Revisiting the Concept of Othering
A Structural Analysis

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The various ways in which nurses relate and interact with patients, who are considered marginal, vulnerable, and in some ways “different,” tend to revolve around the concept of othering. To date, much attention has been given to the immediate situation in which othering may take place, both in terms of process (occurring within interactions) and outcomes (exclusion and marginalization). Drawing on current literature from feminist studies and critical theory, we have drawn attention to broader historical, political, cultural, and social factors that come to shape nurse-patient relationships and propose a new dimension to the concept: structural othering. **Key words: critical theory, feminist studies, nursing, othering**

In the nursing literature, a distinct body of knowledge has been dedicated to the understanding of the nurse-patient relationship. While the literature on this subject is neither conceptually nor methodologically monolithic, the various ways in which nurses relate and interact with patients, who are considered marginal, vulnerable and, in any way “different,” tend to revolve around the concept of othering. According to Roberts and Schiavenato,¹ this concept is intimately linked to processes of exclusion and subsequent marginalization with effects that “are profound and far-reaching in nursing practice and across professions.” ¹(p179) The concept has been used to describe a process of differentiation that takes place between nurses and patients—one that is enacted through discursive, textual, relational, and clinical practices.¹-³ Interestingly, while conceptual analysis of othering requires us to focus on both the interpersonal (micro) and larger structural (macro) dynamics involved in its enactment,¹,³-⁵ much of what has been published on this concept to date has done so within the confines of the nurse-patient relationship; that is, much attention has been given to the immediate situation in which othering may take place—in terms of process (occurring within interactions), accountability (nurse’s use of power), and outcomes (exclusion and marginalization). Critical works that make explicit power dynamics at play in any given situation of exclusion and that seek to address its root causes do exist,¹,⁶ calling for culture-wide paradigmatic shifts by investigating, for example, “mechanisms by which dominant social standards are used to formulate fixed gender and racial categories in nursing, which facilitate othering and related exclusionary processes, such as marginalization”.¹(p179)

However, the materialization of these calls to

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Statement of Significance

What is known or assumed to be true, about this topic?
The concept has been used to describe a process of differentiation that takes place between nurses and patients. While conceptual analysis of othering requires us to focus on both the interpersonal (micro) and larger structural (macro) dynamics involved in its enactment, much of what has been published on this concept to date has done so within the confines of the nurse-patient relationship; that is, much attention has been given to the immediate situation in which othering may take place—in terms of process (occurring within interactions), accountability (nurse’s use of power), and outcomes (exclusion and marginalization).

What this article adds:
In this article, we seek to engage with the literature informed by feminist and critical theory, which draws our attention to broader historical, political, cultural, and social contexts that come to shape nurse-patient relationships, in hopes to strengthen theoretical conceptualizations of othering and explore ways in which it can be addressed in research and practice. We first present the concept of othering and then formally propose introducing a new dimension to the concept: structural othering.

OTHERING: THE CONCEPT

There are many ways of conceptualizing othering. Generally speaking, however, the definition of othering in the literature remains relatively consistent to the extent that it highlights processes that create divisions between individuals and groups (known as the “‘us” and “them” phenomenon) on one hand, and practices that foster exclusion, discrimination, marginalization, and the like on the other. Inherent to this understanding of othering are issues of power (domination and subordination) as well as the overall negative connotation it carries.1,2,8,10

Simone De Beauvoir11 is often referenced as the author from which the concept of othering originates. In her work The Second Sex, she presents othering as a process rooted in gendered (power) dynamics—more precisely the ways in which women have been defined as “other” and subsequently marginalized according to a dominant male standard. According to Roberts and Shiavenato,1 it is precisely this notion of difference that is the foundational attribute of othering. We would argue, however, that with difference, other concepts such as power are equally foundational to othering. In nursing, the concept of othering was formally introduced by Canales in 2000.10 Her conceptualization is unique and differs from the general literature on othering because it encompasses 2 distinct, but interconnected processes. According to Canales,10 power and difference within a relationship can be used in both exclusionary and inclusionary ways. Parting from the traditional “negative” understanding of the concept, Canales proposed that othering could lead to “positive” outcomes when power and difference are used to include—rather...
than exclude—the patient. As Canales explains, exclusionary othering is a process by which the power in the relationship is used to differentiate, to exclude, to neglect, and to oppress the other. By way of contrast, inclusionary othering is a process by which relational power is used to build a sense of connectedness, to include, to transform, and to foster stronger social ties with the other. Both processes can be fluid and complex, but they nonetheless share a common origin—power. As Canales points out, othering is strongly embedded in power relations negotiated and enacted at the point of care, which inherently implies notions of intent, individual choice, and agency:

The difference between Exclusionary Othering and Inclusionary Othering relates to how power is used, by whom, and with what consequences. Inclusionary practices attempt to use power to create transformative relationships in which consequences are consciousness raising, sense of community, shared power, and inclusion.10(p25)

These questions of agency and intent are particularly relevant for our reflection, as it highlights much broader theoretical thinking on the foundations of othering. Rather than assuming that othering practices are explained by the intentions of identifiable individuals, critiques of “intent” in the context of othering push us to investigate the complex network of relations between power, knowledge, and the body12 that produce normative social standards at the root cause of othering—which are often being enacted unintentionally.13,14

Over the past decades, Canales’ work has been used to explore a wide range of topics, including interprofessional communication, power relations, and hostile workplaces in the context of nursing practice and nursing education,15,16 race, identity, culture and immigration and racism,17-23 nursing education, nursing research, and cultural competence,15,16,24-26,28 as well as nursing practice in psychiatry, forensic psychiatry, acute care, and HIV/AIDS,2,3,10,29-37 just to name a few. Interestingly, much of the literature published to date continues to focus on exclusionary dimensions of othering.1 and this is no different in Canales’ own work:

Ironically, my own work has become part of this exclusionary othering discourse. […] I have failed to expand the theory beyond the original ANS piece2 and, similar to other authors within nursing, have focused primarily on exclusionary othering practices.6(p28)

As such, the relative invisibility of the inclusive dimensions of othering in the nursing literature has brought on questions regarding the concept itself, and the possible need for revision and expansion.6 Along with Canales,6 Anderson,4 Vandenberg,7 and more recently Roberts and Schiavenato,1 we see the need to open up a space of analysis to explore those dimensions of the concept that remain difficult to operationalize in practice; that is, to take the current use of the concept of othering in nursing research, and arguably clinical practice, as a source of reflection on the way it is currently conceptualized. Our article is thus a response to current calls from nursing scholars who have highlighted a broadened understanding of othering, which remains relatively underdeveloped in current conceptualizations.1,4,5,7

It is equally in line with current calls in the field of sociology,8,38-40 where symbolic processes arising from individual interactions (such as othering between the nurse and the patient) are being re-examined in relation to the macro-level (structural) dynamics that come to define them. We believe that it is important to incorporate current reflections on the topic of difference and to think of othering in another way, as a concept that is “both symbolically realized in individual interactions and structurally embedded.”8(p10)

For instance, such a reflection distinguishes othering at an individual and structural level by sensitizing us to the ways in which othering can “result outside of a model in which one person does something bad to another.”39(p382)
Thinking about and defining othering from a structural standpoint

The original framework proposed by Canales—focusing primarily on othering as a phenomenon that takes place within the confines of social interaction—does not fully engage with the ways in which macro-level (or structural) conditions create and sustain othering. While she argued that exclusionary othering “operates at multiple levels, within individuals, families, communities, and society as a whole,” this particular dimension of the framework is somewhat underdeveloped and understudied in the current state of the nursing literature and, arguably, may present an obstacle to the identification of inclusionary practices.

As highlighted earlier, nursing research guided by Canales’ framework has largely focused on the micro-interaction between the nurse and the patient. Broader conditions that lead to exclusionary othering continue to be recognized as foundational elements, yet work largely focuses on what nurses do, rather than the context (structures) and relations in which othering operates. As Roberts and Schiavenato suggest, “further investigations are needed to establish a knowledge base regarding the operational elements of othering and an accurate articulation of the way ‘the other’ is generated in clinical and educational settings.” These authors further suggest that future research “might also include investigations into the role of the nursing profession itself and how nursing practice situations affect the pre-existing conditions conducive to othering (i.e. the antecedents).” Such suggestions push us to critically think about “context,” not so much as an antecedent of othering, but rather an active component to be researched and, if possible, modified.

To date, the narrow interaction-based focus of othering has translated into a better understanding of attitudes, perceptions, and behaviors, but has created an important gap in research on social, historical, situational, organizational, and institutional factors that perpetuate exclusionary othering in health care regardless of nurses’ individual predispositions and/or attempts to foster inclusion. As with Johnson and colleagues, we contend that macro-level (structural) conditions such as organizational culture, work environment, and institutional policies and practices contribute to othering by systematically excluding patients who do not easily fit into such things as routines, standardized clinical pathways, and the “normal” ways of providing care. For example, nurses may come to see patients who are “different” or require “different” care as “difficult to deal with” because of the constraints within which they practice (ie, lack of time, flexibility, resources, support, and autonomy). Along the same lines, nurses may construct patients as “difficult to deal with” because their values, behaviors, lifestyles, or beliefs do not align with dominant views in health care (ie, how a person who cares about their health or who respects professional authority should think or act). Or they may apply a policy that systematically differentiates and excludes patients who fail to conform to established norms and codes of conduct—namely because the people who are targeted by the policy have been excluded from policy decisions affecting their care.

Building on the works of Hannem, Hatzenbuehler and Link, and Link and Phelan on structural stigma, we seek to expand on the concept of othering by making apparent the structural dimension that has, to our knowledge, been overlooked by scholars working on the concept of othering. Such an endeavor, we hope, would suggest that individual (face to face) and structural elements of othering are in fact distinct, but related, constructs. As such, we introduce the term structural othering to conceptualize how macro-level conditions may lead to exclusionary practices. Link and Phelan’s examination of structural discrimination impacting persons with schizophrenia is a perfect example of conditions that generate structural othering:
Suppose that because the illness is stigmatized, less funding is dedicated to research about it than for other illnesses and less money is allocated to adequate care and management. Moreover, consider that, because of historical processes influenced by stigma, treatment facilities tend to be either isolated [...] or confined to some of the most disadvantaged neighborhoods in urban settings [...]. At the same time, [...] mental health personnel tend to accrue more status and money by treating less serious illnesses [...] in affluent areas, leaving the care of people with schizophrenia to a generally less accomplished group (Link 1983). To the extent that the stigma of schizophrenia has created such a situation, a person who develops this disorder will be the recipient of structural discrimination whether or not anyone happens to treat him or her in a discriminatory way because of some stereotype about schizophrenia. Stigma has affected the structure around the person, leading the person to be exposed to a host of untoward circumstances.39 (pp372-373, emphasis added)

As with Link and Phelan,39 our structural-level reflections discern the ways in which processes of othering can reside outside a model where one person (the nurse) engages in negative practices toward another (the patient); that is, a person receiving care may experience othering regardless of the nurse’s intents or actions, but as a result of embedded exclusionary processes within the structures that surround them. These exclusionary processes predetermine and govern their interaction even before the encounter actually takes place. In this sense, structural othering may be defined as a process by which power is embedded in and exercised through structures that surround the person, so as to use “difference” to exclude, to neglect, and to oppress the other. In nursing, these may include standardized tools and practices, institutional policies, funding decisions, configuration of electronic charts, space design and layout, attribution of resources and workload, and care pathways, just to name a few. Stigma is a key component of othering, in that its effects often lead to exclusionary practices, both at the interactional and structural levels.

In order to unpack the current limits of the othering framework,10 we draw from 3 separate research examples stemming from the authors’ own work to illustrate structural othering. The initial discussions regarding this publication stemmed from collective work shared between the authors and this is the primary reason we chose to use these examples. We believe they provide insight into structural othering and identify potential avenues for inclusionary approaches that go beyond the individual agency of nurses.

Exemplar 1: Structural othering of people living with HIV

When interviewing people living with HIV about their experience with the health care system, Gagnon41 found othering to be both symbolically enacted through interactions and structurally embedded in disclosure and risk management practices. Although these dimensions of othering were inherently distinct in the way participants were affected, they nonetheless shared the same point of departure; they both originated from a power relation and involved the construction of people living with HIV as “different”—bearing more responsibilities, posing more risks, and requiring additional precautions than other patients.

People living with HIV who took part in the study described exclusionary interactions with health care providers who perceived HIV in a negative way and, as a result, made particular assumptions about patients who had HIV and treated them differently (ie, gossiping, judgmental attitudes, refusing to enter the room, or refusing to touch patients or provide care altogether). And although participants did not see themselves as passive victims, they remained nonetheless acutely aware of the inherent power imbalance in patient-provider interactions, which limited their ability to respond, to report, or in many instances, change providers. Participants’ experiences of micro-level (interactional) othering had a negative impact on their trust in health care providers,
their sense of dignity and safety, and their willingness to seek health care in the future. However, they also highlighted the need to problematize much larger systems that pre-determine nurse-patient interactions, rather than narrowing their othering experiences to mere “interpersonal glitches.”

**Dimensions of structural othering**

Based on her findings, Gagnon explains how labeling of people living with HIV is the product of institutionalized processes directed at the identification and subsequent management of “at-risk” individuals and that justify the need for special (understood as differential) treatment. To this effect, Gagnon identified a number of practices that specifically targeted people living with HIV based on the perceived and unquestioned risk they pose to others and, as we argue, systematically engender exclusionary practices that extend and persist well beyond actual nurse-patient interactions and providers’ intent to do good. These included (a) using scheduling policies, eligibility criteria, and routine procedures to reduce the perceived risk of exposure; (b) breaching confidentiality to warn colleagues and flag the patient (ie, visual sign on the door or on the chart); and (c) reinterpreting routine practices and universal precautions to protect self and others (ie, wearing protective equipment even when not required).

Employing a structural perspective reveals negative views about people living with HIV that are embedded within practices and policies, which were in turn internalized by patients. The way HIV transmission risks were implicitly and explicitly incorporated into day-to-day practices encouraged (if not obliged) self-disclosure from people living with HIV, who came to feel a sense of responsibility for protecting others, thus creating somewhat of a paradox. Over time, new risk management policies and procedures led people living with HIV to believe their status understandably required additional steps in ensuring safety, moving from universal precautions (inclusive to all) to individualization of risk (exclusion of some). Under the guise of a risk management logic, identification and labeling practices contributed to the construction of “at-risk” groups and the implementation of unnecessary protective interventions. What is made explicit in Gagnon’s study are the ways risk management governs (seemingly neutral and nonjudgmental) protocols and practices, thereby (re)producing structural othering.

**Exemplar 2: Structural othering of people living with obesity in the intensive care unit**

Shea and Gagnon completed a study on the experiences of providing care to people living with obesity in the intensive care unit (ICU); they opted to use the othering framework developed by Canales to explore nurses’ inclusionary and exclusionary practices. They found that people living with obesity were not only physically “different” from other patients in the ICU, but they also required “different” nursing care. While nurses spoke of trying to provide people living with obesity with the same care as any other patient in the ICU, they often were unable to do so—largely due to the lack of resources such as proper lifts or additional staff to mobilize patients. They were also unsure how to provide tailored care in the absence of clinical guidelines, practice standards, physical care supports, and so forth. Nurses attempted to compensate by staying away from prejudicial comments and discussions about patients living with obesity, building rapport and connections with these patients and attempting to see a situation through their eyes, all of which were discussed by the authors as indicative of inclusionary othering.

In Shea and Gagnon’s study, some elements of exclusionary othering emerged that, at face value, were the product of face-to-face interactions. At times, nurses experienced feelings of repulsion, disgust,
anger, frustration, blame, and apprehension while taking care of people living with obesity. Yet we contend that such feelings and attitudes are both produced and perpetuated by the work environment itself.

**Dimensions of structural othering**

Shea and Gagnon highlight how both the place of work and nurses’ ambivalent feelings about their work were 2 important drivers of exclusionary othering in the ICU more so than nurses’ feelings about people living with obesity and obesity more generally. They found that negative feelings and views arose from the extra efforts associated with caring for people living with obesity in an environment exclusively designed for patients of “normal weight”—and without any additional staff, equipment, and guidance. In this sense, the ICU acted as a space that structurally produced othering simply by being what it is: a space characterized by fixed and inflexible routines, protocols, and practices, with unalterable schedules, layouts, and workloads designed for standardized patients, as a means toward performance and efficiency.

As such, Shea and Gagnon’s study results suggest that nurses’ individual feelings often stemmed from negative structural experiences such as trying to provide good nursing care in a context where it is challenging to do so. Factors such as the ICU environment (ie, the design, the rooms, and the equipment), the lack of available resources (especially additional staff to assist with physical care), and the priorities of the ICU were identified as contributing to making nurses (1) feel inadequate about the care they provided and their inability to meet patients’ needs, (2) experience frustration, fatigue, resentment, and isolation, (3) perceive people living with obesity differently, and (4) fear they might (re)injure themselves. Importantly, a difference was noted in this study between nurses’ attempts to enact inclusionary practices (eg, staying away from negative conversations about patients living with obesity, building rapport with these patients, and embodying empathy) and the capacity to do so in the actual work environment. The study highlights important conceptual links between structural othering and the concepts of moral distress and moral agency.

**Exemplar 3: Structural othering of people diagnosed with mental illness in the emergency department**

Jacob et al’s study of violence management in a psychiatric emergency department (PED) is a final example that helps advance our understanding of structural othering. This study examined nurses’ practices in a PED and emphasized the way place and power intersect in the provision of psychiatric services. The location of the PED within the emergency department (ED) produced complex dynamics in which controlling nurses’ and patients’ practices and behaviors came to be described as necessary to foster a “therapeutic environment.” The study underscored how discursive and environmental factors fostered and reinforced practices of inclusion and exclusion.

**Dimensions of structural othering**

In this study, nurses spoke of various practices within the ED that reinforced systematic intolerance toward psychiatric patients. For example, they described an internal policy—zero tolerance for violence—as actually perpetuating violence in the ED, rather than eliminating it. Although such polices are widely assumed to ensure safe work and care environments, they promote intolerance toward certain behaviors often manifested by psychiatric patients which, in turn, justifies exacting controlling and even abusive interventions. For instance, psychiatric patients who were both mobile and deemed to be unpredictable were positioned as disruptive and risky individuals and subjected to increased use of control measures (restraints/seclusion/medications) even though they did not exhibit dangerous behaviors, thus violating those patients’ rights. Psychiatric nurses
were perceived by ED staff as being responsible for containing psychiatric patients’ movements and actions in a highly inflexible environment. As a result, and in attempting to avoid confronting interactions that would lead to the use of control measures, PRN (as needed) medications were used to “protect” patients from coercive practices and safeguard nurses from future blame. Drawing on the work of Sibley43 on geographies of exclusion, Jacob and colleagues33 argued that the hospital’s seemingly neutral zero tolerance policy reinforced a divisive culture through and by which both psychiatric nurses and patients lacked a sense of belonging in the ED; that is, they were “different” and out of place.

In this context, structural othering is the result of assumptions about risk, violence, and mental distress that become embedded in policies and practices that legitimize various forms of controlling interventions.44 Here, parallels can be made with the findings of Johnson and colleagues18 wherein the location of psychiatric services in the ED and the dynamics that exist within this context participate in the construction of psychiatric patients as systematically disruptive and in need of containment, thereby eliminating any other (less stigmatizing) subject position. What is evident in Jacob and colleagues’33 study are the many ways in which psychiatric practice is constrained by its location and therefore a fertile ground for the enactment of structural othering practices. The authors stress the need to examine structures that categorize certain health care practices (even abusive ones) as appropriate and unproblematic, by tracking discourses (in this case, discourses of risk) that make certain interventions possible and apparently in line with therapeutic goals.

DISCUSSION

The exemplars presented previously speak to the various ways in which othering is enacted as a deeply interpersonal process entrenched within broader structures from which othering may originate. Surely, there will always be a need for nurses to individually reflect on their practice to foster inclusionary practices. However, as Cloyes5 argues, this may include thinking about how, as nurses, we can support the ways in which patients exercise various forms of “agency as they struggle against marginalization to assert their own political legitimacy.”5(p242) In her critique of the concept of othering, Cloyes5 reminds us about examining our own participation, as health care professionals, in forcing patients into passive or active roles in the provision of care. Cloyes encourages a “risky” form of advocacy, pushing us to advocate for practices that may go against current institutional cultures. In other words, inclusionary othering here is clearly not limited to the immediacy of the nurse-patient interaction, but rather asks health care professionals to engage with and challenge larger structural systems of othering and bolster the political agency of those affected by exclusionary practices.

Despite ongoing calls for change,1,4,6,7,10 we seem, like many others, to easily delineate the ways in which nurses engage in exclusionary processes while having difficulty reporting processes of inclusionary othering. Informed by the exemplars, we argue that the issue is not so much the intention of developing inclusive practices, but rather that the object of our interventions and critique may need to be done at different levels for “inclusion” (both real and perceived) to take place. Canales6,10 as well as Roberts and Schiavento1 have called for the development of inclusionary processes that connect, rather than exclude, through the understanding of difference. For example, Roberts and Schiavento1 draw on the works of Collins44 to speak about the development of a unique reformulation of “the other” into the “outsider within” so as to better understand the complex processes of exclusion and find positive ways to address its negative effects. Here, the authors see a viable potential for change by fostering nursing interventions designed to empower the “outsider.
within” of both patients and nursing colleagues; that is, in keeping with Cloyes’ proposition,\(^5\) to see how those who have been marginalized come to redefine themselves in ways that are empowering, while bringing a unique perspective to challenge dominant ways of doing. As with Anderson,\(^4\) and Canales,\(^5,10\) this perspective seeks to demystify the boundaries between self and other in order to expose the fluidity between these concepts, and the ways in which no one is immune to experiences of marginalization, dehumanization, and human suffering. More importantly, it seeks to foster a critique of dominant cultural discourses that makes explicit (visible), either through those who have been excluded and/or their allies, structural processes of exclusion at the root cause of othering practices.

In this sense, turning our attention to the concept of structural othering helps us conceptualize how exclusionary practices may result from various levels of decision-making, historical contingencies, economic realities, etc, and subsequently reduce the possibilities of inclusionary practices unless concerted, systemic (political) actions are enacted, thus moving beyond the immediacy of the nurse-patient relationship and providing new, expanded spaces for action. As Hannem explains, very often “there is no intent to harm the individual or the population and in fact, the stated goal of policy makers is often to help or improve the situation. However, when the need for assistance is justified by the inherently ‘different,’ ‘risky’ or ‘tainted’ characteristics of the population, stigma is created in the very agencies that are supposed to be providing help.”\(^8(p25)\)

Here, we wish to revisit the question of intent and agency. While the premises of othering may illustrate how nurses are “imbued with a subjectivity and agency that allows him or her to be an active participant in the creation of social situations and in the definition of his or her identity and role in those interactions,”\(^45(p2)\) they do not take into account, at least not explicitly, how interactions and practices are equally shaped by and embedded in social structures. In effect, the interactionist roots of othering seem to take for granted that nurses (or any other health care personnel) are autonomous subjects capable of transcending context and exercising agency when caring for seemingly “different” individuals. That is, in any given circumstance, the othering framework is presented as the foundation from which empathetic/altruistic work can be imagined; it does not systematically consider the constraints to agency. And although the framework is said to provide guidance for nurses to attend to the overarching conditions and structures that create and maintain the “vulnerable” status of the other,\(^3\) it nonetheless focuses on processes that function and are negotiated at the individual level, never explicitly engaging with how “lived realities are constituted and shaped by the limits of social structure”\(^8(p11)\) and its impact on the possibilities of inclusive action.

On this note, we share Cloyes’\(^5\) reluctance in engaging with inclusionary rhetoric as it relates to nursing interventions by problematizing the notion of advocacy and agency in the (re)production of systems of exclusion. We suggest that micro-level actions that seek to foster inclusion may in fact reproduce logics of exclusion to the extent that the “privileged status of one depends on the marginal status of the other.”\(^5(p239)\) Such a conceptualization of how we relate to one another pushes us to reflect on our practices and calls for a deconstruction and critique of the ways in which our own sense of agency and professional identity are often predicated on and inherently reinforce dynamics of hierarchy and division— that is, how advocacy and agency are largely based on the “nonagency of others in ways that propagate hierarchical and ultimately violent power relations.”\(^5(p241)\) Understanding the structural dimensions that govern nurses’ relationships with others is a critical step toward envisioning interventions that will trickle down to the point of care. Without considering the broader context/structure in which individual actions occur, exclusion is bound to persist.
FINAL REMARKS

In this article, we reviewed the concept of othering and articulated a new dimension of the concept: structural othering. We presented 3 exemplars of nursing practice identified through empirical studies in nursing to highlight structural othering processes in the provision of care. We suggest there is a need for further development of the framework to look critically at structural influences that enable or limit nursing practices and, in the process, possibilities for inclusive action.

In conclusion, we recommend that nurse scholars continue our efforts to examine othering beyond current understandings and further explore the empirical and theoretical conceptions of this complex process outlined in this article. If structural othering remains unaddressed, we may too easily cast nurses as the perpetrators of exclusionary practices while, paradoxically, ignoring inclusionary strategies and reproducing marginality and exclusionary othering. There is also a risk of misrepresenting exclusionary othering as the unfortunate outcome of individual intent rather than being mediated by structural considerations. This would lead to misguided solutions that are too narrow in scope to bring about any meaningful change. It would also place a disproportionate amount of responsibility on individual care providers (nurses in particular) to make up for the shortcomings of health care systems that are blind to their own policies and procedures, hierarchies, routines, priorities, and expectations that are rooted in, and may even depend on, the categorization of certain individuals along stigmatizing lines. By revealing structural othering processes, and their impacts on nursing practice and broader social and political systems, real systemic change can occur.

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