2.3: Terminology

**Cultural diversity** refers to cultural differences and how individuals and groups vary based on certain ethnic, racial, and cultural attributes. However, the concept of cultural diversity is complex, as the recognition of this diversity does not mean that the differences of the “Other” are respected and accepted (Bhabha, 1994). Andrews and Boyle (2012) define **diversity** as “differences in race, ethnicity, national origins, religion, gender, sexual orientation, ability or disability, social and economic status or class, education, and related attributes of groups of people in society” (p. 5). Cultural diversity in our country requires that nurses become culturally knowledgeable and conscious of their attitudes toward people from other ethnocultural groups. Issues of race and ethnicity are often conflated and emerge as problematic issues arising from cultural conflicts or misunderstandings between individuals and groups. It is, therefore, important to understand the differences between ethnicity and race.

**Ethnicity and Ethnocentrism**

The context of race and ethnic relations represent a challenge of contemporary nursing practice as our world becomes more global and diversified. Cornell and Hartmann (2007) define an **ethnic group** as “a collectivity within a larger society having real or putative common ancestry, memories of a shared historical past, and a cultural focus on one or more symbolic elements defined as the epitome of their peoplehood” (p. 19). Ethnicity and race represent different concepts, yet they sometimes overlap. For example, Ericksen (2010) underlines that Croatians, Serbs, and Bosniats can be seen as caucasian, but they form various ethnic groups. The same reasoning applies to Asian peoples with ethnic differences that include Vietnamese, Chinese, Korean, and Cambodian peoples. Cornell and Hartmann (2007) reinforce the notion that ethnic groups are self-conscious of their distinct characteristics. Eriksen (2010) defines **ethnicity** as “the relationships between groups whose members consider themselves distinctive” (p. 10). Ethnicity and the values underlying the belonging to an ethnic group may be used to categorize individuals and groups based on some norms or values that can cause prejudice. This process is called ethnocentrism.
Ethnocentrism refers to the “universal tendency of human beings to think that their ways of thinking, acting, and believing are the only right, proper, and natural ways” (Purnell, 2013, p. 7). Ethnocentrism can lead to cultural impositions, which may create conflicts with clients and nurse colleagues because of different worldviews on health, illness, or nursing. Ethnocentrism not only affects interactions between nurses and clients or groups, but also creates or reinforces inequities in accessing health care. Ethnocentrism may affect health and clinical outcomes because underserved and underprivileged groups may refrain from consulting nurses or other health professionals if they feel these professionals do not respect their ethnocultural beliefs (Sampselle, 2007). Ethnocentrism violates nursing’s mandate of advocacy and social justice by bringing prejudices into the professional delivery of care (Boutain, 2016).

Race, Othering, and Racialization

Race remains controversial because it is rooted in colonialism, where differences constructed between European and non-European peoples led to marginalization (Driedger, 2003). From a colonialist perspective, race can be used to assign differences based on skin colour, yet the view of race as a strict biological construct is highly problematic because it paves the way to racism. Cornell and Hartmann (2007) argue that race is a social construct as race relates to meanings attributed to certain biological differences. They state that race refers to “a group of human beings socially defined by physical characteristics. Determining which characteristics constitute the race, the selection of markers and, therefore, the construction of the racial category itself, is a choice human beings make” (2007, p. 25).

In other words, race is socially constructed as people select the markers of racial differences based on biological or cultural attributes.

Purnell (2013) argues that “race has social meaning, assigns status, limits or increases opportunities, and influences interactions between patients and clinicians” (p. 8). Racism is a “negative concept, based on the belief that some races are inferior to others” (Driedger, 2003, p. 216). As a biological and social construct, race can be used as a means of social stratification also called othering. Canales (2010) argues that othering is both exclusionary and inclusionary. Othering represents a process of racialization (Ahmad & Atkin, 1996). Canales contends that othering “often uses the power within relationships for domination and subordination with the potential consequences being alienation, marginalization, decreased opportunities, internalized oppression, and exclusion. Othering correlates with the ‘visibility’ (e.g., skin color, presence of an accent, sexual orientation) of one’s otherness” (2010, p. 5). It is hard to reflect on one’s racial biases, but it is a necessary step toward developing and implementing cultural competency and safety.

Our discussion of race and ethnicity underlines that “cultures and cultural differences are not discovered, they are constructed” (Allen, 1999, p. 230). If stereotypes are socially constructed, it is safe to argue that cultural competency and safety are processes by which nurses will deconstruct race and ethnicity to avoid applying racial and cultural stereotypes in their interactions with individuals and groups from different racial and ethnocultural groups. Nurses have an ethical duty to respect other persons’ and groups’ cultural beliefs related to health and illness. This respect intersects with culture and cultural competency to help us move beyond the boundaries of race and ethnicity and to treat individuals who are culturally different from us in a humanistic and caring way (Andrews & Boyle, 2012).

Andrews and Boyle (2012) mention that transcultural nursing enables the development of a “scientific and a humanistic body of knowledge to provide culture-specific and culture-universal nursing care” (p. 4). To provide culture-specific and culture-universal nursing care, nurses have to strive to know those who come from different ethnocultural backgrounds.
Nurses must endeavour to become culturally competent and culturally safe in their interactions not only with clients, but also with other nurses and health care providers.