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Living "In-between"—Vietnamese Canadian Women's Experiences: Implications for Health Care Practice

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Intercultural living—a living that dwells "in-between" spaces of cultures—how it is conceptualized and what its lived experiences might mean, can give the direction for how we ought to care for one another. Drawing from my research with Vietnamese Canadian women, I argue that many immigrant women live and practice health care in "in-between" spaces, spaces that belong neither to East nor to West. Thus, supporting immigrant women's health care practices requires the removal of social ideologies that set apart the West and the "Other." To provide equal and quality health care, caring should occur within in-between spaces, spaces that belong to both those who provide and those who receive health care services.

Intercultural living—a living that dwells "in-between" spaces of cultures—how it is conceptualized and what its lived experiences might mean, can give the direction for how we ought to live our lives and care for one another. For many of us, living our lives and practicing health care are linked to cultural identity, to what and who we think we are. It is imperative for health care professionals to recognize, however, that many Vietnamese women living in Canada are constantly negotiating the differences between Western and Eastern living and Western and Eastern health care practices. In the process of negotiating the differences, there are no binary divisions that delineate or

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reduce these women's lived experiences and health care practice into any fixed identity or category. The ways in which many immigrants live their lives and practice health care involve a multifaceted process—a process of negotiation, which leads to integration as well as resistance.

In this article, by exploring how the "in-betweeness" is conceptualized and what cultural identity might mean to some Vietnamese Canadian women, I argue that many immigrant women live their lives and practice health care in "in-between" spaces, spaces that belong neither to East nor to West. All the names used in this article are pseudonyms.

WHAT IS "IN-BETWEEN" SPACE?

The conceptualization of "in-betweeness" is quite abstract. Thinking about in-between spaces, Trinh's conceptions of "negative space" and "hybridization" come to mind. For Trinh (1992), in cinematography, the negative space designates "the space that makes both composition and framing possible, that characterizes the way an image breathes. To see negative space . . . implies a whole different way of looking at and of relating to things . . . . Emptiness here is not merely opposed to fullness or objecthood; it is the very site that makes forms and contents possible—that is, also inseparable" (p. 142). In talking about hybridization, Trinh refers to "a negotiation of the difference not merely between cultures, between First World and Third World, but more importantly within the culture" (p. 144).

By critically interrogating the notion of identity, Homi Bhabha (1994) mapped out an ambivalent "third space"—a space that is in-between "writing about the identity of the 'deep me,' and identification of a subject, that is, constituting of the subject as the 'written me'" (Aoki, 1996, p. 5). This third space, as noted by Aoki, is a space between the discursive space of "identity" and the discursive space of "identification" (p. 5).

The conceptualization of "in-between" space often denotes a sense of no borders, no boundaries, and no limits. It is a space that belongs to both you and me. It is a space where I am not merely I; a space where I am I, and I am you. It is a space where things can be said and unsaid—a space where new signifiers are obliterated to the dominant designated signifiers. Moving in horizontal spaces, "in-betweeness" exists where the dominant signifiers are opaque. This in-between space is a space where vertical thinking, with its hierarchy, cannot adequately speak to humanly lived experiences. Here, I am reminded of Trinh's words: "Why follow only the vertical and its hierarchies when the oblique and the horizontal in their multiplicities are no less relevant and no less fascinating for the quest of truth and knowledge" (1999, p. 188). Living in-between spaces enables one to forget oneself when one tries to be oneself—the safest of spaces that is. It is a space where one's absence can be made and felt present. It is a place where one is not afraid to speak

and to try out one's ideals that are different from others, a place where my Vietnamese is as visible and audible as your English is. The list could go on.

Informed by Arthur Kleinman's Explanatory Model of Health and Illness (1978; 1980) and postcolonial-feminist perspective (Anderson, 2002; Anderson & Kirkham, 2002), this qualitative study explores contextual factors that influence Vietnamese Canadian women's breast cancer and cervical cancer screening practices. A maximum variation purposive sampling, which is "the process of deliberately selecting a heterogeneous sample and observing commonalties in their experiences" (Morse, 1994, p. 229) was used in this study. In-depth interviewing using a semistructured questionnaire with open-ended questions was the main method of data collection. Fifteen Vietnamese immigrant women and 6 health care providers participated in the study. Vietnamese women's ages ranged from 49 to 78, all spoke Vietnamese, 5 women came from the North, and 10 women came from the South of Vietnam. The average number of years living in Canada for women participants is 22.7 years (range 9 to 26 years). Their education level ranged from grade 2 to university graduate in Vietnam. The health care providers consisted of 4 Vietnamese physicians and 2 community health nurses. The physicians' years of working in Canada ranged from 4 to 21 years. One community health nurse had been working with Vietnamese women for 4 years, while the other nurse worked with Vietnamese women for more than 15 years. All health care providers, except one community health nurse, speak Vietnamese fluently.

The interviews with women participants lasted between 3 and 4 hours (one interview lasted 2 hours). Interviews with the health care providers lasted between 30 minutes to 1 hour. Only two interviews with health care providers were conducted in English; the rest of the interviews were conducted in Vietnamese. The data obtained from interviews were transcribed and analyzed in the primary language of the participants by the researcher.

My in-depth interviews with Vietnamese Canadian women revealed that these women are living and practicing health care in "in-between" spaces. The women participants often talked about their views on Western (Tay phuong) society, Western ways of living, and the Western health care system. They compared these with their Eastern (Dong phuong) counterparts and described how they are in many ways living and practicing health care in what seems to be in-betweeness. This conception of "in-betweeness" might speak to the understanding of how Vietnamese Canadian women view themselves and may have implications for health care practice.

THE VIETNAMESE CANADIAN WOMAN'S IDENTITY

For Trinh (1992), a Vietnamese American woman, identity is a "grafting [of] several cultures onto a single body" (p. 144). Woman can never be

defined, and a female's identity is not unitary (Trinh, 1989). Always resistant to categorization, Trinh insists that female identity can neither be fixed nor fit into categories. For Trinh, the complexity of the politics of identity needs to be fully exposed. Thus a woman's identity should "become more a point of departure than an end in the struggle. . . . In the complex reality of postcoloniality it is therefore vital to assume one's radical 'impurity' and to recognize the necessity of speaking from a hybrid place, hence of saying at least two, three things at a time" (Trinh, 1992, p. 140).

Trinh (1989) asks, "Can identity, indeed, be viewed other than as a by-product of a 'manhandling' of life, one that, in fact, refers no more to a consistent 'pattern of sameness' than to an inconsequential process of otherness?" (p. 95). By asking this question, Trinh is, in fact, urging us to shift our view to not seeing identity as a unifying "cultural pattern," as fixed beliefs and values that govern women's lives, but to see that women's identity is identity-in-the-making which is, in part, a result of a process of othering. This process of othering, from what I have observed, is being produced and reproduced by the ways in which Vietnamese women's image is constructed as "different," as "special" by both the dominant West and the women themselves.

Third World women's difference and their sense of specialness have taken many forms. In the eyes of the dominant West, Third World women have been viewed as from being "hot" sexual objects to being hard-working, sacrificing, tolerating, and submissive individuals (Donnelly, 2002). Difference, in this context, is essentially "division" (Trinh, 1989). As Trinh has pointed out, "difference as uniqueness or special identity is both limiting and deceiving. If identity refers to the whole pattern of sameness within a human life, the style of a continuing me that permeates all the changes undergone, then difference remains within the boundary of that which distinguishes one identity from another. This means that *at heart*, X must be X, Y must be Y, and X *cannot* be Y" (1989, p. 95).

The mainstream dominant creation of the "difference" and "specialness" of these women is in contrast to the ways in which some Vietnamese women themselves use and make use of their sense of being "different." For dominant others, "difference" often has been used to create "division," but for Vietnamese Canadian women, "difference" is a tool of self-defense and a source of motivation.

LIVING "IN-BETWEEN"—VIETNAMESE CANADIAN WOMEN'S EXPERIENCES

Living "in-between" can take many forms. For Vietnamese women living in Canada, it often involves a complex, nonlinear process—a process in which these women, upon recognizing their special sense of being different,

negotiate their differences. In the process of negotiating these differences, many contextual factors are considered by these Vietnamese women in order to come up with solutions, which they see "fit" not only with who they think they are, but also with what they evaluate as the best solutions for their specific circumstances. The result of this negotiation process can be integration or resistance or both.

Acknowledging that Vietnamese women are different from Canadian women, Mrs. Hai, a 50-year-old Vietnamese woman, said,

> For me, I am most concerned about my children. . . . I think about the family situation for my children. I am concerned with looking after the family, eating, cooking. Because I am a woman, I have to pay attention to those things. I see some Canadian women, they don't care so much about these things. They would rather go out to eat. But Vietnamese women, we go to the market, we cook. We organize our family. We take care of the family financial situation, how to spend, making sure we don't have too much debt. I think Vietnamese women spend more carefully. They don't just spend the money for whatever. We know how to control the family financial situation. If we have money, we know how to save it for the future. We don't spend all our money. We are concerned with our children's future. We are also concerned with our parents from both sides [the wife and the husband sides]. We are concerned with our sisters and brothers. We are also concerned with our friends and people around us.

Then she proudly proclaimed;

> It is the Vietnamese women's tradition. We have our tradition, our determination. . . . I think [difficulty] makes us more determined. If we have difficulty, we try harder. We will go up as the result. But if you keep on depending upon others, not trying to be independent, but waiting for others to help you, then your life will not go up. . . . We work so much and so hard. In general, yes, we have come a long way. From not knowing any English. At the beginning, when they asked me, "Are you married?" I didn't even understand what they meant.

To survive and thrive, Mrs. Hai embraces her differences and makes them strengths. This, as I see it, is also her way of resisting dominant forces. As pointed out by Aptheker (1989), women are active agents and their resistance to the dominant forces has taken many forms. Although we may not see many of these resistance activities as revolutionary or as taking the form of political activities, the kinds of women's resistance that go unnoticed by the public are many. These include the ways in which women struggle to improve the quality of life for themselves, for their children, and for other women (Aptheker, 1989).

Living in an intercultural environment—a living with/in "a hybrid place" (Trinh, 1992), Vietnamese immigrant women constantly negotiate differences between the so-called Canadian culture and Vietnamese culture. In this process of intercultural negotiation, they retain their values and beliefs, all the while incorporating some of the Western values into their ways of life. Furthermore, by calling into question the practice of the Other—the Canadian Other, some have, in fact, also questioned their own values:

> *Mrs. Hai*: I think maybe Vietnamese women are going to the extreme. We forget about ourselves. Maybe we should think about ourselves a bit more. . . . I saw my mother-in-law; she is doing the same thing. It's too extreme. We are here. We don't need that. We have money, not like when we were in Vietnam. . . . I save and save money. But I didn't save money for myself. When my children need it, I gave it all to them. Talk about selfish. I don't have it. My daughter, after graduation, her student loan was more than $10,000. . . . So I gave her. . . . I think it was my duty. But Canadians, they don't think that way. . . . Their children, after high school, do whatever. But I think that supporting my kids to go to school is my duty.

What I am hearing in the voice of Mrs. Hai is the insistence of who she is—a Vietnamese woman who follows the call of motherhood's "duty"; echoing in her voice is also a resistance to be identified as the Canadian Other and yet a secret desire to be the Other. Here, difference "implies the interdependency of two-sided feminist gestures: that of affirming 'I am like you' while pointing insistently to the difference; and that of reminding 'I am different' while unsettling every definition of otherness arrived at" (Trinh, 1991, p. 152).

Bhabha's (1994) notion of "doubling" seems to speak to this experience. My reading of Bhabha's "doubling" notion suggests that to really understand the "depth" of identity, its integrity, we have to understand its dimension of "doubling." To Bhabha, doubling of identity refers to a splitting, a spatialization of the subject—a subject that is not "complete," not finite, a subject that cannot be seen as totality but is incomplete, partial, infinite, and in-between. It is in the world of "double" inscription that we come to understand who we are, our identity. On the one hand, we portray our identity by our identification—our physical characteristics, the way we communicate, and the ways in which we perceive things, which makes us belong to a certain group or society. These things distinguish us from the Other. On the other hand, there exists a deep desire, an ambivalent desire for the Other. This ambivalent desire for the Other leads to the "doubled" desire in language—the language that "*splits the difference* between Self and Other" (Bhabha, 1994, p. 50), the language that makes both the Self and the Other's positions partial, incomplete. "Neither is sufficient unto itself"

(Bhabha, 1994, p. 50). Thus, the understanding of difference between the Self and the Other cannot be complete without the understanding of both oneself as other and other as oneself.

Mai-mai Sze (quoted in Trinh, 1991) once said,

> [Fervently] we have wanted to belong somewhere at the same time that we have often wanted to run away. We reached out for something, and when by chance grasped it, we often found that it wasn't what we wanted at all. There is one part of us that is always lost and searching. It is an echo of a cry that was a longing for warmth and safety . . . however our adult reasoning may disguise it, the search continues. (p. 160)

Mrs. Mai, 73 years old, is living with the memory of how difficult her life was back in Vietnam and the vivid images of the war still as fresh in her mind as if it happened just a few weeks ago. Having gone through very lengthy treatment for cervical cancer in Vietnam, only then to go through another 2-day ordeal with the United States bombing of North Vietnam, she is very grateful to be in Canada:

> *Mrs. Mai*: I lay there [in the hospital] so that they could do all the necessary things, taking blood and all that. I had to lay there for a few months before they did the surgery. My [five] young children were at home. I had to leave them. No one was looking after them. My husband would look after them after work. It was very difficult. Thirty years ago my life was that difficult. With a laborer salary, you know, lived under the communist regime we don't have much. We were lucky to have enough to eat. Now, I am here. Whatever it might be, here is the heaven. I am grateful to Canada and to my children for sponsoring me here. Just eat and sit. You see, at my age of over 70, I would not be able to be like this in Vietnam.

Although very grateful and glad to be in Canada, she sadly says:

> Old people like myself, we miss our homeland. I miss it the moment I open my eyes. I always want to return to it. But if I go back, I would not have money to live. So I am stuck. I miss my homeland so much. When I go back there, I meet people on the street, we speak to each other in Vietnamese. Here, all I see is Westerner. I don't know them, I can't speak to them. See, on this side, they are Chinese. On that side, they are Westerners. Living across from here is a Chinese woman. I have not seen her husband for few months and I was wondering if he is okay, but I couldn't say anything to her. I can't speak to anyone. When my husband is not around, I would just listen to the Vietnamese music. I sit here and I knit. My hands are sore, but I still knit. It helps me to forget. I would sit here alone and cry. I miss my home. I would never forget Vietnam.

Difference should not be equated to separateness nor should it be viewed as a precondition for conflict to arise (Trinh, 1991). Difference should not create conflict. The process of negotiating difference, for some women, actually may replace conflict. Ms. Ngoc told how, by adopting Western ideology and the value of individualism, she has, in fact, strengthened her sense of self and relation with others. Speaking from a position of in-between, Ms. Ngoc considers herself to have benefited from both Eastern and Western thinking:

> I am not in conflict with Western thinking. It actually helped me. It is an addition to my traditional way of thinking. I used to be so concerned about and go through great pain to make other people understand me. . . . now, I don't think about it too much anymore. As long as I act correctly, I am satisfied. . . . What I have learned from the Western ways of living and thinking is to look within myself, value myself, and care for myself.

Ms. Ngoc's in-between space embraces aspects of both cultures—of Vietnam and of Canada. In the process of adaptation to their new life, rather than giving up their ethnic origin and cultural identity in order to assimilate into the new society, Vietnamese immigrants retain aspects of their cultural values and beliefs At the same time, they interact with and adopt certain aspects of mainstream society.

Recognizing that there is always a danger of "falling over" to the other extreme, however, Ms. Ngoc cautiously guards herself: "But I have to be careful not to go to the point that I would not want to help others. That would be very selfish. If you only care for yourself, that would be too selfish. And that is the difference." When asked in what ways the Western emphasis on individualism has benefited her, Ms. Ngoc responded that a balance between Eastern collectivism and Western individualism has made her feel calmer and more relaxed. It has helped her resolve some conflicts within herself. Under the influence of traditional Vietnamese culture, Ms. Ngoc was taught by her parents to always sacrifice her own happiness for others, for her husband, children, and for the husband's family, values that she always willingly accepted and acted upon. Still, for her, happiness is when she saw that the others are happy. The difference she now feels is that making others happy is the desire that comes from within. She continues to make others happy, because she, herself, values it. She continues to make many sacrifices, but she does so out of her own will, not because she is conforming to the dominant forces. At the very least she now has a choice without needing to feel guilt.

Recognizing that within differences there are similarities, Ms. Ngoc observes: "Here, many people [Caucasian Canadians] think that their families

are very important as well. I think a mother's love for her children and the family is something that is fundamental to human nature."

Trinh (1999) found that by weaving French theory and Asian thought, she has disrupted the boundary that separates "the critical continental theories with traditional Asian philosophies" (p. 63). She says,

> What interests me is not a return to the roots nor an assimilation of French theory but rather how I can use all the tools that I have in their radical resistance to one another; how I can read Zen Buddhism and Taoism in light of contemporary critical continental philosophy. The process of cultural and theoretical hybridity gives rise to an "elsewhere within here"—a space that is not easy to recognize, hence to classify. (p. 63)

As a learned teacher who can recite the whole 3,000 verses of *Kieu* and who taught Vietnamese literature in Vietnam, Ms. Ngoc insisted that not only does she not have to let go of her beliefs and values but also that she can see some of Confucius's teachings within contemporary Western thinking. To Ms. Ngoc, the boundary that divides Eastern and Western modes of thinking is permeable:

> No, no, I keep everything that is mine. If it is good, I keep it. For example, the old verse that tells us how to treat others: "Nhan, Nghia, Le, Chi, Tin." Nhan means kindness; Nghia means justice; Le means respect; Chi means wisdom; and Tin means trustworthy. But you see, Westerners have these principles also. So if you take this Confucius concept and compare it with the teaching here, you can see that people here have been taught all that as well.

Here the in-betweeness and the resistance to the division between East and West, between Self and Other, echoes what is said by a Vietnamese woman in *Surname Viet given name Nam*: "Our history is always on the borderline of this north and south, but I speak from somewhere in both places, in between, and I will not accept this division, and I will not think truth divides itself in that way" (Trinh, 1999, p. 22).

IMPLICATIONS FOR HEALTH CARE PRACTICE

Canada is a multicultural society and equality is a basic social value underlying the Canadian health care system. According to Storch (1996), equality in health care means that all citizens ought to be given equal access to health care regardless of wealth, race, gender, or ethnic origin. The Canadian multicultural policy, as then Prime Minister Pierre Trudeau put it, aims "to break down discriminatory attitudes and cultural jealousies . . . (and) form the base of a society which is based on fair play for all" (House of

Commons Debates, October 8, 1971: 8545, cited in Li, 1988, p. 9). This policy supports the belief that different ethnic groups are an integral dimension of the Canadian national mosaic and the source of the nation's enrichment and strength. For health care, the passage of the Canadian Multiculturalism Act emphasizes the following: (1) Because ethnic diversity is an important dimension of the Canadian national mosaic, it is a legal and ethical mandate within societal institutions to promote changes that will enhance cultural sensitivity and reduce discrimination (Elliott & Fleras, 1992); (2) Sensitivity to and respect for ethnic diversity are important dimensions in planning health care services (Anderson, 1990; Dyck, 1989); (3) It is an ethical and legal mandate for health care professionals to address the cultural needs of individuals, families, and communities (Kulig, 1995); and (4) to ensure that all citizens have equal access to health care services, health care institutions are obliged to consider ethnic diversity in planning resource allocation and in decision-making processes (Donnelly, 1998).

Even though Canada has one of the best health care systems in the world and the Canadian health care system has changed its services to some extent to accommodate the health care needs of clients with different ethnocultural backgrounds, many immigrants living in Canada are experiencing difficulties accessing the current health care services. Based on ethnographic data obtained from immigrant women living with diabetes, Anderson and her colleagues (1993) argued that a significant number of her informants had difficulty in their encounters with health care professionals. The women, especially non-English speakers, were unable to obtain the services they needed because health care professionals often failed to understand that the position and conditions in which the women worked and lived could be a major barrier to the appropriate management of illness. As a result, the current health care system, which is based on the Western ideology of health and illness, remain inadequate to meet the health care needs of clients from different ethnocultural backgrounds (Anderson, Blue, & Lau, 1991).

Given that there is a large number of Southeast Asian-born people—the so-called Oriental—entering Canada each year, government policymakers and health care professionals need to recognize that immigrants have special mental, physical, and cultural health needs, and that these needs arise as the result of the impact of the migration process and the very different environments and circumstances from which immigrants come.

As observed by Said (1994), in many Western societies there are two popular ideologies that set apart the Oriental and the West. One is "the line that draws between the two continents. Europe is powerful and articulate; Asia is defeated and distant" (p. 57); and two is the conception of the Orient as insinuating danger, and that it is irrational and mysterious. Said insists that these ideologies, in many circumstances, have been used as justification for the West to see the Orientals' experiences as something inferior, backward,

and of lesser value to the West. These ideologies might have shaped the ways in which people from 'the Orient' are experienced, talked about, and related to.

In health care practice, these perspectives manifest themselves in the ideology that considers that traditional medicine (such as Vietnamese or Chinese medicine) does not work, and that biomedicine does. There is an assumption that eventually people will become "rational" in their decision making and seek Western medical treatment (Stephenson, 1995). This binary, stereotyped ideology has not only put Western medicine and traditional medicine into opposition, but also has limited the practice of traditional medicine. As evident in Canada, Western medicine is covered by the universal health care system, while traditional medicine, which is viewed as alternative medicine, is not (Stephenson, 1995). Mrs. Phan, a Vietnamese Canadian woman, found that although acupuncture is the most effective treatment for her sciatic nerve problem, she could not seek this type of treatment due to financial constraints. Like other Vietnamese women participants, Mrs. Phan recognizes the differences between traditional Chinese medicine and Western biomedicine, and uses both types. For her, health care practice cannot be reduced to either Eastern or Western modalities, but, rather, it is based upon what she sees as appropriate treatments for particular diseases:

> I use both traditional Chinese medicine and Western medicine. For diseases, which affect the nerves, traditional Chinese medicine is better. But Western medicine is better at treating other diseases such as women's infection problems and general infections. With these diseases, we need antibiotics to kill the bacteria. We cannot use traditional Chinese medicine to treat these diseases because its effect is much slower . . . . So I use traditional Chinese medicine for the diseases that can be treated by these medicines, and Western medicines for infectious diseases that need antibiotics.

CONCLUSION

Canada's multicultural society is made up of people from many different ethnocultural backgrounds. How can we, together as people of one nation, live in harmony despite our differences? How do we find a balance—a balance that is "in-between," which might accommodate everyone and treat everyone in a "just way" but not the "same way." With the recognition that each of us will always be different from one another, our task should not be to eliminate the differences so that everyone can be the same, but, rather, to change our ways of thinking about difference. "Difference" should not create conflict nor should it be used as tool of division to conquer. "Difference" should be used to create strength. We should produce knowledge and create

discourses that celebrate and appreciate difference as a "thing" that brings color and fragrance to life, instead of something that is awkward, uncivilized, or inferior.

Differences create both strengths and losses. While differences create many difficulties—dissociation, losses, and grief—they also create strength and resilience. Embedded and interwoven in immigrant women's narratives are many strengths and wisdom from which health care providers can gain insight. Adjusting to and living a new life are very difficult and there are many sad stories. These stories illuminate how these women, against all odds, have maintained their dignity and self-respect. It is imperative for health care providers to recognize that clients from different cultural backgrounds live their lives and practice health care in "in-between" spaces, spaces that belong neither to the East nor to the West, and that "[their] ability to shift and to remain multiple defies all reductive attempts at fixing and classifying" (Trinh, 1999, p. 62). Aside from "such understanding . . . would enhance trust and therapeutic alliance and thereby provide clinicians with the opportunity to intervene when necessary" (Lin & Cheung, 1999, p. 777), quality health care services and meaningful health care relationships can come about only when there is a mutual respect between health care providers and clients. Helping can be accepted only when a genuine sense of caring is felt by the clients—a sense of caring that is borne not out of pity but out of true understanding, respect, and compassion.

Shall We Dance?

By Tam Truong Donnelly

Can you hear my silent voice?
Can you see my absent presence?
Can you feel my pain?
Can you touch my soul?
Can you taste my bitterness?

Who am I?
Asked—a floating shadow
Invisible to naked eyes.

You
Over there
in the center
fully clothed.
Me
Over here
walking around your circle
naked, from the margin.

Acknowledge me,

know me through my white masks.
The color of white—the color of invisibility.
To survive, I wear white masks,
scream with my silent voice,
taste my own bitterness,
feel my own pain,
swallow my ego,
climb mountains.

You asked me
How is life at the margin?

Listen to me!
If you want to hear me,

cover your ears.
For my true voice can only be heard
with your heart
your mind
your conscience
Close your eyes if you want to feel my smiles.

Recognition/negotiation

Come!
to the in-between
the interspace
the third space
the hybrid place.
Shall we dance?

REFERENCES

Anderson, J. M. (1990). Health care across cultural. *Nursing Outlook, 38*(3), 136–139.

Anderson, J. M. (2002). Toward a post-colonial feminist methodology in nursing research: Exploring the convergence of post-colonial and black feminist scholarship. *Nurse Researcher: The International Journal of Research Methodology in Nursing and Health Care, 9*(3), 7–27.

Anderson, J. M., Blue, C., Holbrook, A., & Ng, M. (1993). On chronic illness: Immigrant women in Canada's work force—A feminist perspective. *Canadian Journal of Nursing Research, 25*(1), 7–22.

Anderson, J. M., Blue, C., & Lau, A. (1991). Women's perspectives on chronic illness: Ethnicity, ideology and restructuring of life. *Social Science and Medicine, 33*(2), 101–113.

Anderson, J. M., & Kirkham, S. R. (2002). Postcolonial nursing scholarship: From epistemology to method. *Advances in Nursing Science, 25*(1), 1–17.

Aptheker, B. (1989). *Tapestries of life: Women's work, women's consciousness, and the meaning of daily experience*. Amherst: University of Massachusetts Press.

Aoki, T. T. (1996). *Narrative and narration in curricular spaces*. Paper presented at the Green College, University of British Columbia. Vancouver, BC: Canada.

Bhabha, K. H. (1994). *The location of culture*. London: Routledge.

Donnelly, T. (1998). *Perspectives on the health of Asian immigrants: Minimizing inequality and improving access to health care services in British Columbia*. Unpublished master major paper. Vancouver: University of British Columbia School of Nursing.

Donnelly, T. T. (2002). Representing "Others": Avoiding the reproduction of unequal social relations in research—A methodological issue. *Nurse Researcher: The International Journal of Research Methodology in Nursing and Health Care, 9*(3), 57–67.

Dyck, I. (1989). The immigrant client: Issues in developing culturally sensitive practice. *Canadian Journal of Occupational Therapy, 56*(5), 248–255.

Elliott, J. L., & Fleras, A. (1992). *Unequal relations. An introduction to race and ethnic dynamics in Canada*. Scarborough, Ontario: Prentice-Hall Canada.

Kleinman, A. (1978). Concepts and a model for the comparison of medical systems as cultural system. *Social Science and Medicine, 12*, 85–93.

Kleinman, A. (1980). *Patients and the healer in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. London: University of California Press.

Kulig, J. C. Culturally diverse communities: The impact on the role of community health nurses. In M. J. Stewart (Ed.), *Community nursing: Promoting Canadians' health* (pp. 246–265). Toronto: W.B. Saunders Canada.

Li, P. S. (1988). *Ethnic inequality in a class society*. Toronto: ON: Thompson Educational Publishing.

Lin, K. M., & Cheung, F. (1999). Mental health issues for Asian Americans. *Psychiatric Services, 50*(6), 774–780.

Morse, J. M., & Lincoln, Y. S. Designing funded qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 220–235). Thousand Oaks, CA: Sage.

Said, E. W. (1994). *Orientalism*. New York: Vintage Books.

Stephenson, P. H. (1995). Vietnamese refugees in Victoria, BC: An overview of immigrant and refugee health care in a medium-sized Canadian urban center. *Social Science and Medicine, 40*(12), 1631–1642.

Storch, J. (1996). Foundational valves in Canada health care. In M. Stungl & D. Wilson (Eds.), *Efficiency vs. equality: Health care reform in Canada* (pp. 21–26). Halifax, NS: Fernwood.

Trinh, T. M.-H. (1989). *Women, native, other: Writing postcoloniality and feminism*. Bloomington and Indianapolis: Indiana University Press.

Trinh, T. M.-H. (1991). *When the moon waxes red: Representation, gender and cultural politics*. New York: Routledge.

Trinh, T. M.-H. (1992). *Framer-framed*. New York: Routledge.

Trinh, T. M.-H. (1999). *Cinema interval*. New York: Routledge.