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Social Justice: A Concept for Undergraduate Nursing Curricula?

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Abstract

As nursing enters the 21st Century, the profession continues to experience the effects of heterosexism, gender inequality, and racism/ethnocentrism, in large part because these concerns are not explored and processed by students prior to entering professional practice. This paper evolved out of my concern that social justice issues are not examined in the majority of undergraduate programs in nursing, or if they are, they belong to the realm of one or two courses and are not integrated into the framework of the entire curriculum. Students examining these issues in their college programs frequently do so through electives in sociology, anthropology, women's studies, or English. A critical pedagogy not only gives students the tools needed to perform a postmodern critique of these issues, but it also assists students in understanding social practices that determine what and how they think about issues of social justice and oppression.

This paper begins with an exploration of the development of power/domination constructs in the profession of nursing and how these constructs influence nursing education, nursing practice, and the delivery of patient/client care. Equally important is an examination of the current state of nursing education and the reasons why change must occur before an integration of social justice issues can be realized. The paper will also illustrate the ways in which students benefit from the integration of social justice discourses into the undergraduate nursing curricula. Changes in the areas of values, ideology, focus, goals, and practice, can assist students in developing critical thinking skills that consider the multiple realities and contexts which define their own and their patients' identities.

Key Words: *nursing education, nursing curricula, social justice, discrimination*

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Aside from a course or a class in transcultural nursing, nurses graduating from most undergraduate nursing programs are not exposed to the concept of social justice, or related discourses such as racism, postcolonialism, postmodernism, imperialism, or white privilege. These issues may or may not be studied in graduate school, depending on program objectives

and individual faculty. However, since many of the nurses practicing today and in the future will be baccalaureate-prepared, how can we expect that changes in nursing practice will occur on a global level if we save the study of social justice issues for graduate education?

All disciplines, including nursing, benefit from education for freedom and a transformative pedagogy.[1,3] In an increasing number of university programs, social justice education begins in the core curriculum. It is during the third year that many students concentrate on their majors and, in an ideal educational structure, social justice will then be integrated into their areas of specialty. Not only are many nursing students not receiving the benefits of a core curriculum that concentrates on critical reflection for issues of democracy and social justice, many are also recipients of a nursing education that is focused more on clinical expertise than one that *also* prepares world citizens committed to social justice in the diverse areas of health care.

Equally important is an examination of the issues of power and domination within nursing that lead to apathy and horizontal/vertical violence.[4-8] Allen[9] suggests that nursing schools create and reinforce models of compliance, conformity, and obedience. The process moves from the top (accreditation) down (to students) and leaves in its wake a path of anger, resentment, and resistance that affects faculty as well as students. It perpetuates faculty efforts to dictate and control how and what students learn and reinforces the students' passivity and subordination.

This paper begins with an exploration of the development of power/domination constructs in the profession of nursing and how these constructs influence nursing education, nursing practice, and the delivery of patient/client care. It is important that nurses understand the sources of their own oppression before they are able to look at the oppression suffered by other marginalized people, many times at the hands of health professionals. Equally important is an examination of the current state of nursing education and the reasons why change must occur before an integration of social justice issues can be realized. The paper will also illustrate the ways in which students benefit from the integration of social justice discourses into the undergraduate nursing curricula. Changes in the areas of values, ideology, focus, goals, and practice, can assist students in developing critical thinking skills that consider the multiple realities and contexts which define their own and their patients' identities.

Power and Domination in Nursing or Is That a Yoke around My Neck?

Prior to the evolution of hospitals into places of healing, as opposed to places of death, nursing practice occurred in the home and the community. During this period, nurses had much more autonomy than they did at the turn of the 19 th century when the direction and education of nurses came under the control of physicians and hospitals. This change of power resulted in a Victorian-like male domination of their behavior and practice that led to the stereotype of nurses as the "handmaidens" of the physicians, serving "men's needs and convenience."[10]

Training at the beginning of the 20 th century consisted of some classroom work and many hours spent in apprenticeship arrangements on the wards. Much of the teaching was done by physicians themselves and "it was ideal as a means of keeping a female group in subjection to male-dominated groups."[10p75] It also left nursing equally vulnerable to the domination and control of practice by hospital administrations.[10]

Roberts[7] summarizes the characteristics of oppressed groups described by Freire[1] and illustrates how the attitudes and behaviors of nurses identify them as an oppressed group. Despite the myth of "autonomy" that exists in the profession today, in reality, nurses lack autonomy, authority, and control over their practice. Nurses have become so acculturated to the status quo that they do not even see themselves as being oppressed. Cleland states that "dominance is most complete when it is not even recognized."[7p30] Although unions provide some improvement in salary, benefits, and working conditions, nursing practice is still highly controlled by physicians and hospital administrations. The economic bottom-line seems to be the basis for many of the decisions made at the institutional level. It is a sad commentary that nurses comprise the largest group of employees and yet have relatively little, if any, voice in the decision-making process.

Marginality has been described as a state of successful assimilation[7] —an empty space in which the marginalized person is without a cultural identity. Marginalized people reject their native culture in an attempt to adopt the dominant culture, expecting that they will also receive the power and control experienced by this group. When this does not happen, and it never does, the marginalized person realizes that he or she does not fit in anywhere and is relegated to an existence in the 'borderlands' of their own group. This positionality is evident by the attempts nurses have made to model nursing theory, practice, and research after the "mechanistic model of medicine," assuming that "if they could only attain the characteristics of the powerful, or professional status, they too would be powerful."[7p26] Many times a little power *is* thrown their way but it is only a paternalistic attempt to pacify and thereby maintain the dominant norm.

Nurses often think of themselves as second-class citizens. This evidences the lack of self-esteem that is characteristic of many nurses, resulting from the fact that the qualities exhibited by nursing, such as caring, warmth, nurturance, and sensitivity, are devalued by a dominant medical culture that prizes intelligence, decisiveness, and lack of emotion.[7,11] Injured self-esteem leads to self-hatred and a dislike for other nurses, explaining the fragmentation nurses experience on a national level (i.e. lack of involvement in professional organizations and political action groups) and on a local level (i.e. divisiveness in hospital and community committees).

The divisiveness experienced in nursing causes nurses to lash out at each other because to do so with their oppressors, the real source of their anger, could have devastating consequences. This behavior is known as "horizontal violence" and has the unfortunate effect of providing "proof" to the dominant group that subordinate people *are* unable to be rational and to organize/govern themselves. The inability of nurses to unify on professional and political issues keeps them vulnerable to the dominant culture, again maintaining the status quo.[1,6,8,9,11]

If It Isn't Broke, Why Fix It?

How do we determine if a particular nursing program is successful? There are many sources available for critiquing a school/college of nursing: accrediting organizations, alumni, present students, staff members in local hospitals, etc. The yardstick that is accepted as being the most reliable measure for the present and future success of a nursing education seems to be the percentage of students who passed the NCLEX-RN, a concept supported by Sayles, Shelton, & Powell,[12] in their paper on *Predictors of Success in Nursing Education*.

Do high NCLEX-RN percentages and equally high GPAs mean that institutions are offering their students the best possible education? Do outstanding grades and scores automatically translate into empathetic, caring nurses who also demonstrate exceptional critical thinking skills while equally valorizing propositional and practical knowledge? Spence[13] has suggested that the persistent requirement for students to pass state examinations is actually a barrier to the progress of nursing education:

Legislation … requires that statutory bodies monitor standards of practice…. Yet the ability to memorize large amounts of very specific information gives no assurance that successful candidates will respond appropriately in the highly contextual situations of nursing practice. Much of what is important to nursing cannot be measured in this manner.[13p190]

Over the last two decades, there has been discussion regarding the need for a *paradigm shift* or *curriculum revolution* in nursing education. These discourses refer to "the widespread replacement of behaviorist, Tylerian nursing curricula with those oriented to emancipatory, caring—educative strategies."[14p125] Kuhn's[15] notion of paradigmatic thinking has influenced much of what has been written in recent nursing literature as scholars have applied his theory of scientific revolutions to issues of curriculum reform. Thorne, Kirkham, & Henderson[14] describe paradigmatic shifts as "extreme turns in direction in a manner that is philosophically incompatible with the dominant paradigm, and imply that a complete break from former educational process and content is required."[14p126,15]

This *curriculum revolution* is actually part of a larger movement within general education toward a more liberal pedagogical model influenced by humanist existentialism, phenomenology, and critical social theory.[14] Nursing seems to be shifting from the behaviorist model more slowly than other disciplines, presumably because of the nature of the information nurses must acquire to pass licensing examinations.[16] The behaviorist model of education has been compared to what Freire[1] describes as the "banking system" in which teachers deposit information into student receptacles. The hallmark of this model is the lecture, described as "one of the most patriarchal forms of education"[17p3]in existence.

In her discussion of critical scholarship, Thompson[18] describes the process of critical scholarship as resting on "reflection and insight," allowing one to see oneself in new ways. This reflection and insight also reveals the ways "in which the self has been formed (or deformed) through the influence of coercive power relations."[18p33] It is a goal of critical scholarship, and critical education, to make these power relations transparent, providing nurses with the ability to see through them, "for these relations lose power when they become transparent."[18p33]

An emancipatory paradigm promotes process-driven curricula rather than those that are content-driven. The focus, however, has been described as both *student-centered*[14] and *client-centered*[19,20] Varcoe[20] asserts that by making the client the focus of empowerment, one cannot help but address "the hegemonic influences of institutions" in health care settings, a concept which has not been discussed very often in nursing literature.[13] The hierarchical relationship between teacher and student can be broken down through the development of a *dialogic relationship* where student and teacher together study the object of learning.[21] This mutual

learning process itself challenges the authority of the teacher and encourages the technique of 'drawing out' both prescribed information and received knowledge.[9,22]

The movement to curricula reform is complex, unsettling, challenging, exciting, and in some ways, intimidating. For professionals with a history of oppression, change can provoke fear and feelings of inadequacy. It is for this reason that faculty, clinicians, clients, students, and administrators need to work together for transformation—supporting, rather than opposing one another. Only then can a climate for the discussion of social justice issues be created and only then will the goals of fostering human worth and dignity and optimum health care be realized.

Five Coins in the Fountain

The five discourses discussed in this section provide a framework for the integration of social justice concerns in undergraduate curricula. It is beyond the scope of this paper to provide more than a cursory treatment of each discourse, especially since volumes have been written on each one in the context of professional nursing and education.

1. Change in Values: Social Justice and Critical Theory in Higher Education

The need for the academy to deal with issues of social justice is evident on both an internal level and an external level. On the internal level, the need to address social justice is illustrated in documented cases of sexism in the hiring, decision-making, representation, salary, teaching and promotion of faculty.[23-28] Additional evidence is found in examples of sexual harassment of students and faculty by other students and faculty members.[25,26,29] Also relevant are examples of racism inflicted upon faculty, as well as students.[30-41] Social justice is also challenged by harassment, safety, and job security issues resulting from homophobia directed toward students and faculty.[17,42,44] Another concern involves verbal and non-verbal behaviors affecting those with different mental and physical abilities from that which is considered to be the "norm."[45-48] And finally, questions of social justice are raised by stereotyping and/or encountering pressures to meet socioeconomic expectations endemic in academic culture.[17,36,49] These analyses also suggest that the external realities of social justice questions mirror the microcosm of what is faced within academic walls by those students and faculty not identified with the dominant culture.

Young[50] suggests that oppression is a central category of political discourse, however, many do not equate oppression with social injustice. In her essay on the *Five Faces of Oppression*, Young differentiates between the traditional use of the term "oppression" and a more contemporary usage—the former meaning "the exercise of tyranny by a ruling group" and the latter designating "the disadvantage and injustice some people suffer … because of the everyday practices of a well-intentioned liberal society."[50p36]

Critical pedagogy seeks to alter the discourses responsible for repressive and oppressive institutions by empowering the individual through the process of conscientization. Only when students understand and accept the responsibility they carry for either maintaining social institutions or causing them to change, can there be any hope for social transformation. Drevdahl, Kneipp, Canales, & Dorcy[51] provide a critical illustration:

What would happen if we treated people in poverty as if they were drowning? Addressing poverty with such immediacy requires that nurses, along with other health professions, first create a climate of unacceptability for socioeconomic differentials, including those in health. We must take risks if we want to expose and change how the economy, the state, and civil society with particular emphasis on the overpowering dominance of market philosophies and policies generate health inequalities…. Service is key—we must demonstrate our commitment to social justice through our actions. This will require nurses … to maintain an ecologic view of health, to take seriously the public health core function of policy development, and to develop political competency. Although we speak the words of social justice, it is how we act that demonstrates our philosophy.[51p26]

Similar sentiments are expressed by Kirkham & Anderson:[52]

We have come to realize that our nursing scholarship needs to look beyond individual experiences of health and illness to encompass the social foundations that determine health status to a large extent….Influenced by the realization of a society structured by discrimination and inequities, as well as legislated and public health policies that mandate equitable and accessible health care, nursing scholarship has begun to examine the role of the profession in fostering social justice.[52p2]

Taylor[53] agrees, "We must move beyond the comfort and safety net of "multiculturalism" and "cultural diversity" and simultaneously address broader issues such as racism, sexism, and classism, and how these operate, both within nursing and nurses, to deny access to optimal health for populations/women of color."[53p40] The case has been clearly presented that an understanding and commitment to social justice is required for nurses to be able to act, on the parts of their patients, to improve access to health care. Yet, it is equally clear that nurses are not receiving education for social justice in their nursing programs.[52,54]

2. Change in Ideology: Post-Colonialism, Post-structuralism, and Postmodern Feminism

Post-colonialism

Post-colonialism focuses on the effects and aftermath of colonization, a process whereby a powerful country (European or U.S.) conquers a less-powerful country and subjugates the people and resources of the land. This process has also been called *cultural imperialism* and was legitimized by the belief that Europeans were closer to God because of their appearance, education, and civility. Every other "race" was considered to be "less than" and with Europeans at the pinnacle of the hierarchy, it continued downward based on skin color and tone. It was believed that at some point science would support the superiority of the white race, even as the people of the 16 th and 17 th centuries believed religion had.[55] Even today, studies show that lighter-skinned persons of color experience less discrimination than darker-skinned people.[56-58] Postcolonialism is a multifaceted concept and is best understood when it is seen from an interdisciplinary point of view.[52]

The term *postcolonialism* originated with the writings of Frantz Fanon[59-61] and Aimé Césaire[62] around the middle of the 20 th century. Edward Said's[63] contemporary work, *Orientalism*,

initiated a new mode of academic inquiry and theory in the form of colonial discourse analysis. As a philosophy and as a theory, postcolonialism provides nurses with the ability to interrogate their own perspectives on racism, ethnocentricism, and white privilege, and to understand how the health disparities present today are a result of a *neocolonialism* that exists in the dominant culture of the 21 st century.

For example, Duran & Duran[64] describe the effects that colonialism has had on Native Americans forced to leave their families as young children to live in boarding schools until their educations were completed. The residential school program was developed by the U.S. military in the latter part of the 19 th century as a means of assimilating Indian children into the dominant culture.[65] Most schools were organized and run by religious communities. Conservative estimates place the sexual and physical abuse in these schools at 80%, though the testimony of the adults who survived them places it closer to 95%.[66] There was little in the way of teaching or health care in these schools and hundreds of children died from disease and injury. The off-land boarding schools were closed by 1930 but the reservation school system lasted until the 1990s, leaving a legacy of generations of abuse, poor education, loss of culture, dysfunctional families with unprecedented rates of domestic violence, substance abuse, and suicide, far greater than the national average, all leading to the most painful sacrifice—the loss of soul.[64-66] The horizontal violence described in the nursing scenario at the beginning of this paper, is the same construct at play in the lives of marginalized people who turn their anger inward on themselves and on their families, generation after generation. These are the people who will become the patients of our nursing students and it is important that they have a postcolonial framework in which to understand this construct and its responsibility for the underlying physical and psychological symptoms exhibited by their patients. Without such a framework, stereotypes can be fostered that will look past the patients reality and make it difficult, if not impossible, for real healing to occur.

Kirkham & Anderson[52] found that undergraduate programs were failing to educate nurses for social justice, as evidenced by the fact that these discourses had not yet found a home in our discipline, “Although postcolonial discourses are still infrequent within nursing, there is a growing call for the integration of postcolonial perspectives into our science as an alternative to the culturalist approaches that predominate nursing theory.”[52p2] Anderson[67] explains why this is important for nursing education and scholarship:

I believe that a *postcolonial* feminist perspective promises a more inclusive nursing scholarship. It would give voice to racialized women who have been *silenced*, and provide the analytic lens to examine how politics and history have variously positioned us, shaped our lives, knowledges, opportunities, and choices. A postcolonial feminist perspective also has the analytic power to illuminate how ‘cultural facts’ are socially constructed and produced.[67p145]

Post-structuralism

The values of logical positivism are the values of the mechanistic medical model and are not congruent with the *varied* ways of knowing that comprise the values situated in the framework of nursing practice. This is not to say that there is not a place for logical positivism in nursing research, only that the empirical model is one way of knowing—and borrowed, at that. Doering[68]

explicates, “The feminist poststructuralist framework provides a theoretical means of unmasking the conflicts and contradictions between the experiences of nurses as women and as professionals and the socially institutionalized definitions of women’s and nurses’ nature and their social and professional roles.”[68p32] Doering describes the importance of intuitive knowing which does not rely on the quantitative elements of medicine but on the “nonquantifiable elements in the nurse-patient relationship that are not based on environmental cues.”[68p31] Equally as important is the contextual, phenomena-centered knowledge which “values and focuses on personal experience [assuming] an intimate link between the knower and the thing to be known.”[68p31] This subjective and personal knowing is in contrast to the empiricist need to objectify, control, and manipulate. Nursing knowledge is concerned with the concept of caring, a function which is experiential, and only measurable in its outcome.

Postmodernism

As opposed to post-structuralism, *postmodern* thought developed throughout a range of disciplines during and since World War II. Postmodernism had its beginnings in art and architecture but its influence has spread over the years to virtually all fields of culture and study.[69] Similar to post-structuralism, postmodern thought has been influenced by the French theorists, most notably Foucault and Derrida. Its premise is that the Cartesian dualisms on which Western society is constructed, are not appropriate for understanding the multiple realities present in the world today.

Nursing must accept and work within the discourse of postmodernism just as other disciplines are learning to do, otherwise it will not be possible to provide competent care to patients whose realities and experiences differ from those of the dominant culture. If a postmodern perspective is not part of the theoretical framework and design of nursing research, the research will be limited in scope and not reflective of the global diversity within and beyond U.S. borders. Watson[70] appropriates a quote from Edward Said[71p225] that emphasizes the importance of postmodernism to nursing, “Is it possible for [nursing science] to be different, that is to forget itself and to become something else—or must it remain a partner in domination and hegemony?”[70pp62-63] Change will occur only as nursing education instills within its students the theory, skill, and reclamation of power necessary to foster a climate of creativity, innovation, and transformation.

3. Change in Focus: Identity Politics

The second half of the twentieth century has seen the emergence of a number of large-scale political movements that were the result of groups of people reacting to the injustices done to their particular communities (e.g. racial/ethnic, gays/lesbian/bisexual/ transgender, women, etc.). These injustices came through many different means and at the hands of the dominant social class in the form of cultural imperialism. Identity politics starts with the analysis of the oppression, moving to a rejection of the dominant culture’s assessment of the group’s inferiority, and resting in the reclamation and redescription of one’s own sense of value and worth. Vandenberg[72] explains, “One has to ‘position’ oneself, or acknowledge the ‘position’ from which one speaks, for one supposedly is always a gendered, racial, classed, ethnic subject, never an abstract subject capable of universalizing thought.”[72p365] Thompson[73] expands upon this concept

when she suggests that “identity is not static, but fluid and changing ... not unitary, but fractured and split by the different positions one occupies, by the different members of the group, by the parts of oneself that are repressed, or by the members of the group who are silenced.”[73p26]

The intersection of identity politics and various forms of multiculturalism is an important area of investigation for nurse educators. A critique of identity politics suggests that “celebrating” identities of difference may have stereotypical effects and may lead to distorted impressions of power and identity. Pedersen[74] for example, describes the phenomenon of “false cultural awareness” in which students perceive themselves to have adequate skills when, in actuality, they lack an understanding of multicultural experiences. This may occur when students rely on cultural stereotypes with which they have become comfortable as substitutes for the actual experiences, finding out after the fact that not all persons in any particular culture are the same. Eliason[75] in her study of undergraduate nursing students’ comfort with culturally diverse groups discovered that lack of knowledge, skill, and exposure to different groups of people was the primary factor that elicited discomfort among students around issues of race/ethnicity and patient care. Results also maintained that the more exposure students received to different lifeways, the more culturally sensitive they became.

4. Change in Goals: Praxis

The study of social justice discourses yields many opportunities for student reflection—on themselves, their families, their community, the nation, and the world. The study of praxis provides students with a context for transformative action. As with many of the social justice discourses, *praxis* is difficult to define. Given the ways in which praxis has developed and adapted through various disciplines over the years, it is easy to understand how the term could be described as dynamic in both its evolution and its meaning.[76]

Nursing has an interesting history with the concept of praxis. Some scholars understand this discourse from the perspective of bridging the theory-practice gap.[77] Bevis[78] explicates: “In a clinical field, such as nursing, the praxis of caring occurs; theory and practice live together, each informing the other.”[78p56] Given the fractured relationship that theory and practice have had in the history of nursing, this statement is particularly poignant. Other scholars view praxis from a critical theory perspective in which the bridging of theory and practice motivates the professional to *reflect* on the hegemonic power structures in play and to *act* in ways that will change those structures, thereby empowering the profession of nursing and improving access and quality of health care to clients.[20,79-81]

Action must be informed by critical reflection if it is to be considered emancipatory. The action may involve risk-taking when an individual chooses to challenge the status quo. Ford & Profetto-McGrath[79] explain that there are two essential features of action in the critical thinking model—improvement and involvement: “Improvement is a consequence of taking the appropriate action in a specific context and involvement is a manifestation of a commitment to action”[79p343] based on critical reflection. Both elements are significant in the context of a profession that is seeking emancipation from powerful structures of oppression and from a group of professionals moving towards resistance.

In her essay on *Leadership for Social Justice and Equity*, Brown[82] expresses concern that schools are not developing leaders who will commit to issues of social justice and transformation, stating that there is a need for "professors to retool their teaching and courses to address issues of power and privilege—to weave social justice into the fabric of educational leadership curriculum, pedagogy, programs, and policies."[82p78] There is concern among scholars as to the feasibility of attempting to teach the concept of praxis to undergraduate students.[77,79,82-85] However, Brown[82] counters these concerns by stating:

Because contemporary researchers (Argyris, 1990; Banks, 1994; Senge, Kleiner, Roberts, Ross, & Smith, 1994; Wheatley, 1992) have found that effective leaders take responsibility for their learning, share a vision for what can be, assess their own assumptions and beliefs, and understand the structural and organic nature of schools, preparation programs need to carefully craft authentic experiences aimed at developing such skills. Students need time to think, reflect, assess, decide, and possibly change.[78]

It is beyond the scope of this thesis to discuss the many ways in which Brown's model may be appropriated. Praxis is a dynamic process that incorporates both inductive and deductive reasoning, involving reflective dialogue, coupled with transformative and emancipatory action, as a tool for dismantling the oppressive structures within our society. Many baccalaureate graduates will never attend graduate school. If they do not develop a meaningful praxis in college, where and when will this occur?

5. Change in Practice: Multiculturalism

During the last decade, much has been written on the subjects of transcultural nursing, racism in nursing, heterosexism, the politics of difference, how we should and should not do nursing research, etc. All are facets of the multicultural debates; all are contested discourses in and of themselves. And why not? The definition of multiculturalism is as varied and contested as the discourses surrounding it. Kincheloe & Steinberg discuss five type of multiculturalism currently popular in the U.S., not all of which fit into a social justice context:[86]

1. *Conservative Multiculturalism*: monoculturalism; individuals blame minorities for their own problems; never occurs to them that they are in any way responsible for the hegemonic imbalance of power that makes it impossible for many minority populations to rise above the dominant forces that "keep them in their place."
2. *Liberal Multiculturalisms*: basic goal is the attainment of a world where there is only one race, that being the human race; they work with a color-blind notion of perfect harmony in which all people share more commonalities than differences (Kincheloe, 1997; Wallace, 1993) [It just so happens that the commonalities that are shared happen to be white, Western culture].
3. *Pluralist Multiculturalism*: appears when students learn about the customs, practices, religions, values, and belief-systems of various cultures; emphasis is on 'multicultural literacy,' especially as it relates to a "truly democratic citizenship;" fails to interrogate the issues of whiteness, structures of power, and the Eurocentric norm.
4. *Left-Liberal Multiculturalism*: also known as *left-essentialist multiculturalism*; predicated on the belief that identity is comprised of a set of unchanging properties (essences), and

ignores the historical and cultural "situatedness" of difference as well as its relation to the location and appropriation of power (Kincheloe & Steinberg, 1997).

5. *Critical Multiculturalism*: differentiates itself from other forms of multiculturalism by its emphasis on critique, reflection (including self-reflection), and transformative action (Kincheloe & Steinberg, 1997).

If nursing students understand the dominant texts that lie beneath the surface of the various forms of multiculturalism, they acquire the ability to reflect on their own understanding of these issues. Traditional students are forming adult understandings of their own identities as they move through four years of college and they must determine what they believe and how they will respond, not only for themselves but for the profession, their communities, and on behalf of the patients for whom they will be caring.

It is an expected paradox of modern macrocosm/microcosm that the institutions which have always been symbols of liberal and democratic educational opportunities find themselves, in many ways, providing just the opposite. The discourses discussed in this paper are complex issues that require students to think critically about many of the policies and programs embedded in a western society that values capitalism over justice and socioeconomic equality.

It is necessary for students to receive an education that assists them in identifying ways in which social injustice affects a global, multicultural population and how their own actions may implicate them in the perpetration of many of these injustices, whether or not their actions are intentional. A critical pedagogy not only gives students the tools needed to perform a postmodern critique of these issues, but it also assists students in understanding social practices that determine what and how they think about issues of social justice and oppression.

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