone. As a result, Nadia perceived that she had to give a level of care beyond “just doing [her] job.” While Nadia did not suggest that this was an example of using cultural competence, attempting to see to her patient’s wishes of female mediated labor seem to fit into her model of attempting to understand patient’s cultural background. Nadia’s inherent understanding of structural faults in the American birthing culture complicate her perceptions of the importance and uses of cultural competence which I will continue to discuss in the next chapter.

When nurses are confronted with other types of laboring, whether it is that of the affluent American woman or a ‘foreign labor,’ they must work to ‘teach’ the patient and ‘manage’ the labor so that it can be successfully accomplished within Urban Hospital. This means that the L & D nurse must be cognizant of whatever model or expectation of childbirth the woman brings with her, which is reflected physiologically as well as through her communication and requests. The nurse then must manage between the patient’s requests, hospital policies, and trends among providers, in order to achieve the ‘appropriate’ birth outcomes expected by larger American society, Urban Hospital, and
the patient. This involves learning what the patient considers an appropriate birth model and in turn ‘educating’ her in the way one must labor in America, and at Urban Hospital. Alternatively, the nurse will learn the type of labor a patient is exhibiting is “Latina” labor, for example, and ‘manage’ it appropriately – by incorporating aspects that do not interfere with the nurses’ models for birthing, and by discouraging women from aspects that might. At the same time, whether or not technocratic, American labor is the “best” way to labor is beside the point once a woman enters Urban Hospital - nurses acknowledge that this context may not allow women to labor in the ways they would ideally like to. Once women are inducted into the Urban Hospital patient population, they learn to negotiate how to ‘properly’ labor within that space. Nurses function as cultural mediators, or ambassadors, using cultural competence not [only] to better understand patients’ needs and desires, but as a tool to help convince patients of how they ‘should’ labor.

However, even within this indoctrination into American birthing that L & D nurses attempt to participate in, through teaching patients how to correctly labor, nurses also make active attempts to create or allow some agency for patients. This is seen in in the negotiations between doctors and nurses, in which nurses advocate to give women time to experience normal physiologic labor without (or with only minimal) interventions, and thus a better chance to deliver vaginally(Edmonds & Jones, 2013). Nadia’s example further showed that some nurses go above and beyond this, however in that they actively stand in between the mistreatment of their patients by doctors, and the patient. Other nurses displayed similar advocacy for patients by interrupting doctors,
clarifying symptoms or treatment plans for their patients, advocating for patients’ goals, and giving general advice. All of these are considered to be acts of resistance which work against the hegemonic technocratic model of birth which a hospital inherently espouses, even while they teach the patient to labor within it.

In a discussion of nursing and migrant women’s maternity care in New Zealand, Ruth DeSouza suggests that the Western healthcare system was created for a predictable “ideal” user. “Other” mothers, in this case migrant mothers, cannot receive adequate care and nurses are forced to provide culturally sensitive or competent care that marks the patient as a bearer of difference. This difference requires the management of maternity so that normative motherhood is reproduced. In this analysis, nurse’s discourses of migrant mothers show the mother as an irresponsible figure that does not hold the necessary western ideals to be an appropriate mother. Nurses use disciplinary and normalizing techniques in order to liberate “other” mothers from their difference (DeSouza, 2013).

The nurses at Urban Hospital serve as a fascinating contrast to DeSouza’s study. The nurses do not try to normalize the mother into a western idealized model, but rather learn about their differences in order to advocate for their appropriate management. The descriptions of “foreign birth” or the birthing practices/beliefs of non-U.S.-born women show that Urban Hospital is clearly a hub of healthcare for immigrants to Metropolis; and that L & D nurses are very aware of this unique nature of the patient population. What is fascinating about the function served by Urban Hospital, however, is that it was, historically, one of the only institutions in the city specifically designed for a ‘un-ideal’ consumer of healthcare. I discussed in the last chapter how the marginal patient
population contributes to the perception of an environment where dis-ordered medicine is practiced. So, while nurses may attempt to normalize patients into the ideal of motherhood for which the maternal care system was created, in the New Zealand example above, Urban Hospital instead stands as a place that was and still is created and continually re-created to serve and reproduce marginal populations of Metropolis – serving “different” mothers is part of the identity and institutional culture of Urban Hospital.

Rather than using their training to normalize a woman who does not fit smoothly into anticipated models of birthing behavior, nurses focus on teaching the woman enough “tips” to get her through her labor in this American teaching hospital, but strive to also allow women to keep the cultural or “other” beliefs and behaviors that do not interfere with the work of labor and delivery, present in the process. Where DeSouza documented the nurses' understandings of “bad mothering” in relation to different forms of migrant maternity, the nurses in my study acknowledge that the ‘American way’ of labor is not the only or best option. They act on this belief in varied and multiple options by negotiating for the patient, and providing a space for women to labor in whatever way will continue to facilitate movement toward a positive birth outcome. The nurses in DeSouza’s study worked with their patients throughout their pregnancy and post-partum experiences. As my study is specifically focused on Labor and Delivery nurses, I believe the nature of Labor and Delivery nursing at Urban Hospital, by creating a brief and significant time period in which nurse and patient work with each other, allows nurses to
swiftly and on the spot negotiate between systems, ideals, and expectations of birth that influence the situation, without critiquing women as bearers of difference.

**“Primitive Pelvises”**

Interestingly, in conversations about crossing cultural divides stories about labor indicated differences in pain tolerance, indications of impending delivery, and speed of labor according to group characteristics. Some of these women’s preferences were seen by nurses as a product of their individual, national, or cultural socialization – e.g., wanting an epidural as an older woman or asking for a Cesarean section as a Brazilian. However, some of the differences observed by nurses seem simply to be a product of biology, being a ‘good birther.’ What seems to be an experiential knowledge of birthing differences, when attributed to a biological difference as opposed to a product of socialization, may allude to old anthropological theories of “primitive pelvises.”

The primitive pelvis and obstetrical hardiness are part of a longstanding tradition in which we consider some bodies in society to be more “primitive” than others. “Obstetrical Hardiness” is the belief that Black women are naturally impervious to the pains of childbirth due to their primal nature (Hoberman, 2005). This belief often extends to other socially disempowered women, such as the marginal population that would labor at Urban Hospital. The racial logic at work here is not consistent, as the “primitive woman” is often predisposed to certain types of diseases while still carrying a vitality that allows reproductive ease. While racial views of “different primitive” types of humans have been discredited, the beliefs and ideas about certain types of women have a gift for reproducing due to their race still endure (Bridges, 2011; Hoberman, 2005). Hoberman
argues that the racial folklore that persists, even as science proves that no biological differences of race account for difference in labor, is a result of the stories that physicians pass down to students (Hoberman, 2005).

The racial logic which has endured for black populations extends to other populations, especially in an atmosphere characterized by caring for the marginal and culturally diverse populations of a city such as Urban Hospital. Nurses are also not shielded from racial discourses among other healthcare professionals such as physicians. However, while other studies have shown that racial discourses among physicians may in fact be a contributor to health disparities in that the flawed racial logic causes physicians to treat some patients differently or just be disrespectful during a visit (Bridges, 2011; Hoberman, 2005), few consider nurses closely.

As I suggested in the previous chapter, the nurses had a profound awareness that the vulnerability which creates problematic births and poor birth outcomes is often socially produced. Even in the face of knowing that the Urban Hospital patients often are predisposed to experience poor birth outcomes because they are “sicker” than patients at other hospitals, nurses also acknowledged that these women’s labors are fundamentally, physically different than those of the “ideal” or “normal” American patient. To an extent, these cultural or foreign labors may be an example of culture replacing racial discourses. “Culture” especially in the discourse of “cultural competence” in healthcare often becomes a way to pathologize difference by essentializing cultural differences and pathologizing those differences that cause patients to become problematic to Western medical models of care. In other words, culture can be “just as racist as racism” (Bridges,
2011, p. 134; Lee & Farrell, 2006) when it is construed as unalterable and becomes a way to continue racial thought (Visweswaran, 1998).

Inconsistencies in the cultural and racial logic that nurses shared, such as in their problematic constructions of the “Latina patient” expose that “culture” has allowed us to essentialize certain groups of patients. What is fascinating, however, is that while sometimes the nurses suggested the presence of very physiological differences among and between laboring women, they also often understood this as a function of different systems of birthing that are not necessarily worse than the one(s) in place at Urban Hospital. In addition to the faulty racial logic and understandings of childbirth practices that the nurses use to understand the way women labor is the fundamental acknowledgement that all women at Urban Hospital are vulnerable due to their social status in Metropolis. While stories of working with vulnerable patients led to conversations about working against structures that create health disparities, similar acceptance of diverse labor practices led to an inconsistent reinforcement of cultural marginalization. Understandings of diversity in childbirth practices do lead to a particular advocacy for patients to deliver in ways that are best for the patient. Simultaneously however, they continue the unjust racial notions that certain groups of women are able to deliver better than others.

**Practicing Labor and Delivery in a Borderland**

Urban Hospital (and Community Hospital) is well known for its specific reputation of birthing a certain type of baby. I was told, in my informal interviews around the community, that people continued to call themselves “Community” babies,
referencing their birth in Metropolis Community Hospital. These “Community babies” often came from a long line of Community babies, and went on to birth their own babies at Community or Urban Hospital. Being a Community baby marks you as a specific person in the population of Metropolis.

Urban Hospital is a space that was created for and welcomes marginalized people. Marginalized citizens are born here and are forever marked by being a product of a borderland. Immigrants are drawn to Urban Hospital as one of many groups that are welcomed into the folds of their marginalized patient population, making this a place where marginalized Metropolis and American citizens are born. While childbirth is always a monumental moment, all births, birthing practices, mothers, and babies are not equally welcomed in society. Despite the stigma attached to the Urban Hospital patients, L & D nurses showed a profound respect for the nature of labor and delivery, and the varied forms it takes among these borderland patients. They portrayed this in stories they shared, and in their stated preference for this specialty and work-site, over any other [part of the] hospital they had worked in. However, they also understood that their own practice of birthing work was not typical.

The L & D nurses placed a particular emphasis on the specific work that was done in the unit as something which differentiated them from any other unit or practice of cultural competence within the borderland of Urban Hospital. This practice is, for them, shaped by structural and behavioral forces of American birthing culture, “foreign” birthing culture, patient behavior, and the internal ‘culture’ of nurses at Urban Hospital. No dominant way of birthing can be fully realized in this context. In this marginal space
where dis-ordered medicine is the norm, American birthing rituals are not done ‘properly’ and are often specifically resisted by both patients and nurses, in a bid for the psychosocial and physical well-being of the patients and babies. The instability of American birth rituals can thus allow the support of other, non-dominant types of birth rituals in the name of “cultural competence” as long as the nurse and patient can successfully negotiate doing less-than-technocratic birth safely enough to ensure a smooth delivery and good outcomes.

Very few of my conversations with nurses discussed the actual baby produced through the practices of L&D. Nurses emphasized the work that they did with mothers and families, and the ways that they negotiated a positive outcome. Once the baby is produced, the new couplet is stabilized and taken to a recovery room, with a new set of nurses who are ready to then transition the family out of the hospital. The negotiation of birthing activities, acceptance of ‘other’ birthing rituals, and resistance of dominant societal values by nurses is all done only within the time – frame of labor and delivery. The emphasis of this small but significant time period in maternal-care suggests that similar resistance may not be found in all hospital specialties and that this resistance does not change the marginal status of patients.

Considering birth as a border activity allows us to see the negotiations and a-typical birthing work as a product of the marginalized context in which actors who are inherently different work together to create a positive birth. In the previous chapter I suggested Urban Hospital is a unique social field among the hospitals in Metropolis. In
this field, nurses use altered hospital rules and general instability to suspend the stigma that is attached to the marginalized identities that Urban Hospital patients possess.

In describing understandings of their L&D work, nurses displayed the principles that regulate their social field and the ways that they negotiate within the boundaries that these principles create. Wacquant suggests that all fields have specific rules:

"...each field prescribes its particular values and possesses its own regulative principles. These principles delimit a socially structured space in which agents struggle, depending on the position they occupy in that space, either to change or to preserve its boundaries and form... a field is a patterned system of objective forces... which it imposes on all the objects and agents which enter in it."

(Wacquant 1992:17)

Within the borderland of Urban Hospital, which is defined by the social inequalities of Metropolis, the L&D unit is further created as a unique field that is additionally shaped by American birthing trends. Nurses occupy an interesting place in this field because they must negotiate with both the providers who are located at the top of the hospital hierarchy and the patient who is doing the laboring. While nurses act according to the rules of American hospital birthing through acts such as teaching women how they should labor within the hospital, they simultaneously struggle against the boundaries of L&D practice.

Nurses allow women to remain imperfect patients by acknowledging their “other” birthing practices that do not align with the rules of the birthing practices at Urban Hospital. By using their knowledge of both properly-ordered medical practice and the ‘culturally-competent’ understanding that birthing practices are malleable, nurses struggle against the boundaries of the social forces that shape their L&D field. Resistance against hegemonic birthing practices showcases a struggle with social structures that
nurses know work on their patients. However, nurses are still subject to the same social forces as their patients. That is, even while they show resistance and attempt to invert the outside social forces that stigmatize patients and force them to labor in certain ways, nurses still end up preserving the principles that regulate their field. This preservation is seen in the ways nurses continue to essentialize groups of women based on observations of labor practices that are attributed to “culture” and use this knowledge to teach or convince women to behave appropriately in the field.

This phenomenon shows the importance of understanding how nurses are especially suited players for the field of Urban Hospital L&D, in that they are willing to play a unique form of L&D and advocate for their patients. But this desire or ability to subvert dominant forms of medical practice does not protect nurses from also being forced to practice according to the structural forces that are imposed on them. In the next chapter I will consider specific discussions of diversity and cultural competence which will illuminate both the limitations of this language and the ways nurses learned to play in this chaotic social field.
CHAPTER 6: Culture and Diversity

“Celebrate diversity through cultural competency” (Miss America 2013, Nina Davuluri)

“Amercia’s a big melting pot” (Nadia)
“[America] is not a melting pot” (Isabelle)

It is well established that America is a diverse nation and Metropolis in particular is uniquely characterized by its hyperdiversity (Good et al., 2011). Hyperdiversity is not only a quality, but a situation that healthcare has had to adjust to. The emergence of health disparities literature along with a push for equal rights among minority populations spurred the development of a vast cultural competence literature that would address the problems that diversity poses to healthcare in the United States. In this chapter I revisit the theories of cultural competence and hyperdiversity that were the original focal point of my research question. Rather than argue for or against a specific type of cultural competency model or practice, my aim is to show how the L&D nurses constructed cultural competency and diversity.

The nurses of Labor and Delivery spoke of diversity as something that was inherently tied to the hospital identity and which was uniquely more prevalent in Urban Hospital compared to the others in the area. This diversity mediated their practice of L&D nursing. Conversations about diversity were excited and elaborate. Well before we touched upon the subject of cultural competence, the fact that people are so different from each other and the knowledge that must be used to mediate this during labor was emphasized. Comparatively, “cultural competence” was a subject that would be met with an exasperated sigh, long thoughtful pauses, and quizzical looks. Despite the distaste for
the word, every nurse created a theory of cultural competency and suggested different ways that it is useful within the hospital. These stories and theories illustrated the importance of experiences with patients and the knowledge of cultural systems, social situations, and patient worldviews that are not taught by nursing or medical schools and the hospital institution.

**We are more diverse**

Seth Hannah’s theory of hyperdiversity, which was developed from research within several of Metropolis’ psychiatric facilities, establishes that a “more complicated form of diversity exists that goes beyond a particular configuration of census based racial or ethnic categories (Hannah, 2011, p. 291).” With this theory, Hannah suggests that in cultural environments of hyperdiversity, cultural differences between groups become less salient than within group differences and that boundaries are often drawn from any number of distinctions beyond race or ethnicity (Hannah, 2011, p. 293). Working within this city-wide environment of hyperdiversity, the L&D nurses reflected this complicated understanding of diversity, especially privileging categorizations of patients through marginal identities rather than the “census pentad.”

When describing diversity, Esperanza, Margaret, Nadia, and Mary clearly understood the concept of hyperdiversity. They suggested an almost limitless amount of different categorizations of patients. I was often told to research the historical waves of immigration into Metropolis such as when Esperanza suggested that “now” (compared to when she started in 1989) not only are there “black, white, and Hispanic” patients but also patients from “everywhere” including those that “just got off the plane from
Morocco” or from “the Earthquake in Haiti”. And they emphasized that the diversity of Urban Hospital is institution-wide, that is, both patients and staff are diverse.

Nadia similarly defined several different types of diversity, however, rather than describing specific cultures or ethnicities she said that there is both cultural diversity and socioeconomic diversity. Her emphasis was that diversity did not imply foreign-ness. The cultural diversity could be from within different neighborhoods of Metropolis and generally, that what is “normal” in America wouldn’t work for everyone.

Isabelle and Agatha however offered different theories of diversity that did not just reflect specific categories, but a more general understanding of the context of diversity. Isabelle briefly scolded me for not “prepping” her for this question since there was “so much” involved in the answer. Her understanding of diversity was directly opposed to the American image of a “melting pot”.

*I like to look at it as everybody being who they are, coming with a different set of values and all coming together but not mixing. Just appreciating each other. And respecting each other’s values (Isabelle).*

Diversity was not so much a representation of certain populations as much as a way in which she viewed her relationship with patients and other people in general. Most importantly, she made sure I understood that diversity implied that people were not becoming homogenous but still working together.

Agatha provided one of the most profound definitions of diversity as she separated multicultural from “diversity”. She also located diversity not only as a condition inherent in serving many different types of people but as something that is also within people.
I think diverse is probably, “multicultural” is a piece and “diversity” is a piece but, the diverse care that I think we provide, it doesn’t have to be from a different culture, it’s because, the patients who present themselves come from such a myriad of backgrounds. Whether they’re indigent, whether they’re an illegal immigrant, whether they’re, you know a victim of violence. (...)So I think from a diversity standpoint we have those patients, that’s what it means to me, it’s a myriad of diagnoses or opportunities that present themselves to us. It’s not just one individual who comes with the same background as somebody else.

So, there’s different socioeconomics, they come with a whole host of- I don’t want to say baggage, but their lives are richer in a different way although they wouldn’t say its rich; there are certainly disparities that provide that diversity. It’s not that it—it’s the word diversity to me (...) is just that it’s many individuals with many issues present the diversity (...) Not that they’re coming from a certain area a cultural area, it’s just, diversity to me means that the patient presents with a whole host of a number of issues, here, than they would somewhere else. (...) So, again, the socioeconomics, the health disparities, the cultural piece, all of it, their background is the diversity.

At the end of this quote, Agatha created what seemed to be a pie chart with her hands on the wooden table – each of the pieces she named – socioeconomics, health disparities, and culture – was one “slice” of the chart. Agatha wanted to clearly extricate “culture” or group backgrounds from the idea of diversity. Rather, it was the idea that some patients come to Urban Hospital with fundamentally different lives that are “richer” than patients that frequent other hospitals. Diversity in this hospital is not simply identified with different categories of people or difference, but within patients. She ties this to health disparities – the idea that the differences and health outcomes are not random, but targeted toward some groups, the product of society. Going beyond inter-group differences, Agatha was very adamant that I understand that diversity at Urban Hospital was about the patients here that were different due to a whole host of life circumstances.

Agatha’s understands what many of the nurses struggled to succinctly convey in their descriptions of diversity at Urban Hospital. That is, that Urban Hospital does not
only represent the hyperdiversity of Metropolis – where common ethnic and racial categories are no longer useful – but that at Urban Hospital, the diversity was fundamentally different than diversity throughout the city.

The understanding of a diversity that is unique to Urban Hospital or that the patient population holds other qualities beyond diversity would suggest that cultural environment of hyperdiversity does not work in the same ways within a borderland. Borderlands do not necessarily suggest an environment of hyperdiversity. In fact, while they are often spaces of diversity, the contentious nature of many borderlands suggest that the inhabitants often occupy or hope to occupy specific categories (such as citizenship to one nation or another) which leads to clashes. The border crossing displayed in public hospital settings asserts the necessity of crossing particular borders in order to be treated, such as between two positions of power (doctor-patient). However, within the borderland of Urban Hospital, the “borders” that must be crossed in the L&D encounter are numerous and encompass an altogether different type of interaction than one where just “diversity” or multiple cultures are present.

As I discussed in the last chapter, when “other” types of patients are introduced into a technocratic system of labor which was created for a universal “ideal” patient the “other” patient presents problems for the system. That is, in a diverse or marginalized patient setting, nurses are unable to delivery “cookie cutter” labor. Not only do patients present a wide variety of needs based on the “foreign labor” models, but they are sicker than at other hospitals. Serving marginal and vulnerable patient populations means that they present more problems through their level of pathology and social instability. And,
in general, creates a situation in which the normal processes of medicine cannot be upheld, so that players within the system must strategically find ways to negotiate appropriate birth outcomes.

The different types of labor and birthing customs that I explored in the last chapter were just a portion of the “diversity” stories in which nurses attempted to show me how diversity was practiced on the floor. Within these diversity stories, nurses showed the different dimensions of diversity and how they attempted to reconcile all of the different types of difference that they were exposed to. They portrayed that Urban Hospital patients were different than any other patient population in Metropolis. But the patients themselves were different from each other because of the different types of labor they displayed and the characteristics associated with them. Within these conversations there was the distinction that labor is a different “state” of being than any other time of a person’s life, therefore there is something intrinsic in labor while at some level everyone labors differently.

Diversity was defined through labor and delivery practices as well as institutionally in order to illustrate the image of Urban Hospital as a whole. As an institution, the Urban Hospital patient population’s diversity is not only a product of changing immigration patterns and “multiculturalism.” Rather, Urban Hospital’s diversity is a product of its social justice mission to target all of the marginal in the Greater Metropolis area. Yes, they are hyperdiverse as is the rest of Metropolis, because treating patients becomes a task of understanding their individual identity: patients may be in a particular cultural group (e.g. “Latina”) as well as have specific pathology (e.g. obesity)
and social problems (e.g. incarcerated) that at any time in the labor and delivery process become the most important identity characteristic to which nurses must attend. However, Urban Hospital is more diverse, because the patients with multiple identities and problematic characteristics is the reason for the hospital’s existence. The diversity stems from the borderland identity, that the chaos of having a marginal population means that every person you interact with is an “other” patient and diverse.

**Cultural Competence**

Although this was intended to be an exploratory study and meditation on the concept of cultural competence, I found that it allowed my participants and me an opportunity to discuss a range of other understandings of their workplace and job role even as we theorized about what this theory is and could be. As my study was based on gathering the understandings and concerns of the nurses at Labor and Delivery, I did not provide any definition of cultural competence or decide on one working theory to critique. As such, I found that all of the nurses understood the idea of cultural competence differently, and some outright rejected it. What was common, however, was that the hyperdiverse situation that Urban Hospital works within necessitated that something be done. This something refers to the practices or values within the hospital that eclipse medicine. Medicine is not the only thing that happens when doing the work of Labor and Delivery. It was well understood that with this particular patient population the hospital needs services and the nurses needed understanding which would attest to different birthing systems, structural forces constraining people’s lives, and the ways in
which “standard” healthcare is ill suited for people with multiple language and ritual needs.

Isabelle provided a short and practical definition for cultural competence. Even though she no longer works directly with patients often, she suggested that diversity was at the heart of cultural competence:

*What it means to me is really trying your best to understand and work with aaalll\(^\text{11}\) the diversity that we have. And provide the best care that you can with the patient ... [with the] most comprehensive information you can get from the patient.... [to] get them on the path of wellness or at least get them taking care of themselves again. (Isabelle)*

When I pressed Isabelle to provide a definition for cultural competence, she first complicated the idea of diversity. Her particular emphasis on the inclusivity of “all” of the diversity serves as a reminder of the hyperdiverse patient population where “diverse” references a vast number of identities. From there, however we can see the ways in which cultural competence implies the breakdown of medical care. Isabelle qualifies “best care” to imply that the ‘best’ is dependent upon the limits of both the institutional context (Urban Hospital might be lacking certain resources that other hospitals may be able to deliver) and the information that the patient is willing or able to provide. The gathering of information from the patient is necessary in order to put them back on the path that they have fallen off of – wellness. In this quote we can see that in some ways, the patient and their diverse identity is a barrier to wellness and to themselves. The medical professional must gather information and provide care to put the patient back in a healthy situation and *convince* them to stay that way.

\(^{11}\) Isabelle’s emphasis
While Isabelle certainly was aware that the particular ways that healthcare is run in Metropolis and especially at Urban Hospital are not always optimal (or the only way to do L&D), her actual definition of cultural competence shows a particular understanding of power. This very practical form of cultural competence may be conceived of as enhancing patient compliance. That is, if a provider is culturally sensitive and attuned to the patient’s lifestyle and culture, then they are more likely to communicate with the patient, build trust, and enhance compliance with the prescribed treatment plan (Langer, 1999). While facilitating a way to create better health outcomes and “do the work”, this individualistic approach is sometimes critiqued as not attending to the power differentials in society which both define concepts such as “wellness” and prohibit an individual from staying on this “path” (DeSouza, 2013; Hester, 2012).

Agatha, who distinguished “multicultural” from “diverse” defined cultural competence in the most ambiguous terms of all the nurses:

*Well I think, just from a multicultural standpoint, is to just be aware of the cultures, the many cultures that we are not only here for but also work with and to be cognizant and-and to be respectful and to, you know, embrace them on a conscious level. (Agatha)*

Agatha suggests going beyond an awareness of culture to consciously embracing it. Interestingly, she does not mention patient care or the patients in general. In fact, she suggests that the “cultures” are both within the patients (the people we are “here for”) but also the people they “work with”, which could be staff or even community members or family – anyone with whom the hospital is affiliated. This differentiation is particularly interesting in light of the vast diversity in staff at Urban Hospital. Rather than suggesting
a practical use for cultural competence – facilitating patient care – the ambiguous nature of this definition implies that in “embracing” culture, the nurse and institution may be dealing with more than delivering medicine. As Agatha is currently working in an administrative role for the nursing department, the ambiguous nature of her definition might allude to the reality that cultural competence is not something that is defined institutionally.

Several of the nurses actually worked through the phrase “cultural competence” like Nadia did:

* I would say it means understanding that there’s differences throughout, you know, the different cultures, and that we need to take those into account when you’re caring for the patient and understand that, even though their belief system may be completely different from yours, and maybe they’re not in their own country, they’re here now, that you need to direct your care around what their experience is and their belief system is; and so being competent in that is to fully embrace that and understand that, even if it goes against your own, you know, values or morals. (Nadia)

Nadia suggests that there are discrete cultures that consist of belief systems and experiences that one must work “around” as a nurse. The understanding of cultures being tied to specific places and being transported within people is particularly useful in elaborating on the importance of the space of Urban Hospital in Chapter four. ‘Cultures’ and ‘belief’ systems that are not consistent with a nurse’s own culture are located in ‘other’ geographic locations, often outside of the country, and even after being relocated to the United States within a laboring woman, retain ties to their geographic origin. Even though Nadia’s definition of diversity specifically divorced foreign identity from diversity, suggesting that diversity is abundant in Metropolis citizens without including
immigration, her understanding of discrete ‘cultures’ when defining cultural competence specifically ties it to immigration. While Nadia does not fall into the much-critiqued trap of cultural competence that defines the ‘other’ as having culture while the health professional does not, she does distinguish ‘cultures’ that must be recognized. The danger in identifying cultures as “things” which one can work ‘around’ alludes to the oversimplification of culture that often accompanies ideas of cultural competence. This oversimplification leads to the illusion that cultures are fixed entities rather than fluid and ever-shifting (Drevdahl et al., 2008, p. 21). While Nadia’s understanding of cultural competence ascribes a problematic rigidity to ‘different cultures’, she expresses more of a willingness to alter her own practice of nursing than when she suggested the utility of the concept in establishing trust with laboring patients in the last chapter. Attempting to define ‘cultural competence’ illuminates inconsistencies in conceptions of diversity and labor practice within the phrase itself.

Finally, Mary outright rejected the idea of cultural competence altogether:

Well I like the concept of cultural humility rather than cultural competence, because I sort of feel like, especially at [Urban Hospital]. where our patients come from so many places--if you like, worked somewhere where the population was, you know Irish and Mexican, it would be easier to say, “OK, we’ll learn a bunch about Mexican culture. And a lot of times people will follow each other; like all maybe the Mexican’s come from similar places, you know; or all the Mexicans come from (place name - Oaxaca). But we have women come from so many different places at [Urban Hospital] that it’s even hard to get to know the kind of broad range of what childbirth might look in Haiti, never mind where different women are at; we might get a well off woman from Haiti versus a woman from a shanty town in Haiti, and they might have very different expectations.

So, I sort of feel like it’s more, kind of expecting that (there’ll be different) expectations and kind of trying to make as much room for that as possible, asking questions, trying to ask a question in a way that the patient understands ... we have some flexibility to a point. And also teaching, too ... saying, “No, it’s really
Mary again begins by explaining the importance of understanding that diversity at Urban Hospital is more complex than at many other institutions. The idea of being competent in culture, then, is facilitated by the space and type of diversity within which one is working. At another hospital that has a homogenous population or particular diversity with more discrete groups of people, a competence in specific culture could be possible.

However, as a nurse at Urban Hospital, she subscribes to “cultural humility.” Rather than attempting, then, to know what any particular expectation is for a culture, she suggests an acceptance of different expectations. Practically, teaching and facilitating patient conversation allows Mary to negotiate the expectations of difference that one must have when working within hyperdiversity. She also specifically addressed the idea that medicine is a culture. While other nurses did suggest the flexibility, such as in negotiating labor practices, Mary specifically identifying this as a culture suggests the understanding of hospital practices as socially negotiated.

Nadia showed agreement with Mary’s statement that the place in which one works changes the form and need for cultural competence:

*Well, I think it depends on where you work, you know, there’s a lot of places where it doesn’t really matter ‘cause there’s no cultural or ethnic diversity at all, you know, and you’re of the same culture and belief system as all your patients and so you don’t really necessarily need to have that conversation. But, America’s a big melting pot, especially in the big cities, you’re gonna have a diverse patient population and I think that its critical because you can’t, you know, just do cookie cutter mold for every patient ‘cause every patient and every labor is different. So, I think, really, it’s important.* (Nadia)
Nadia’s quote shows an inherent paradox in theories of cultural competence as well as the thought process I witnessed several of my participants go through. As the nurses attempt to define this theory, they suggest that it is vastly important in institution such as Urban Hospital because they see a wide range of difference in their practice all the time. There is an understanding that Urban Hospital’s amount of diversity (along with its marginality) is unique among hospitals. Therefore, there are hospitals were cultural competence may be unnecessary. However, she then invokes the image of America’s diversity as a whole, understanding that diverse cultures exist throughout the country. Then, she goes back to the discussion of labor. Every patient is different, and every labor is different. This thought pattern, from the uniqueness of Urban Hospital’s diversity to the acknowledgement that all labor is unique, and “cookie cutter” L&D is impossible is exemplary of a common paradox. By understanding cultural competence as only necessary in the face of great difference, we suggest that other places are “normal” and do not need to have any special understanding of culture, because cookie cutter mold is possible (everyone wants the same thing). However, when it is individualized, that every patient labors differently, this suggests that discrete cultures are not the problem. It’s not that we have too many “cultures” but that labor is always something that must be negotiated. Both labor and diversity problematize how or when one employs cultural competence.

*Learning Cultural Competence*
As I discussed previously, there are many different ways in which it is suggested that one should learn cultural competence, from immersion programs that expose students to different cultures (Bohman & Borglin, 2013; Kelleher, 2013; Maltby & Abrams, 2009; Stanley, 2013) to various structured models such as certifications in transcultural nursing (DeSantis, 1994; Leininger, 2002), to name a few.

The L&D nurses were constantly and consistently vocal about the lack of formal cultural competence training from Urban Hospital, but they often suggested that working within the hospital was the basis for their understanding. Several of the nurses cited informal sessions about culture throughout their time at Urban Hospital, such as OB grand rounds, where they discuss cultural or religious beliefs about OB practices. Isabelle also mentioned a hospital-wide cultural awareness week where employees are encouraged to bring items from their culture including music, food, and items that can be “displayed.” This multicultural week is sponsored by the Urban Hospital administration. One of the directors of the event described its purpose by saying, “[Urban Hospital] has a diverse patient and employee population that we wanted to celebrate and highlight through music, art, food and entertainment. The goal was to educate one another about the unique cultural backgrounds that we all have” (personal communication).

These informal discussions of culture sponsored by the Urban Hospital administration provide educational moments where nurses can learn about “culture” and the specific cultural beliefs and practices of different people within the hospital. While the nurses do not cite this as cultural competence training, they suggest that these
opportunities contribute to their understanding of culture and ways to think about and manage diversity.

Mary and Margaret also cited these types of informal conversations as imperative to their understandings of diversity in birthing practices. Mary learned the ritual of a Muslim family whispering a prayer in the baby’s ear through a Muslim chaplain in a different hospital. Margaret articulated that as the nursing staff experienced different waves of immigrants, the staff would discuss the different beliefs and practices and how to manage them (such as female circumcision). These events, either discussions or presentations among staff, or hospital wide events celebrating diversity, show that the employees acknowledge diversity consciously in their practice. As staff is confronted with different beliefs or practices that they must work through professionally, the staff will attend to the new practices that they are encountering.

Training in cultural competency through these discussions emphasizes acknowledgement of specific beliefs and practices that nurses should know in order to work with the patient. Without a specific training or underlying model, I heard of when Margaret learned about “hot and cold” or when Isabelle discussed how Muslim patients feel about assisted reproductive technology and abortion. While these are all “cultural practices,” learning about different cultural practices was not part of the definitions of cultural competency articulated above. In fact, much scholarship in cultural competence is highly critical of a model of cultural competency that boils down cultures to discrete sets of beliefs and practices. The ways in which nurses discussed working with diversity
were much more nuanced than the specific practices that they said they had learned from the hospital when they were trained about culture.

Agatha provided a slightly different understanding of training and cultural competence and did not cite the informal cultural competency training in OB rounds or conversations between employees. However, even as she acknowledged not really knowing of a specific formal cultural competency training for the staff, Agatha did highlight that during initial training for hospital employees, they receive information on the culture of the hospital itself:

You know, a cultural competence is probably, we here, at [Urban Hospital] run classes for staff on cultural - it’s not necessarily a competency, we run an internal cultural competency, which is kind of like your organization’s culture….It doesn’t get specific, really, really specific into the true cultures that we care for, it’s more of the organization, working in a multicultural organization. (Agatha)

Agatha’s distinction between the cultures that are cared for and the culture of a multicultural organization emphasizes the way that Urban Hospital as an organization holds a unique identity. This training, rather than teaching specific practices that the nurses had discussed as improving their understanding of certain patient populations, teaches the nurses about what Urban Hospital’s beliefs and values are. While many borderlands are ambiguous spaces, the borderland of Urban Hospital is a defined organization. Much of Urban Hospital is defined by what lies beyond its property line; it

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12 It is also worth noting that there is a tension in what “the hospital” means when referenced by any given nurse. For Agatha, it might mean the whole institution what it means as a place and its function in society. For the other L&D nurses, when they reference “the hospital” they were discussing it bureaucratically - the hospital as an entity that makes policies about food, or that creates or administers training programs. When the nurses defined “Urban Hospital” in general and how it was unique in the community, it reflected the identity of the institution and everyone affiliated with it and the ways it was socially produced. Whether “the hospital” represents the administration in charge of policies and programs or its social representation, it is clear that Urban Hospital’s culture is defined in both ways.
is changed by its surroundings and relation to the city and other hospitals. And there is a clear story of Urban Hospital being defined by its patients who are “out” in the community and even the world creating the institution from across the globe in the form of immigrants and refugees and potential American citizens. However, as ambiguous as Urban Hospital may seem in how it is a place that gathers the marginal people in its reach, it is a defined space with a mission and administrative team teaching employees about what the hospital is. The borderland is not necessarily carried around in the people and places that Urban Hospital is affiliated with, but it is in fact the place where they come to be together and do healing practices. As representatives of Urban Hospital, the nurses must understand the “culture” that is tied to this specific place in the community and how working at this institution is unlike others. However, even in acknowledging that the institution has its own culture which nurses must become competent in (and accept as they become inducted into it), the culture is “multicultural”. If nurses must learn the culture of Urban Hospital and that culture is one in which you must work within multiculturalism, becoming a competent nurse inherently carries a notion of being able to successfully work with many cultures rather than any specific discrete culture.

These two examples of cultural competency training--informal practical discussions and learning the culture of the organization--are lacking when compared to the formal training that Nadia received at a local community hospital in New England. This cultural competency training featured a message from the administration explaining that they expected the nurses to ‘keep up their image’ of catering to the roughly 22 different languages and cultures in their patient population. Along with the vocalization
of expectations related to diversity and patient care, this training included specific tools such as working with interpreters and doulas. Nadia also experienced immersion cultural competence training through a program where she did nursing work abroad. This cultural competency training consisted of specific education on the culture of the people she would be working with, including the types of language she should use and customs she should be aware of.

**Language Services**

The lack of explicit training on working with the patient population at Urban Hospital was troubling for Nadia when she observed a misuse of interpreters. This observation was interesting in light of Urban Hospital’s public literature that promotes interpreter services:

[Urban Hospital] values its diverse patient population and is committed to honoring their ethnic, religious and cultural differences. The Interpreter Services Department at [Urban Hospital] is one of the most extensive in New England. In addition to providing face-to-face interpreters on-site in 21 spoken languages, American Sign Language and Certified Deaf Interpreting, the department utilizes the latest advances in technology such as telephonic and video interpreting, in order to provide 24 hours a day/365 days a year Interpreting services to our patients. As part of the Health Care Team, our interpreters help to break language barriers as well as serve as cultural brokers to patients and staff (Anonymous, 2013c).

While Nadia appreciated the presence of interpreters themselves, she observed that staff did not know the proper way to interact with them. In her own training, she learned that as a staff member, one should speak to the patient. Then, the interpreter can translate exactly what you said to the patient and a true conversation can happen between patient
and staff. Rather, she saw many employees talk to the interpreter saying “tell her….” She emphasized that this was problematic because the interpreter is not delivering an exact translation to the patient.

The hospital literature reflects a growing acknowledgement in the United States that diverse clinical environments require an investment in interpreter services. However, investment in these services often results in a paradoxical situation: substantial resources are used to train, hire, and employ professional medical interpreters who are educated on how to work with clinicians and medical staff. However, the parallel training of clinicians (on how to conduct a clinical interaction with interpreters) is not required, even though this would in fact help the clinical encounter run more smoothly (Good et al., 2011, p. 89).

While Nadia saw this misuse of interpreters as a failing of the institution’s training program, Isabelle saw inherent difficulties in the very idea of using interpreters. While she acknowledged the need to overcome language barriers with patients, she expressed a profound mistrust in them. This mistrust stemmed from the fact that “you don’t know what the interpreter’s saying to the patient” and similarly, she didn’t know if the interpreter was translating what the patient really said. She also suggested that rather than being cultural brokers, the presence of the interpreter might be a cultural barrier for the patient to share complete information. In some cultures, having a male interpreter for a female patient might cause her to hold back some information “especially in a field like OB and GYN” (Isabelle). So even though Isabelle hopes and assumes that the information she is getting from the interpreter is correct, she assumes there is some information loss in the interaction.
Several of the interviews ended with a conversation about what the nurses needed or wanted as far as knowledge or resources in order to help them work within the hyperdiversity of Urban Hospital. These requests most often revolved around the necessity of language resources. The issue of language barriers for different patients may even be seen written upon the walls of the hospital, on signs that are written in two if not three or four different languages. While the hospital represented the interpreter services as cultural brokers and serving patients’ language and cultural needs, nurses’ representations of their misuse and inefficiency highlight the ways that culture and language, though not inseparable, function differently on the labor and delivery floor. While language is a source of difficulty and a barrier to information and proper patient care – culture is something that the nurses understand changes the practice of L&D itself. Cultural “things” and learning to work within an environment where different beliefs are held is a skill that facilitates a better birth experience and outcome for patients.

**Other Forms of Learning**

Experiential learning was one of the most important sources that lead to theories of cultural competence for the nurses who never received formal training in cultural competence. Often this came from actually working within diverse patient and employee populations which Isabelle characterized as a “good education.” Patients would teach her words in their own language, or talk about the reason behind certain customs such as drinking hot and cold beverages. Acknowledging patients as a source for culture and language knowledge is reminiscent of Kleinman’s explanatory models (A Kleinman et al., 1978). The nurses learn how the patients view L&D and the different rituals or
behaviors that need to take place. This information is then used to help the patient have a positive birth experience by facilitating whatever is needed to accommodate the patient’s model of birth. However, rather than simply viewing this as an individual transaction between this patient’s explanatory model and their own, the nurses view this as a source of information that can be used to help understand other patients with similar cultural characteristics.

Other sources of information on culture include the diverse staff at Urban Hospital. Isabelle and Mary suggested that the working with diverse nursing staff created opportunities for conversations about the nurse’s beliefs. Isabelle talks about teaching nurses about the beliefs of her own religion, especially during times of the year when she would fast. These types of conversation were seen as education into the specific cultures of staff members.

Another source of cultural competence education was simply from the upbringing and family background of several of the nurses. Mary suggested that growing up in a bi-ethnic family, especially after traveling to her mother’s family home in Europe, helped her understand that the American way of living was not the only one possible. As an immigrant, Isabelle acknowledged that she held a different religion than many nurses and knew of different birthing customs. As such, she was able to recognize “American” ways of birthing and beliefs. This recognition and her experiences raising children in America lead to her understanding of diversity where you take “the best” from every culture.

Agatha similarly suggested that her “upbringing” and church provided some of the basis for her beliefs; however ultimately, she said that Urban Hospital was the
foundation for her beliefs. For her, this went further than a belief about cultural competency, to the idea that individuals have the right to care regardless of background or cultural preference.

**Framing Cultural Competence**

Cultural competence, however it is defined, is a frame that allows health practitioners to respond to the difference that comes with working in a diverse clinical setting. Studying cultural competence in a hyperdiverse space that does not actively discuss the concept creates a conversation about understandings of diversity and the ways in which nurses have individually learned to identify themselves in relation to that diversity. The L&D nurses suggested that diversity is something, *within* which they must work, in their nursing practice. The cultural competence that the L&D nurses understand and practice is specific to Urban Hospital and taught through an experiential process of working with patients, personal formation, outside professional experience and informal attention by the institution. The hyperdiversity that characterizes Urban Hospital is thought to be different and substantially more diverse than at other hospitals in the area. This is not only due to the many different types of people who traverse Urban Hospital with multiple important identities, but because the patients themselves carry a richer difference within themselves.

Further, cultural competence is created through personal values and understandings. In all of the cultural competency conversations, the nurses said “I think …” or “at Urban Hospital” to qualify their theories and understandings. The nurses did not reference cultural competency theories that the floor in general puts into place. In
their own experiences and their own nursing practice, they employ a certain way of orienting themselves to diversity, but allow for others to orient themselves differently. The exception to this might be Nadia, who was taught a specific type of cultural competence as a professional skillset. Even for Nadia, however, working within an environment of hyperdiversity implied a need for continuous learning about beliefs and values. There is a profound acknowledgement that cultures are abundant at Urban Hospital such as in Esperanza’s words: “But good lord, if we’re not immersed in culture here. I mean it’s just - it’s part of the job.”

Cultural competence is not only a tool that is used to mediate difference in clinical encounters but is often described as a social justice tool – a way to eliminate racial disparities in health outcomes. Rebecca Hester questions medical education’s teachings of cultural competence on the basis that it does not accurately display the complexity of interplay between “cultures of biomedicine, the cultures of the medical professional, and the cultures of the patient as they are negotiated in the clinical encounter (Hester, 2012, p. 280).” There was a tension in the ways that cultural competence mattered for the different nurses I interviewed. When actually discussing cultural competency, they focused on the ‘culture’ of the patient and the ways that they should conceptualize and act toward the difference that was inherent in the clinical encounter. To some degree, all of the nurses understood that they had their own culture and that American biomedicine had a specific labor culture. Further, the hospital in its policies and general “culture of multiculturalism” were described as another layer of culture that had to be mediated.
Beyond this, many times, the cultures of patients were considered within discrete practices that the nurses had to learn in order to deliver care. That is, patients with different identities have different expectations. For some nurses, these differences had to be mediated in order to deliver proper care, for others, it was something to be conscious and respectful of. While the conceptualizations of the patient population showed a profound awareness of the structural inequities that work on marginalized patients when discussing Urban Hospital as a space or labor practices of diverse peoples, those understandings were not attributed to cultural competency even while forms of marginalization (e.g. the homeless) were attributed as certain types of culture.

In their constructions of the borderland and border practices, nurses defined a social field that is set apart from other hospitals and units. While we assume that in this field there would be a common understanding of diversity, there were in fact many different ways of understanding and defining it. While all appreciated the diversity at Urban Hospital and understood its importance in mediating their practice, the different discourses around diversity showcase the all-consuming instability of the borderland. Nurses need not all hold the same beliefs about their work environment as long as they accept it and succeed in practicing their border work.
CONCLUSION: Birthing in a Borderland

In the midst of analysis, I shared my data with a classmate, expressing my fascination that my discussions of cultural competence had yielded a wealth of information on the peculiar space of Urban Hospital and the dis-ordered birthing practices that are performed within it. They exclaimed “I like this! Your thesis isn’t even about cultural competence, at Urban Hospital, it doesn’t even matter.” After the initial joy of shared academic interest gave way to analysis of their words, I realized that my thesis is, indeed, all about cultural competence.

Cultural competence is suggested as one practice that will help alleviate health (and birth) disparities in the face of a rapidly diversifying country (Anonymous, 2012; Smedley et al., 2002). The L&D nurses at Urban Hospital are constantly confronted with the marginalized populations of Metropolis who embody the social inequity that cultural competence should help alleviate. L&D nurses conceptualized the hyperdiversity of their patient population by grappling with birth as a fluid phenomenon that is done by all people, incredibly personal and individualized, and yet based on social history, beliefs, and experiences. In grappling with childbirth, they attempt to reconcile the evolution of childbirth in America (with changing procedures, technological advances, and diversity of demands from women themselves) with the rituals and beliefs that are presented by women of ‘diverse’ backgrounds who do not know how to birth in America. While anthropology of reproduction focuses on the ways that hospital treatment of marginal women reinforces social disparities through reminders of “her unruly body” (Bridges, 2011; Davis-Floyd, 2003), the work of “laboring” with the woman at Urban Hospital
proves to be so immediate that these social issues were suspended. While other analyses of maternal-child nursing have suggested that the nurses play a role in reinforcing the dominant ways of being in the world, usually liberal white values (DeSouza, 2013), Urban Hospital, which was made for the marginalized populations of society, does not need to fully instill those dominant values during the birthing work. Rather than attempting to completely socialize diverse women into American birthing practices, the L&D nurses accepted them as imperfect patients and only tried to teach and learn enough to make the birth happen in the most acceptable way possible for all parties involved.

The nurse’s discussions of managing labor and negotiating with both patient and provider complicate the notions of cultural competence that attempt to mediate the dyadic power dynamics between patient and provider. The nurses do so by allowing and helping patients, to the extent possible, to do their own culture’s birth rituals. However, nurses also work within the hospital’s technocratic birth model by teaching patients to labor within the hospital and attempting to convince the patient to follow the nurse’s treatment plan. This is in fact the essence of a borderland; the nurses are simultaneously rebelling enough against the normalized practices of American biomedicine while working within them enough to successfully complete the birthing work that is before them in any given 12 hour shift. Birthing within this inherently unstable space is characterized by knowing that multiple models of birth will be at work at one time, thereby abolishing the fiction that there are discrete cultures that perform birth correctly or incorrectly.

Studying resistance and the ways that nurses and patients negotiate within the structures that anthropologists have recognized to mediate healthcare, and especially
healthcare disparities, is an important way to complicate our analysis of hegemonic birthing practices. The L&D nurses did acknowledge that ‘culture’ and practices ‘other’ than the medicine delivered in the hospital had a big impact on defining their L&D practice as well as the space of Urban Hospital. While specific cultural competence practices were not something that were agreed upon by all of the nurses, using this concept allowed us to discuss all of the ‘other’ things that go into their job. It was a way to talk about the breakdowns of medicine and the ways that medical models cannot always be reconciled. For example, in my introduction, I alluded to the story that Nadia told of a ‘reactionary’ Latina patient whose experience she had to mediate, understanding that the structure of the health system was not what the patient wanted. Nadia could not completely reconcile this situation – she cannot always provide a woman who ascribes to a female centered L&D model with an all-female birthing experience – but she was able to find what the patient would have preferred. Discussing culture and other birthing models gave her a way to frame the multiple ‘issues’ going on, to understand the complexity that the situation holds.

Urban Hospital was created by and reproduced through the marginalized patients for whom it was created. It was clear in explanations of this patient population that nurses had a profound understanding of structural inequities in society and the forces that shape their patients’ lives. This understanding of health disparities and marginalization contributed to their pride in the hospital and the work that they do within the institution. Nurses attempt to remedy these health disparities by pushing for better birth outcomes in this marginalized patient population by combatting the unequal treatment of patients that
would happen in other institutions as well as in society at large. In combatting the unequal treatment of patients, the nurses suspend the stigma attached to the patient’s marginalized identity and do not try to change it. Rather, they accept and treat the patient without changing them. An example of this might be when a nurse does not try to change an addict’s behaviors, but understands their behavior in order to utilize that information for more effective L&D practice. While this does not change the structures of inequality, this directly impacts the quality healthcare that marginalized patients are able to receive.

Hyperdiversity is a characteristic of Metropolis as a whole, showing that the healthcare industry across the city needs to create cultural competence models that work with the multiple layers of identity that patients hold (Hannah, 2011). While nurses actively discussed hyperdiversity, there was an underlying theme that Urban Hospital itself, rather than health care in Metropolis, is more diverse than other institutions. This was not only because of the plethora of patients with multiple identities but because of the marginality that complicated their diverse status. While nurses did categorize the patients that they worked with – the ‘Latina’, the ’16-year old’ – these attempts at classification functioned as a way to locate the patient, and anticipate her needs within the Urban Hospital context of marginality and hyperdiversity where it is well established that any one understanding of childbirth is incapable of meeting a patient’s needs. Urban Hospital is recognized as reflecting the diversity of the urban Metropolis population but, within that diversity, certain targeted people come create Urban Hospital’s “special” diversity. The unique identity and space of Urban Hospital that allows for a unique
practice of medicine, nursing and birth, mediates experiences, meanings of diversity, and discussions of the state of society as a whole.

My study with L&D nurses attempted to understand how nurses working in a highly diverse and marginalized environment construct understandings of cultural competence in their interactions with patients. In attempting to understand how cultural competence research is used on a daily basis in clinical interactions, I found that cultural competence is a vehicle that allowed nurses to discuss diversity, problems within American healthcare, immigration patterns, social inequality and personal experiences of injustice, growth, and thus to locate themselves within the Metropolis healthcare field. Cultural competence and diversity created an opportunity for nurses to examine the many types of difference that they encounter and the problems that diversity of childbirth practices poses to healthcare. Cultural competence became a frame that is dependent on the context in which one practices and experiences the world.

Cultural competence is an abstract concept that does not hold any one salient meaning for all of the nurses in my study. Each of their theories is reminiscent of branches of cultural competence work, which suggests that the theories currently in circulation are helpful in addressing specific aspects of the nurse’s intersections with culture. The nurses even reflected the older racialized anthropological notions of ‘primitive pelvises’ in which race or culture is used to show why certain women are “better birthers” than others. Even when cultural competence is used to advocate for patients or expand understandings of the social situation that mediates hospital practices, attempting to observe culture among even the most committed of practitioners can
sometimes lead to the deceptive essentializing of cultural bodies that cultural competence theories have begun to combat in the last decade.

Cultural competence was a theoretical space where we could consider what it means for nurses to work in a diverse setting. However, cultural competence should take into consideration the particular context of nursing work, as the specific diversity that is being confronted mediates the ways that nurses work within it even while emphasizing a wariness of essentializing any group.

And Beyond

I found that in order to get to understandings of cultural competence, I had to go through the realities of the borderland of Urban Hospital and the border practice of Labor and Delivery. In emphasizing that I must understand the social field of Urban Hospital, the nurses seemed to suggest that cultural competence was about understanding the rules and boundaries of the field that they work within and successfully negotiating their way around the field in order to successfully birth a baby.

While the social field is created by the historical social structures that have created health disparities and the hegemonic hospital system in Metropolis, nurses use their knowledge of these social structures and the uniqueness of their field to reinforce their work with vulnerable patients. They both resist the social structures by suspending the stigma that marginalized patients may feel elsewhere and allowing patients to remain imperfect. While this allows nurses to treat marginalized patients more effectively than other institutions, they are under no illusion that their temporary work with patients will ultimately change the hegemonic social structures. In this way, the borderland, as a social
field structured by the historical development of healthcare in Metropolis, helps maintain the boundaries of healthcare so that other institutions can continue to practice normal, ordered medicine with non-marginalized patients.

Drevdahl and Canales call for the discipline of nursing to move past ideas of “cultural competence”, not to create a new vocabulary of discussing difference, but to work on macro-level change that will alleviate health disparities and think critically about how nurses engage with and talk about “difference” (Drevdahl et al., 2008). I would like to contribute to this discussion by reframing the issues of cultural competence and diversity in terms of the structurally oppressive L&D hospital practices, general structural inequity, and institutional identities which became the focal point of my cultural competence discussions. I suggest that in the ever refining and changing fields of medical anthropology and cultural competence, we continue to ask as health practitioners and patients what we want or need from cultural competence. Rather than being focused on the skills that healthcare professionals must individually acquire in order to interact with the patient, we might consider discussing different discipline’s approaches alongside each other. That is, as we recognize that there are multiple actors helping to manage any given labor and delivery – providers, nurses, and interpreters (pharmacists, social workers, lab technicians, students etc.) – cultural competency must be reformulated as something that takes place socially. Care cannot be culturally competent if nurses and doctors are sometimes poised as ‘at odds’ with each other, a situation that puts nurses in the unfortunate position of mediating among the multiple identities and power positions at work in a hospital interaction. If culture is created within social interactions, then we
must create a cultural competence that situates itself in interactions with different disciplines and different social environments. And as the focus of cultural competence shifts to communities of practice, the language of difference should be considered at institutional levels. While ‘cultural competence’ definitions from my participants sometimes led to the traps of simplifying cultures and utilizing culture for medical means – the discussions of space, childbirth, and diversity provided valuable understandings of marginality and the structural inequities found within Metropolis as a whole.

**Limitations**

I focused my study on the practices of one unique unit within the hospital. In the context of specialized hospital care, the experiences of nurses on L&D may not be representative of other units. As nurses suggested that L&D is ‘special’ among hospital units, it may be interesting to explore how other units incorporate patient beliefs into care and whether or not the nature of L&D allows for greater flexibility in individualizing care.

Further, I spoke with specific nurses who showed an interest in my study. Other nurses who did not elect to participate may not be as knowledgeable about structural forces shaping health disparities or as passionate about theorizing about cultural competence as these nurses. For instance, one nurse discussed a co-worker who was an immigrant who was able to establish herself in the United States without falling into the marginalized immigrant population like the patients they work with often do. She suggested that this nurse looks down on the immigrants from her home country who take the state’s money (since she never did). While the defined social field of Urban Hospital
would suggest that there is a common understanding of diversity and the social structures that work on marginalized people, the nurses hold their own diversity of understandings, influenced by their own marginal or diverse identities. Even while my participants may have self-selected themselves as people who are personally interested in diversity, they acknowledge that all L&D nurses are able to work in the particular social field of Urban Hospital. In the chaos of work within this borderland, nurses need not hold similar beliefs or understandings about their working environment to be one of the “special persons” to work here. Whether or not other nurses were interested enough in this topic to participate in my study, the fact that they contribute to the “loveliness” given to patients on the floor suggests that, to an extent, they also possess a unique habitus that allows them to work in the borderland. A further study of the ways a larger sample of nurses came to work in the borderland could illuminate the ways that this particular flexible habitus is created.

Another limitation lay in my inability to shadow nurses. I originally hoped to actually observe the ways that nurses employed their understandings of cultural competence with patients. However, because of the difficulties in getting access to the research population, I was unable to triangulate my study with this data. As such, this study was based on a discourse of diversity rather than an observation of practices. Observations would have illuminated a number of aspects of diversity and cultural competence about which I can currently only speculate. This might include data such as the ways that nurses interact and discuss patients on the floor throughout shifts as well as during shift changes, or how working with multiple patients at a time changes the diverse
practices with which nurses can engage. Further study could illuminate these important aspects of L&D nursing change the way cultural competence is employed.

**Implications**

The L&D nurses themselves suggested several resources that would be helpful in light of the hyperdiversity that characterizes their nursing practice if unlimited resources were at their disposal. Most often, we discussed resources that pertained to language skills and interpreter services. As interpreters cannot be present for every interaction on the floor and using interpreter services is sometimes burdensome, several of my participants suggested that effort be put into teaching nurses some basic language skills. This might include flexible classes since one nurse mentioned that their twelve hour shift schedule might not be optimal for a multi-week course. I would suggest that training in interpreter services might be even more useful than teaching nurses other languages. If hospital staff learned the proper way to interact with interpreter services, then trust could be developed and different ways of managing the relationship with the interpreter might be better understood. Other recommendations included improving hospital policies that do not accommodate patient values. This included food services that did not accommodate specific dietary requests (e.g. Halal meals).

Beyond these practical adjustments, I would suggest that the hospital more explicitly undertake an understanding of their role as a borderland characterized by health disparities and diversity. In a discussion with an Obstetrician, she suggested that when she walks into an L&D room, cultural competence no longer matters – her job is to medically save the baby and mother who need a physician’s attention. If the hospital as a
whole does not hold a consistent understanding that cultural competence provides a way to understand the work of the whole hospital and healthcare team rather than providing the “extra” services that make a patient happy, we will continue to see cultural competence reduced to a list of ‘other’ cultural practices.

I, like others, want to suggest that cultural competence is not something one achieves in any one training program or class, but rather a frame for discussing a whole host of other important issues in a given context. If we are to continue to use this concept, we must recognize it as a personal development defined by life-long experiences and the needs of the particular patient population among whom one works. At its heart, we need to understand the way healthcare and healthcare providers function in society – that healthcare is situated in a constantly fluctuating context and is socially produced. The lessons that nurses suggested learning – other forms of birth, negotiating and loving patients, understanding marginality, being savvy, and knowing the institution and context that one works within and your own culture - may be lessons that we learn outside of cultural competence. In a world where we consider biomedicine as a standard relative to which we rank all other forms of academia and beliefs, cultural competence helps us step down and consider the ways that medicine works in a social world.
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