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# Does discourse matter? Using critical inquiry to engage in knowledge development for practice

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Recent years have seen an increase in critical analyses of discourses of policy and practice. However, some argue that this form of scholarship is not central to understanding the concerns of day-to-day practice in the health care context. We propose the converse and contend that critical analyses have particularly important contributions to make because they challenge us to examine what are largely taken for granted aspects of practice. One context in which such examinations have been instructive is primary healthcare. This article is intended to further the dialogue on the ways the culture concept is taken up in health care. We use the case of culture and health to illustrate the ways discourses are taken up in local and official contexts and to demonstrate how different discourses and related institutional practices, shape individuals' relationships with others in the community context.

**Key words:** Bourdieu; culture and health; discourse analysis; health inequalities

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One concern at the forefront of the health care agenda is to ensure primary health care is accessible and responsive to the health needs of the full range of the population (Canada, 2002; Britain, Department of Health, 2006; US, 2006). For generations, Britain has welcomed immigrants from countries throughout the world, most particularly from countries in the Commonwealth. More recently, the formation of the European Union prompted an increase in migration throughout Europe. As a consequence these countries, and a number of others throughout the world (eg Australia, Canada and the US), are increasingly culturally and socially diverse. However, there is evidence that particular groups, notably immigrants and asylum seekers or refugees, face a number of barriers when accessing primary health care and may receive different levels of care. This is of particular concern since these same groups are over-represented among those who experience inequalities in health over the life course.

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Until relatively recently, much of the research that has sought to examine issues of culture and health has built upon methods and traditions of anthropology and has generally resulted in descriptions 'of' the cultures of interest. In recent years, however, anthropologists and scholars in cultural studies have advocated researchers adopt a more critical stance. They urged researchers to consider not only how cultures operate but also the consequences of representation for particular cultural groups (Hall, 1996a; 1996b). Similar positions have also been put forward in health literature (Ahmad, 1993; Culley, 1996; Anderson, 2004a; 2004b).

However, some practitioners argue that such forms of inquiry are largely academic and not central to understanding the concerns of day-to-day practice. We propose the converse and contend that critical analyses, including discourse analysis, have particularly important contributions to make. Discourse analysis challenges us to examine what are largely taken for granted aspects of practice and prompts us to adopt a reflective stance as we examine our roles and strategies for increasing the effectiveness of the care we provide.

In introducing a book on nursing policy in Britain, Traynor (1999) observes 'discourses provide

positions that can be adopted, spaces that can be occupied, categories that can be made available' (p. 27). Traynor's statement underscores the importance of discourses to the health care enterprise and positions discourses as agents of dialogue. His comment also implies that discourses are dynamic. We extend this stance and argue that we must not limit our interest in discourses to the spaces they create but also, we must consider the ideological position that underpins the discourses of interest and the social processes that produce and sustain them. We argue that such analyses have the potential to foster dialogue about, and prompt reflection on, the ways discourses operate. Our intention in this article is to draw attention to potential contributions of discourse analysis to practice. We propose to accomplish this aim by: briefly introducing discourse analysis and the theoretical premises that underpin it; providing examples of insights for practice obtained from studies that have used discourse analysis; and using discourses of culture and health to illustrate some of the unintended consequences of categorical representations of culture.

## Background

To accomplish our aims, we build upon critical theorists' observations of the often overlooked ways discourses or 'authorized forms of language' create structures that privilege or exclude persons or groups. Following from this, we argue there is also a need for the analyst to: adopt a critical stance and consider for whom a 'space' is created; consider whose viewpoints are privileged or masked by a particular discourse; and make visible the processes or practices that sustain or interrupt discourse(s) and with what effect.

In recent years, scholars taking a critical perspective drew attention to the ways professional discourses delineated the mandate of, and strategies for, practice. For example, analysts have illustrated the ways the positioning of practitioners as experts has both legitimated and sustained power differentials between different professional disciplines and their clients (Bartkowski, 1988; Cheek and Rudge, 1994; Porter, 1998; Powers, 2001). In this article, we consider what are largely taken for granted aspects of primary health care practice. That is, our focus is on the ways professional and policy discourses have taken up the concept of culture and consider how these discourses have contributed to a categorization and representation of the clients with whom we work. As Powers (2001) observes 'nursing students are taught the proper ways to interact with a stereotypical "Black person" or "Asian person" without letting the patient determine the structure and process of the clinical encounter' (p. 43). The categorization, evident in the case Powers refers to, arises out of a discourse that characterizes culture as static representations of groups. We argue that such categorization contributes to unintended and frequently undesirable consequences. Consequences, that we hope to show, can have an impact on health.

In beginning this exploration, we are mindful that the categories we draw upon as we navigate our social world are not neutral. In this regard, we draw upon insights of critical feminist scholars whose analyses have illustrated the ways classifications and categories 'conceal the fact that social differences always belong to an economic, political, ideological order' (Wittig, 1996: 24). Moreover, such social classifications or categories become 'institutionalized' or thought of as 'natural' when they are taken up in and permeate both formal and informal discourses.

In this article, we use discourses of culture, as reflected in professional and policy literature and day-to-day interactions, to reflect upon the nature of the 'space' such discourses create, the ways they shape experience and how they guide or inform practice-based interventions.

## Discourse analysis

Discourse analysis is one of a number of analytic perspectives rooted in critical social theory (Powers, 2001). In her presentation, Powers (2001) traces the influences of critical theoretical perspectives and postmodernism on discourse analysis. She contends that a central focus of analysis is on the nature of scientific knowledge and the assumptions that underpin it. She contrasts this tradition with that of 'foundational science' in the positivist tradition. She argues that while foundational science screens out context, history, possibility and situatedness, critical theoretical perspectives, including discourse analysis, foregrounds them (eg, Powers: 7). Powers also contends that the aims of analysis – of foundational science and critical

theoretical perspectives – also differ. A principal difference being that instead of analysing the concept, discourse analysis analyses the *process*.

In what follows, we briefly introduce the work of a selection of theorists in order to draw attention to the nature of contributions critical analyses have made to health care practice. In so doing, we draw attention to the issues different critical perspectives foreground. We then explain why we drew upon Pierre Bourdieu and Dorothy Smith to illustrate the ways discourses of culture and health, the ideologies that underpin them and the practices that sustain them, shape experience.

## Discourse analysis and health care

In his analysis of the theoretical and philosophical underpinnings of different approaches to discourse analysis and analyses of discourses within nursing, Traynor (1996; 2004) observes that the nature of knowledge and one's place in the process of knowledge generation must take into account the contextual influences of history and culture. In further discussing the ways such influences are manifest, Traynor (1996) notes 'discourse analysis attempts to explore the practice of language as it is used to construct a reality that often *serves to support particular institutional ideologies*' (p. 1156, emphasis added). It can be inferred then, that Traynor recognizes the importance of making ideological positions visible and that he also links discourse to broader institutional practices and policies.

Like Traynor, Allen, writing in the US, locates his stance on discourse and discourse analysis within the constructivist paradigm. For example, Allen's (1996) analyses of discourses of culture and gender are informed by this position. He argues culture and gender are not 'objects' or 'things' to be discovered, rather, they are 'constructed through discourse and that such constructions arise from different perspectives and have different purposes' (1996: 96). It follows that different constructions create different types or forms of 'spaces' and have the potential to contribute to a dialogic process of knowledge development. Moreover, a number of authors (eg, Allen, 1996; Anderson, 2004a) argue that when we take a constructivist position on knowledge development, we are able to move away from categorical understandings and move towards understandings that recognize the complexity of social phenomena.

Foucault (1977; Gordon, 1980) provides a critical strategy for discourse analysis that is empirically grounded. His work illustrates the analytic potential of shifting the focus of analysis away from categorization towards processes. For example, his highly influential research on prisons and medicine draws attention to how such processes as 'surveillance' and the 'medical gaze' operate and are legitimated through discourse. Foucault's analyses illustrate the ways different forms of power influence the nature and structure of interactions such as those between patient and practitioner. His analyses also demonstrate how disciplinary discourses have legitimated particular forms of surveillance as aspects of professional practice and defined the nature and forms of knowledge needed in practice.

Disciplinary knowledge develops over time and is subject to a number of influences. As such, some use Foucault's perspective on discourse analysis to examine or trace institutional influences on practice knowledge while also making visible the ways such influences supplant other agendas through competing discourses and the authority accorded them. For example, Cowley and colleagues (2004) drew upon Foucault to illustrate ways structured assessment tools shifted the focus of Health Visitor practice and the nature of relationships established between clients and Health Visitors. Their analysis shows that the introduction of assessment instruments was not a neutral activity. They took direction from Foucault's theoretical position to focus attention on the relationships between knowledge and power and the ways these are used in language and institutional policies and practices – or discourse – to illustrate how health visitor practice was redefined. Their analysis drew attention to competing discourses in community health practice and the ways these played out in interactions between Health Visitors and clients with a concomitant impact on their relationships and the nature of practice.

Smith is a feminist scholar who proposes institutional ethnography as a method to guide critical analyses for a number of purposes, including discourse analysis. Her position is that the prevailing social order (evident in text and narrative discourses) has historically privileged a 'male' perspective. Moreover, her position is that social

structures and the practices that sustain them organize individuals' experiences.

> Institutional ethnography takes up a stance in people's experience in the local sites of their bodily being and seeks to discover what can't be grasped from within that experience, namely the social relations that are implicit in its organization
>
> (Smith 2001: 161).

As such, she argues that if research begins with the viewpoint of those generally outside of the frame – in her case women – the analyst can then draw upon experiences to identify the disjunctures and points of congruence between prevailing discourses and women's experiences. In this way, discourse analysis offers insights into the nature of spaces discourses create and whose interests they reflect. Analyses informed by Smith's methodology make visible the ways prevailing, and often unquestioned, organizational processes and practices can serve to privilege some while disadvantaging others, with concomitant effects on their capacity to access services or mobilize resources for health (Dyck *et al*., 1995; Lynam *et al*., 2003; Perry *et al*., 2006).

In keeping with Traynor's observation that discourses 'create spaces' and Anderson's (2004b) observations that some discourses are historically assigned to the margins, focusing attention on processes and practices that refine or sustain dialogue and/or effect change becomes particularly important. We contend that Bourdieu's perspective offers such analytic tools. Moreover, because his perspective foregrounds an analysis of processes influencing the ways relationships are constituted, it is particularly useful for understanding individual's capacities to develop relationships and to access and mobilize support to foster health. The analysis that follows is informed by our understanding of Bourdieu's theoretical stance as presented in his own writing and others' critiques of it (Bourdieu, 1990; 1994; 2001; Bourdieu and Wacquant, 1992; Schubert, 2002; Dillabough, 2004; Reed-Donahy, 2005).

Bourdieu (1990; 2001; Bourdieu *et al*., 1999) had as a central goal, to make visible the ways broader societal practices, sanctioned in policy and through tradition, structure relationships and shape experiences of those largely outside of formal institutional discourses such as the poor, immigrants, women and/or youth. In earlier analyses I have drawn upon this perspective to critically examine perspectives on health inequalities (Lynam, 2005). In this article we examine particular discourses of culture and health and explore the nature of the 'spaces they create' and their attendant influences on experience. While Bourdieu does not name power as a central concept in his theoretical work, he does examine processes and practices that create privilege and disadvantage and does focus attention on the social processes that assign value to different forms of 'capital' (Bourdieu, 1990; 2001; Bourdieu *et al*., 1999; Bourdieu and Wacquant, 1992). In his conceptualization, it is these processes that are of interest because they contribute to the creation and maintenance of social structures and associated spaces that shape experience. As such, Bourdieu's perspective offers a means of incorporating the perspectives of individuals into discourse analysis. But, Bourdieu takes the goal of such analysis further. His analytic tools enable the analyst to make visible the ways such practices as traditions support particular views of what is 'normal' or 'natural' while also reinforcing particular perspectives of authority (Bourdieu, 1994). His research illustrates the ways such practices create and sustain social structures that may privilege some at the expense of others and in doing so constrain individual's access to resources or opportunities.

For example, Bourdieu's (2001) analysis of forces of change in gender relations that have historically privileged men through processes of 'symbolic violence', has traced the nature of systemic change that has accrued from the introduction of feminist discourses. Bourdieu contends that feminist discourses have been effective in shifting institutionalized practices or traditions, and in introducing alternative perspectives on women's abilities in part, because they have been pervasive, persistent over time and have targeted 'local' and institutional policies and practices (Bourdieu, 2001). However, he cautions that prevailing discourses are socially and structurally embedded and, as such, are slow to change.

Bourdieu's work can be seen as aligned with the constructivist perspective. In addition however, it also requires the analyst adopt a critical perspective. In the case of culture, this perspective offers a means for recognizing the ways traditions and practices accepted as 'normal' can be critically examined. Such examinations hold value because they help to make sense of taken for granted and often categorical or essentializing discourses. 'Dualisms do

not arise from simple namings – rather from historically constituted, pervasive but unquestioned relationships' (Bourdieu, 2001: 105). Bourdieu argues such tacit understandings of 'normal' are 'embodied' as cognitive structures and physical dispositions over time. Moreover, he notes elsewhere: 'The dominated apply categories constructed from the point of view of the dominant to the relations of domination, thus making them appear as natural' (Bourdieu *et al*., 1999: 50). Using gender as an example of such unquestioned relationships, Bourdieu's critical analysis demonstrates that the introduction of feminist discourses offered an alternative language, point of view on, and analysis of, the everyday. This, Bourdieu argues, illustrates the potential impact that can accrue when alternative discourses or 'spaces' are introduced and social processes are put in place to sustain them.

This brief overview of selected critical perspectives on discourse analysis draws attention to their analytic potential and their potential for establishing links between discourse, local experiences and the processes and practices that sustain them. It also offers different examples of ways critical analyses have drawn attention to tacit understandings and the ways these can privilege particular viewpoints. In what follows, we draw upon a research case to examine discourses of culture and health.

## Background to the case: discourses of culture and health

The study that provides the case for the examination of discourse drawn upon in this article, builds from a programme of research that shows the importance of the informal sector as both a source of support for individuals and a largely unacknowledged resource drawn upon by the health care system, particularly the primary health care system (Lynam, 1985; 1990; 1995; 2004; 2005). This article builds on this earlier research to illustrate the ways discourses of policy influence how the client and goals of practice are conceptualized. These impact the nature of resources available to families and primary health care practitioners as they strive to achieve goals in care. We argue it is important for practitioners to consider what influences individuals' capacities to access and mobilize support and resources for health promotion and illness management. The particular study drawn upon in this article explored the nature of the relationships of first generation immigrant women and their teenaged daughters with others in their communities and examined their experiences in accessing supports and resources for health. One of the goals was to understand whether these women viewed the informal sector, specifically their relationships with others in it, as a resource. Answering this question could provide insight into the role of the informal sector as a resource for health. It could also help us to understand ways primary health care interventions could strengthen the resources of the informal sector or foster access to the resources of this sector to supplement primary health care interventions. This article builds on this work and focuses particular attention on discourses of culture and health. We undertake an examination of the ideological premises that inform such discourses and consider their influence.

Key theorists drawn upon in conceptualizing the study were Bourdieu (1990) and Smith (1987). The perspectives that informed the study design and analysis were chosen because they build from the premise that experiences are socially organized and provide direction for analysing individuals' experiences in relation to institutional structures and processes. As Bourdieu and Smith both argue, policies and practices that privilege some groups over others (through eg, gender, class or social location) are so pervasive that they are viewed as 'normal'. They advanced methodological strategies that invite examination of the 'day-to-day' and related institutional practices from the viewpoint of those outside of the process. In addition, they used these viewpoints as a place from which to examine the assumptions of policy discourse and related practices. Giving voice to such perspectives has the potential to 'interrupt' prevailing discourses while prompting reflection on both intended and unintended consequences of such discourses, and challenging prevailing discourses and the assumptions that underpin them.

The methodological premises of the perspective require that the researcher engage with participants while also offering them a mechanism to share their viewpoint and experiences through the interviews. This first stage of data gathering and analysis was followed by a critical examination of policies to explore the ways in which participants' experiences were shaped by social and organizational processes.

After receiving ethical approval for the study in Britain and Canada parents, teens and key

informants were invited to participate in a series of interviews using a process of third party recruitment. Potential participants were provided information about the study by persons in a number of community-based organizations, those who expressed interest were invited to participate. The parents participated in small group interviews and then a series of follow-up individual interviews. The teens and key informants participated in one to three individual interviews with the investigator. Thirteen mothers, nine teenaged girls and one boy were interviewed in Vancouver, Canada. Ten mothers, one father and six teenaged girls were interviewed in London, Britain. Eight key informants from both countries also participated in one to three interviews.

In the study, from which the exemplars are drawn, mothers and their teenaged daughters who were immigrants, refugees or asylum seekers in Britain or Canada, participated in small group interviews and a series of individual interviews. Key informants in various roles (frontline and administration) in primary health care delivery were also interviewed. The nature of these participants' experiences is reported elsewhere. However, a central concern was that their experiences of intercultural relations were characterized by marginalization. In this article, we draw upon this aspect of the participants' experiences to reflect on the nature of 'spaces' different policy discourses open up, examine the ideological premises that underpin them, and consider the ways discourses shaped experience. Using the case of culture and health, we illustrate ways discourses can, often inadvertently, contribute to experiences of 'being on the margins' and illustrate how processes can be interrupted with alternative discourses. In this regard, we seek to illustrate the need to move beyond discourses that provide what are ostensibly neutral descriptions 'of' culture to consider how culture operates. In particular, we seek to illustrate how different discourses and the authority accorded them, shape institutional practices and social relations and influence how individuals view themselves and those around them.

## Does discourse matter?

The participants' experiences would suggest that yes, it does. As noted in earlier works marginalization was central to the participants' experiences and was an important influence on the nature of the relationships they established with others (Lynam, 2006; Lynam and Cowley, in press). Moreover, given the evident importance of relationships as resources for health (Berkman and Breslow, 1983; Cooper et al., 1999; Berkman and Kawachi, 2000), marginalization and the processes of social location associated with it, has consequences for health. As the data were analysed, the processes of marginalization were linked to 'marginalizing discourses'. That is, such concepts as 'exclusion', 'minority' and 'diversity' made their way into the day-to-day language of participants and served to categorize or position them in particular ways. The prevalence of such rhetoric moved individuals to ask: How can I see myself as a person of value, with a contribution to make, if I am characterized as 'minor' and as excluded? In what follows, we demonstrate how these views have both intended and unintended consequences for individuals and how policy is articulated.

While many of the participants in this research had difficulties, their difficulties were not grounded in their cultural beliefs or values as culturalist perspectives would suggest. Rather, their difficulties were related to their social positioning – as immigrants and asylum seekers or refugees. One parent made the following observations.

> They (my children) are not really welcome into their society … because they are, um, why us? Because we are foreigners, because um, we have not the same language, we have not the same culture, and especially, especially because we are refugees, and you know what that means in this, in this country.

In this example, the speaker categorizes the children as foreigners and points out that 'foreigners' are welcome only with caveats. This tenuous social status, perpetuated in part by unchallenged assumptions held and communicated by others about refugees and immigrants, positioned the women, their daughters and families on the margins of the workforce, housing market, neighbourhood or classroom, even once they became citizens.

In the following quote, a health professional speaks about how she is perceived by others:

> When people look at me they see me as a Black person and then make assumptions, that I am not English, not educated.
>
> (Health Professional speaking)

As this woman explained in the interview, the problematic is that she continually is put in a position of defending herself and her credentials. She was educated in Britain, works in her practice field in health and sees herself to be on par with her colleagues. She also has experience to draw upon in her work with clients that others in her field do not. However, this woman's visible features 'speak first'. She is Black, and on this basis people assume she is 'not English' and 'not educated'. As this account suggests, it is peoples' (invalid) assumptions that this professional must continually confront. Moreover, the above accounts show how day-to-day perspectives on migration status, social positioning, visibility and competence merge into categorical appraisals.

The discourses of difference could be seen as contributing to separating out – programmes, resources and individuals. However, there was also evidence of competing discourses in the data. Some of these fostered a view and created structures that were (more) inclusive with concomitant positive effects on experience.

The teens in Britain were more likely to speak of their experiences using terms like racism, or exclusion and often, despite citizenship, referred to themselves as not 'British'. Whereas, Canadian teens, while acknowledging difference, linked this to being 'Canadian'. These latter teens were also more likely to view some of their cultural features or abilities, such as language skills, as assets rather than liabilities. Similarly, although all families were of limited means, the social organization of community-based resources (such as recreation and sports programmes) meant programmes were much more readily available (affordable and geographically accessible) to Canadian teens than their British counterparts. In addition, in Canada it was much more likely that participants in such programmes reflected the social and cultural diversity of the region.

These examples draw attention to the difficulties that can arise when discourses that categorize people of colour and refugees in particular are evident in general conversation and are unchallenged. Following the direction of Smith and Bourdieu, a central concern is that some discourses become part of the day-to-day and are accepted as 'normal' or as 'fact'. To make sense of these different discourses and their influences, we turn to an examination of discourses of culture and health.

## Discourses of culture and health

In what follows, we introduce a number of theoretical perspectives on 'culture' and on 'culture and health' to illustrate the spaces associated discourses open up, the categories they create and the assumptions that underpin them. The goal of this examination is to draw attention to their potential forms of influence when taken up informally in conversations or interactions and in more formal discourses such as those of policy and practice.

Theoretical perspectives are not static. Rather, by theorists' own accounts, they are extended or refined as limits are identified or as the contexts in which they are taken up introduce new theoretical challenges to be addressed. Theoretical perspectives on culture and health are no exception. The issues of culture, diversity and exclusion have received considerable attention in scholarship in Britain. This scholarship has been taken up in countries throughout the world. A review of this literature identified scholars who take a range of positions and engage in a number of debates including the merits and consequences of conceptualizing culture as static or dynamic. In what follows a number of perspectives on culture are considered in light of study data to draw attention to the ways women's experiences of marginalization are socially organized. In this study popularized, and largely unchallenged, images of ethnic minorities, immigrants, asylum seekers or refugees influenced how the women viewed themselves and influenced their capacity to participate in society. Moreover, as relationships are resources for health (Berkman and Kawachi, 2000; Berkman and Breslow, 1983; Cooper *et al.*, 1999) marginalization has implications for health (Hall, 2004; Lynam, 2005).

Stuart Hall (1990; 1996a; 1996b) traces the ways changing discourses have influenced representations of, and assumptions about, people of colour. His theorizing, largely undertaken in the British context, traces the ways history defined groups and cast them in particular roles through language and practices of 'othering'. Such practices are visible in day-to-day conversation and are also taken up in research and policy. Hall argues against such essentializing discourses.

Writing about studies of 'race' and health in the UK, Ahmad (1993) argues that 'the role of ideological considerations has been largely ignored in health and health service research on black

populations' (p. 1). Ahmad, like a number of other analysts, problematizes the culturalist stance because it can be misused when everyone within a 'group' is considered to have the same experience. In addition, by focusing attention on health profiles as associated with a cultural or ethnic group's beliefs and values, the importance of other factors such as the impact of racialization or social location on health are eclipsed, thereby masking other processes operating.

Fiona Williams (1989) also writing about culturalist discourses in the British policy context observes that:

> Although the step forward taken by ethnicity researchers was to examine culture from the immigrant's point of view and in a positive light … and to establish the reality of a multi-racial society, nevertheless, looking at 'minority–majority' relationships in a cultural framework excludes vital elements in the relation of 'race' to class and power, and institutionalized racism. This means, however sympathetic the cultural appreciation, it can still skew the analysis and 'blame the victim' (p. 92).

Williams' observations resonate with the accounts of the participants in this study and draw attention to the need to recognize the impact of processes of categorization but also to consider how other circumstances like gender, or material resources intersect to create multiple forms of disadvantage.

In his appraisal of the health care system's response to persons of 'ethnic minorities' in Britain, Alexander (1999) problematizes the concept of community. He challenges the assumption that people who are members of ethnic minorities constitute geographic and/or social communities. He argues that programmes must take into account the ways communities are organized and notes that this may not coincide with the ways services are currently organized. That is, he suggests that it is incorrect to assume that everyone of the same ethnic background has the same health care needs. Alexander's observations reverberate with Fenton and Charsley's (2000) 'critical interrogation of the concept of ethnic groups as populations' (p. 406). While Alexander points to structural constraints on the ways in which practice initiatives are undertaken, Fenton and Charsley argue that to assume because people have been categorized in a particular way they share common experiences or are part of a discrete population group, ignores the complexities of experience. It also disregards the ways in which other aspects of one's life intersect to shape it. Moreover, the process of categorization that arises out of essentializing discourses can contribute to the negation of the individual and mask the broader social processes at play.

Each of these scholars challenges us to be mindful of the nature of the spaces culturalist discourses create and, in turn, the assumptions about 'sameness' or commonality of experience that are inherent in the culturalist view. With recognition that culturalist discourses shape our thinking about the 'other', scholars sought to make visible the consequences of practices of 'othering' for health. Health inequality researchers in Britain drew attention to associations between social–material circumstances and health, and have shown that some groups are more likely to be socially excluded (Townsend and Davidson, 1992; Shaw *et al*., 1999; Nazroo and Davey Smith, 2001).

> These struggles for equitable health and health care are essentially located in the wider struggles for equity and dignity which have been a part of black people's history.
>
> (Ahmad, 1993: 7)

Processes of social location (including marginalization and social exclusion) that arise out of practices of 'othering' are increasingly being viewed as social determinants of health. Such observations have important consequences for health services delivery and prompt us to consider creating new spaces and introducing alternatives to marginalizing discourses – discourses that foster inclusion.

Culley (1996) undertook a critical review of the literature to examine the theoretical premises of research in culture and health, particularly related to nursing in the Britain. She took up an argument similar to that of Ahmad and issued a plea to move the discourse on culture and health forward.

> (T)he experience of living in a society which is structured by gender, socio-economic and racial inequalities and the inter-relation between the living and working conditions of minority groups and their health status have been given less prominence than issues of 'cultural' difference and problems of communication. Not only are very important

> issues largely excluded from the debate, the dominant way of conceptualizing issues of 'race' and health has many serious flaws which may serve to obstruct the attainment of equitable health and health care.
>
> (Culley, 1996: 564)

Writing in 1996, Culley argues that the discourse in the British health care context is framed within a multicultural[1] perspective that centres on education and changing attitudes. She cites Stubbs (1993) in noting 'within this discourse, the solutions to problems facing minority groups are "essentially technical and professional rather than political" (Culley, 1996: 565). Culley's analysis supports the view that a culturalist stance, while of some relevance to understanding individuals' perspectives, is problematic. This occurs when the culturalist stance shifts attention away from addressing structural conditions that show evidence of sustaining inequities and evidence such conditions have persistent negative effects upon health and health services delivery.

In the same era, Baxter makes the case for the education of health professionals about issues of equality in 'multiracial Britain' of the 1990s. As well as outlining the poorer health profiles of people of colour, she argues that their social location has roots in these population groups' migration history. A substantial number of those who immigrated from the Caribbean or Africa settled in neighbourhoods surrounding London, 'where there was a demand for labour' (Baxter, 1997: 16). She observes:

> A much higher proportion of black and ethnic minority people than white people are concentrated in areas with a high level of material and social deprivation, such as poor housing conditions and underemployment, and therefore they suffer from poor social and environmental and economic conditions. The pattern of social and economic inequalities is closely related to social class.
>
> (Baxter, 1997: 20)

She draws attention to the persistence of processes and practices of categorization and reminds the reader that people of colour are not all immigrants, as many individuals and families arrived in Britain in the postwar years. She observes that it is not their 'culture' or their status as newcomers that accounts for their social standing, as popular discourses and related images suggest, but rather, the persistence of racializing practices of the broader society. Baxter's comments align with Williams and Williams-Morris (2000) observations in the US that racializing practices have changed slowly because assumptions are not challenged and alternative processes are not put in place.

These perspectives draw attention to the social processes and social structural relations that are associated with different discourses on culture and health. As noted at the outset of this article, Traynor argues that discourses of policy and practice can support a particular institutional agenda. Therefore, it is important to consider the perspectives that underpin policy. With this in mind, we turn now to a brief examination of ways the British policy context has taken up and/or contributed to the maintenance of particular discourses of culture and health. In light of the preceding analysis, we reflect upon the nature of spaces these policies create while considering the assumptions that underpin them.

## Shifting discourses: culture, health and health inequalities are new spaces being created?

Despite considerable research in many countries, documenting the systemic nature of health inequalities and linking them to such social conditions as poverty, education, racializing practices and poor working conditions, governments have not, historically, made a commitment to broadening the health agenda to include restructuring and financing to address these issues.

At the time this study was being completed however, Britain had moved away from an era of policies of restraint and had made a commitment to redressing health inequalities and mitigating social exclusion. A key initiative was the establishment of the Social Exclusion Unit (SEU) (Britain, SEU, 1998). Also in this time period the government made a commitment to modernize the public services, redress inequities faced by racialized groups

[1] The term multicultural, like other terms holds different meanings. Culley's use of the term I interpret to be what Ahmad refers to as the culturalist approach. That is, a view of culture that focuses on beliefs, values shared by a 'cultural' group and one that does not direct attention towards the analysis of the social and institutional processes that influence action.

(Britain, HO, 2000, March) and amend the Race Relations Act (Britain, HO, 2001a; 2001b; 2001c; 2001d). These initiatives suggest that the government is attentive to inequities and recognizes the structures (including social processes) that sustain them. They therefore proposed to put in place mechanisms to ensure inequities and their consequences are at the centre of the policy agenda.

Such initiatives suggest a shift in the ideological premises underpinning the broader policy agenda. In what follows, I trace the steps that suggest the social roots of health inequalities are being recognized and describe a number of initiatives that seek to consider the consequences of marginalizing discourses. In the brief review that follows, I draw attention to ways this shifting ideological stance competes with racializing and marginalizing discourses inherent in some conceptions of culture and health.

The language of policy has taken up and proposed to address the experiences of being on the margins. That is, it seems policy makers have recognized that marginalization and exclusion are experienced at the local level, in neighbourhoods, and that opportunities to develop capital are not readily available to those of limited means. The policy initiative 'Tackling Health Inequalities: A Programme for Action' (Britain, Department of Health, 2003, July) for example, elaborates on these initiatives and delineates in detail the nature of community based strategies for remedying structural inequities in service delivery by working in partnership with community and voluntary organizations while also building community capacity (Britain, Department of Health, 2003, July). The premises of this policy era align with the ideologies underpinning the work of key researchers in health inequalities. It can be argued that these policy initiatives seek to foster social cohesion (Wilkinson, 1996; 1999), address inequalities in health experienced by ethnic communities through structural change (Nazroo, 1999) and enhance the accessibility of services (Benzeval and Donald, 1999).

The intersections of family poverty and parental unemployment on children's wellbeing has also been recognized in this policy era. 'The vicious cycle of poverty, social exclusion, educational failure and ill health is mutually reinforcing. It needs to be broken. It can be broken' (Hutton, 2000: 8).

The recent action plan (Britain, Department of Health, 2003, July) proposed the introduction of extracurricular sports and arts programmes in schools in disadvantaged neighbourhoods. Introducing these as health initiatives suggests the government is concerned with addressing the social conditions that undermine capacity building of youth thereby contributing to health inequalities. It can be argued that such initiatives represent policies of inclusion by making resources available across all social sectors and creating opportunities for youth.

In these British documents, there is evident recognition of the social roots of health inequalities and how they have been taken up as health issues. The central concepts evident in this policy discourse include recognizing: the ways different social conditions intersect to create disadvantage; the characteristics of the social (particularly neighbourhood) environment as a resource for health; education as a resource for health; and community involvement through representation and partnerships as contributing to health. Fostering social cohesion as a feature of the community that can contribute to health is also an evident interest. An ideological shift can also be identified in that by seeking to ensure all initiatives are mainstreamed and seen as central to the NHS mandate (Britain, Department of Health, 2003, July), discourses of inclusion are being taken up in British health policy. This suggests movement beyond rhetoric to structure and process.

These health initiatives are to be further reinforced by concurrent initiatives within the SEU. This unit has an overarching mandate. A review of the extent of initiatives under their purview draws attention to efforts to recognize that inequalities are the result of a range of conditions and that some sectors of the population are particularly vulnerable.

> Ethnic minority people are more likely than the rest of the population to live in poor areas, be unemployed, have low incomes, live in poor housing, have poor health and be the victims of crime.
>
> (Britain, SEU, 1998, Cm 4045: 8)

These British policy initiatives represent a new era in social and health policy discourse and announce the intention to recognize the ways a number of social conditions intersect to contribute to health inequalities. This necessarily brief review suggests that the British policy discourse has moved towards a vision of inclusion and in the process, has proposed a number of initiatives to address the

structural issues (such as low income and poor housing) that contribute to health inequalities.

However, drawing upon Bourdieu's perspective, we must be mindful that these shifts need to be accompanied by a critical vigilance. For, as evaluations of previous policy have shown, if resources are not committed to implement policy shifts, then goals are not always achieved (Britain, Department of Health, 1999). Moreover, formal policy discourses need to find their way into formal and informal domains if they are to challenge historically constituted practices. Discourses co-exist and those that continue to single out people as vulnerable on the basis of particular features continue to reinforce stereotypical-categorical images. Such categorization will continue unless efforts are made to focus attention on, and change, the processes that assign groups to the margins.

## Summary

In this brief analysis of policy, we sought to offer insights into ways discourses of policies and the ideological premises that underpin them create the contexts that shape individuals' experience. As such, they have the potential to create, or erode, community contexts for health. We drew upon exemplars from a study that began by describing women's experiences and then, taking direction from Bourdieu and Smith, proceeded to consider the extra-local conditions that shaped them. In this article, we sought to demonstrate that considering ideological premises of policy and other discourses and how these are enacted in practice, in relation to viewpoints of those outside the policy process, can offer guidance for change or serve as hallmarks of success while drawing attention to the complexities of the policy and practice arenas. We also illustrated the importance of recognizing competing discourses and of noting disjunctures or congruence between formal policy and implementation plans.

Bourdieu's perspective offers the possibility of analysing peoples' experiences not solely as individual experiences, but also as experiences that accrue from the ways in which society is organized. The significance of this for research in culture and health is that we gain insights into ways of understanding and working with individuals. Such insights could create the spaces needed to foster dialogue and could enable us to more critically examine assumptions inherent in theory and policy discourses. More importantly, they also offer a way of drawing upon different viewpoints to trace the impact of different discourses on experience. In such analyses, a key consideration is the pervasiveness of discourse and whether there is evidence that dissenting views are considered as forces for change at the organizational or policy level. We posit that such change may rectify existing inequalities or take these into account as programmes are being developed or care is being provided. By critically analysing the assumptions that underpin conclusions about health inequalities, space can be created for broader understandings of social determinants of health and the ways they contribute to health inequalities. Such analyses are in line with research that has helped to shift the balance away from individual responsibility for health inequalities towards a view that such responsibilities are shared with society (Butterfield, 1991; Graham, 1993; Wilkinson, 1994, 1996; MacIntyre, 1997; Cooper, 2002).

**Does discourse matter** to professional practice and the people we work with? We would argue yes they do, in that they have the ability to exert an impact on many levels. For these reasons discourse analyses have much to offer in knowledge development for professional practice. The analytic approaches employed here offer a means for showing that when discourses are taken up on the ground, when their impact is pervasive and when discourse is supported by institutional policies, they 'make a difference'. If however, discourse remains 'on the books' or while espoused, if challenges are not acted upon, disjunctures become evident. Such contradictions are noted by those who are, or are not, served. Such contradictions are evident in data or accounts as 'disjunctures' between policy and practice, or evident in voices whose views are denied, eclipsed or minimized with their attendant effects. Such insights prompt us to attend to the ways broader institutional practices shape the relationships we are able to establish with others and influence our actions as practitioners.

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