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Caring in the Margins

A Scholarship of Accompaniment for Advanced Transcultural Nursing Practice

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Nurses must learn essential skills based in transcultural nursing to address issues of equity and social justice. The development of a model for nursing practice for an urban nurse-led drop-in center for individuals experiencing marginalization provides an opportunity for student nurses to learn transcultural nursing skills that shifts care from acknowledging the need of others to accompanying others on their health journey. The practice model provides the opportunity for undergraduate and graduate nursing students at Augsburg University to de-emphasize tasks and build relationships. Students learn to listen to others' stories and acknowledge their struggles in the margins. Four stages of nursing practice skills, acknowledging others' needs, attending to their struggles, affirming strengths, and ultimately accompanying others, are taught and experienced. At the core of the nursing practice model is the concept of "hospitality." The nursing practice model serves as guide for student nurses to learn to suspend disbeliefs, withhold judgment, and ultimately reduce stereotypes and stigma to offer a safe space for individuals living in the margins seeking care. The future of nursing requires essential knowledge, skills, and attitudes that shift care from need-based care to accompaniment to address health inequities and provide culturally appropriate care. **Key words:** *accompaniment*, *collective action*, *marginalization*, *nursing practice model*, *relationship*, *transcultural nursing*

DEVELOPING a model of nursing practice for an urban nurse-led drop-in center for people experiencing marginalization offers a structure in which faculty, students, and volunteers can begin to learn to decode structures of oppression that exclude individuals from discovering means of health. Often care providers unknowingly contribute to structural inequities and assaults on human dignity for those who struggle with social exclusion. Decoding the culture of biomedicine to provide inclusive health care that transcends oppressive structures requires essential knowledge, skills, and attitudes based in transcultural nursing (TCN). As a theory-based human science, TCN is both a process and an outcome.[1] As a process, TCN requires intention and skill in creating human connections across ideologies, geographic space, and time. As an outcome, TCN knowledge provides a narrative of hope and restoration for

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Statements of Significance

What is known or assumed to be true about this topic:

Health care is shaped by altruistic care offered by providers, but health care also holds deeply embedded stereotypes, social norms rooted in othering, historical practices of institutionalizing racism, and a technocrat system that does not always provide equity of care for all people. In particular, those who are socially marginalized from society are labeled "noncompliant" or "health illiterate" due to differences in cultural norms or belief systems that are misunderstood by care experts. As a result, deeper divides in communities further polarize care providers and those seeking health. Individuals of all socioeconomic statues, cultures, and backgrounds need to be considered vital to health and healing processes.

What this article adds:

This article provides health care providers with innovative skills and approaches to create connections in the social margins of society in meaningful and sustainable ways. A practice model grounded in advance practice transcultural nursing serves as an example of how nurses can practice building collective agency, applying social justice praxis, and upholding human dignity in health care. This model is the result of cumulative care experiences over the last $2\frac{1}{2}$ decades at a health-focused, nurse-led drop-in center where faculty and students engage in the community to offer relationship as a means to connect through barriers. The stages of this model allow nurses to move from acknowledgment of need to accompaniment.

communities broken by indifference and fear. Achieving TCN outcomes extends beyond a nurse generalist's scope of practice and necessitates advanced nursing competence. The knowledge, skills, and attitudes required for advanced practice transcultural nursing (APTCN) can be described as moving from *acknowledging the need* of others to *accompanying others* on their unique health journeys. Embodying accompaniment involves forming professional caring relationships in sociocultural situations where nurses are often outsiders. These relationships move nurses away from the center of the biomedical industrial system toward a shared culture of health with persons living in the margins. Creating transcultural relationships aimed at negotiating medical culture and mediating health care encounters is central to the APTCN practice model. It was through nursing practice at the Health Commons, the nurse-managed health center located in an inner-city church, that this model of APTCN evolved. The model illustrates stages of nursing practice from acknowledging needs in relationships to attending to the struggle, affirming strengths, and ultimately accompanying others. These stages require an APTCN practitioner to learn about membership in cultural collectives.

Cultural collectives provide a sense of identity, a guide to action, and a ground of meaning, all essential components for health. All persons, whether they realize it or not, are members of cultural collectives. APTCN practitioners must learn to decode the structures and dynamics at work in mainstream collectives that exclude persons of other collectives from membership, thus jeopardizing the health potential of entire populations. Growing awareness of nurses' own marginalized status within the health care system is necessary for accompaniment of other marginalized collectives. Familiar with the use of stealth and cunning, a technique often utilized by socially excluded individuals as a means of survival to remain unnoticed from the social elites, nurses learn how to recognize and negotiate in the margins when medical orders and institutional policies impede personalizing care.[2] It is in the cultural collective that nurses learn about the mind-set of the

collective and gain access to benefits of membership in diverse and often marginalized collectives. They can then combine these skills with more direct, collective action to address issues of equity and social justice.

THE HEALTH COMMONS

In response to the injustice of the socially excluded, the Augsburg University Department of Nursing faculty organized a space, called the Health Commons, where nursing students can learn TCN skills in practice. The Health Commons is a drop-in center that support health and healing. Actions and decisions are informed by radical hospitality and needs of all who visit. The innovative vision of the Health Commons opened up opportunities for practice outside of the expectations for a "clinic" or a "nursing center." Furthermore, "The Commons" (a phrase often used by the community to identify the Health Commons) reflects the broad diversity of people participating in a spirit of mutuality and TCN.

Social exclusion and life in the margins are familiar to many people who come to the Health Commons. Exclusion has many sources. People may be immigrants—documented or undocumented; they may be stigmatized by medical diagnosis and behavioral challenges—mental illness or substance abuse; they may have criminal records; they may be experiencing homelessness; they may not be educated enough or white enough or attractive enough to be included in the mainstream US society.

Social marginalization can threaten health by increasing social isolation, alienation, and generalized distrust of others. The Health Commons aims to be a free and safe gathering space, welcoming everyone without judgment. No proof of eligibility, identity, or need is required. No one has to sign in, give a name, or identify a problem or concern to be unconditionally welcomed.

The Health Commons is organized and staffed by the faculty and students of Augsburg University Nursing Department as well as committed nurse volunteers, students, or faculty from other college departments and people who have been regular visitors to the Health Commons. Students of the nursing program at Augsburg University come to the Health Commons during their baccalaureate completion program, in addition to students in the master of arts in nursing and doctor of nursing practice (DNP) program. The Health Commons is a 25-year, ongoing collaboration with the social action efforts of the inner-city church called Central Lutheran Church. This church provides resources and support for individuals experiencing homelessness and poverty in Minneapolis through their Restoration Center.

The faculty expertise required for nurses who practice and teach in this setting is unique. Faculty traditionally have practiced TCN in a variety of settings with an emphasis on engagement as scholarship. Not only is cultural knowledge relevant and policy awareness important but also faculty must be able to facilitate discussions on sensitive topics as it relates to health. In addition, faculty must be able to model and provide examples of the skills required for APTCN, which is an innovative role for faculty, as the vital component for teaching in this setting is how to care through accompaniment with those who are marginalized.

SETTING

The setting for the Health Commons is intentionally open and non–clinic-like. The atmosphere is more social than medical and culturally closer to a living room than a hospital waiting room. Located in an inner-city church, the Health Commons literally and figuratively occupies an interstitial space between cultures of care and help seeking. Equipment and procedures that are reminiscent of a clinic atmosphere have been actively removed from the space. Curtains and walls that could mystify activities are absent. Potential status symbols such as laboratory coats, scrubs, and stethoscopes around the

neck are considered cultural markers of professional privilege and may limit establishing relationships.

Many discussions occur about the purpose of keeping records on visitors who come to the Health Commons. Foucault described the threats inherent in the process of official record-keeping as both "a means of control and a method of domination"[3(p189)] as text can be reductionist of the human condition and individual agency. He further described records as inscribing people in text[3] that can oversimplify the complex human condition and undermine personal agency. Agency, in its various forms, implies that a people have the "ability to self-organize, co-create, and shape the world around them."[4(p248)] "Patient charts" certainly represent a process of professional control over how problems are named and "assessed." Sometimes, socially excluded people appreciate a repository for their history when they have to carry their present life on their back while living on the streets. In this case, a "health passport" is offered, which is a brief record they can carry with them. In addition, a record of the number of socks provided each day by the Health Commons is tallied to obtain a glimpse of the number of individuals who have visited. (Only a single pair of socks is offered per person, per day for financial sustainability.) Overall, record keeping is responsive to visitor needs. Visitors express worry that written records can reinforce stigma by labels that get attached to their lives and shape future interactions in harmful ways.

Thus, any semblance of a structured health assessment process is eliminated as completely as possible. The Health Commons staff view structured assessments as establishing power differentials between providers and patients in the health care system. Foucault described this process incisively as "hierarchical surveillance and normalizing judgment."[3(p192)] The process is a barrier to mutuality and hospitality. Thus, the Health Commons aims to shift away from a professional expert model.

PRESENTATION OF THE MODEL: SHAPING A RITUAL TO CROSS CULTURAL BORDERS

An initial experience in nursing practice at the Health Commons raises awareness of risks inherent in crossing thresholds into unfamiliar territory. Van Gennep described this process of crossing cultural boundaries as a ritual to "unite oneself with a new world."[5(p20)] People entering the Health Commons come from social margins, which carry a weight of stereotype and prejudice, stigma, and discrimination. They may be situated as addicts, excons, transients, or recent immigrants, have diagnosed or undiagnosed mental illness, and live on the streets or in shelters. These individuals share a common struggle with financial scarcity and frail social resources. They often experience exclusion. In this experience of otherness,[6] or in the process of engagement "with those perceived as different from self,"[6(p16)] professional providers can be seen as threats; therefore, a ritual of welcome is needed to initiate a trusting encounter for both the nurse and marginalized individuals.

Risks are often felt by nursing students and faculty new to this social context. People of mixed status and backgrounds are evident in the outdoor spaces and indoor halls that students must traverse to get to the Health Commons. Many of the students have never been in the inner city, and their expectations are shaped by menacing portrayals of its inhabitants in popular media. As professionals, they also sense risks in entering this intentionally nonclinic space. They mainly come from highly technical, medically specialized health care settings with hierarchies and radical division of labor where efficiency in completing specified tasks is a priority. Therefore, engaging in the Health Commons community at an inner-city church is unique. At the Health Commons, tasks are de-emphasized and students are urged to take time to listen, to sit down, and to spend time with people. Introductions using first names are encouraged. Conversations in the moment that offer meaning are considered more important than

inscribing people's problems and responses in records. In short, expectations of practice are very different at the Health Commons compared with the culture of health care.

A ritual of simple tasks that offer familiar cultural practices could help ease professionals' encounter across this threshold. The initial ritual was shaped by the experiential knowledge shared by some individuals of the marginalized community. The Health Commons staff do not perform a "community assessment" to determine "needs." "Satisfaction surveys" are not completed. Rather, relationships are built with people who come to the Health Commons, whose stories of expressed felt needs, as well as insider knowledge is shared in their own time and in their own way.

Experience at the Health Commons made it clear to nurses that people negotiating scarce resources value new, clean socks, diapers, menstrual pads, and small-sized toiletries that could be slipped into a backpack. These are the items most often requested. From a perspective of health promotion, these items can be considered basic in protecting people from getting sick. In addition, nursing students need to feel useful, helpful, and knowledgeable. Therefore, the first cultural encounter happens as charitable giving and grateful receiving. A threshold-crossing ritual is established with socks, diapers, and general hygiene products.

CONCEPTUAL CONTEXT FOR THE MODEL

The Health Commons practice model describes how the learning process can move from practice in professional structures to autonomous practice that is based on common cause and accompaniment (see Figure, Supplemental Digital Content 1, available at: http://links.lww.com/ANS/A10, which illustrates the Health Commons practice model). Acknowledging the difficulties of negotiating social margins, essentially TCN, and the lack of experience most practitioners have in those margins requires the humility of a practice model that is not about intervention to fix people. It is not about solving their social problems. It does not apply a therapeutic process to explore the sources of their emotional turmoil. It is not about experts naming the problem and prescribing a solution. Such endeavors reside in the realms of health care culture and although transcultural nurses need some familiarity with them, diagnosis and prescription are not the organizing framework for TCN work.

This practice model is structured as Gustavo Esteva admonished "humble actions,"[7(pp15,202)] "in a local context,"[7(pp32-33)] "at a human scale."[7(pp23,34)] Humility guides practitioners to acknowledge their own ignorance to be open to wisdom from unexpected sources. Taking action can then be based in mutuality of purpose and process. By grounding nursing practice in a particular locale, complex circumstances can be taken into consideration when reflecting on issues of concern. Actions to address these concerns are cocreated on the basis of local context and made relevant for daily life and removed from the data-driven abstractions of research.[8] Human scale is conceptualized by Esteva as "thinking ... on the proportion ... that humans can really understand, know and assume responsibility for the consequences of their actions and decisions upon others."[7(p23)] Practice in this model becomes focused in this particular reality that is deeply complex rather than widely generalized.

Concerned about social justice, and aimed at collective action, the model takes Scott's "rules of thumb" as guidelines: "take small steps; favor reversibility; plan on surprises; and plan on human inventiveness."[9(p345)] Social justice is defined as "the equitable balance between social benefits and burdens; movement toward a socially just world."[10(p37S)] It relies on nurses being able to understand the constraints that inequities impose on human dignity and structural barriers that impede health of the socially excluded.[11] The model can guide nurses to this insight as practice that enlivens the abstract ideas.

The Health Commons practice model conceptualizes a process of relationship building that crosses cultural boundaries and shifts both marginalized difference and professional privilege[9] to a meeting grounded in common cause and accompaniment. Practice at the Health Commons aims to coincide with Wendell Berry's idea that "health is membership."[12(p144)] As he eloquently stated, "I believe that the community—in the fullest sense: a place and all its creatures—is the smallest unit of health and that to speak of the health of an isolated individual is a contradiction in terms."[12(p146)]

Connecting isolated and alienated people to a community not only brings them resources from that community but also makes their strength and experience available to others. Therefore, membership benefits the entire community. This mutuality and reciprocity is basic to the importance of nurturing cultural diversity in society. In contrast, innovation and action that come from people living in the margins can be minimized by the professional staff "providing service" to them. Acknowledging the benefits nursing faculty and students receive from marginalized individuals who come to the Health Commons becomes part of the consciousness-raising outcomes. Utilizing these outcomes and forging collective agency and autonomy from informal community can result in change for a common cause. This aim is basic to the Health Commons and its practice model.

Membership and belonging constitute basic elements of autonomy, which is here defined as self-contained sociality.[13] Persons are viewed as being constituted by relationships rather than as self-defined individuals. Everyone has been a member of some kind of society, even if years have been spent in institutional confinement and/or without family contact. That social history and experience continue in some form within a person. If personal history is grounded in experiences of mistreatment, antisocial behavior, or stigmatized appearance, building trust in others can be particularly complex. In circumstances of trust, however, aspects of this sociality can be accessed and activated to strengthen participation in other communities. Gaining access to resources from a broader membership can reduce the alienation and isolation of being socially marginalized. It can become collective agency, society's ability to act in the world as a whole for the common good.[14]

In a parallel process, reducing social privilege in the role of professional expert and coming to a common ground of understanding can enlarge the social/cultural resources of professionals. Abandoning identity as a professional expert can open ways for transcultural nurses to participate in collective agency and join efforts to overcome barriers to inclusion and social justice. This deconstructing process of the privileged status of staff is one of the primary aims of the practice model. Building relationships across cultural difference moves practitioners from a center in health care culture to a shared culture. In this shift, difference that may have evoked a sense of threat can be redefined as opportunity.

THE HEALTH COMMONS MODEL

Relationship building as a rite of passage

Social role change in professional identity requires a transition embedded in rites of passage. Arnold van Gennep,[5] an early 20th-century anthropologist, compared rites of passage presented in ethnographic literature and described 3 phases that are common to this ritual process of social role change: first separation, when the initiate moves away from a social role and status; second liminality or transition, when the initiate enters a space of ambiguous identity where one is to reflect on and question all that they have learned before and where they have taught by other members of the society what will be expected of them in a new role, with a new identity; and third incorporation, when they reenter society with a new identity and role. Nursing students' experience at the Health Commons reflects these phases to varying degrees. This conceptualization of movement

through a cultural rite was central to the early Health Commons model and describes a consciousness-raising process basic to emancipatory praxis.[15] This practice exemplified emancipatory praxis as it "embraces and nurtures social justice goals and outcomes, where practice becomes praxis. It is nursing aimed at forms of knowing and doing in order to better humankind in all its variant and valued manifestations."[11(p2)]

The nature of the Health Commons space becomes the first element of separation, as it is far from the familiar settings of health care practice for students in this rite of passage. Moving from certainty into ambiguity is an essential element in separation as it unsettles expectations among participants. This confusion sets the stage for the second rite of passage, the experience of liminality. Blurring markers and procedures that are assumed in a culture of health care is essential to a practice that can lead to common ground for nurses and marginalized people. No fees, no identification, and no particular problems are needed to enter and participate at the center except, that is, for the nurses. All nursing students at Augsburg University are licensed professionals and in school for a bachelor's of science in nursing, a master's degree in nursing, or a doctoral degree in TCN. The principal aim of the ritual is to establish a nonthreatening encounter across boundaries of difference. It becomes the first stage in building relationships and easing transitions. Their primary challenge is to enter an unfamiliar setting where their role is not structured by the institutions of health care and medical orders. They are challenged to learn a practice of independent nursing based on praxis and collective agency. This third phase completes the ritual process of social role change as students learn to deconstruct their own privilege leading to practice as accompaniment.

Stage I: Acknowledge the need

Being responsive to expressed felt needs, rather than structuring needs by assessment and planning procedures, is a complicated issue for health care professionals working in a community. Responding to expressed needs must include some recognition of the agency involved in asking for help. Service providers can easily overlook the courage and risk involved in asking for help; they can ignore their own benefit from dependence on being needed. Awareness of both the risk and benefit supports developing a ground of mutuality and reciprocity.

As people come to the open door of the Health Commons, they are invited in. They are assured that there is no need to sign their name, show any identification, or prove eligibility with an insurance card. Instead, they are offered free supplies, such as soap, shampoo, toothpaste, and socks. Nursing students often begin their experience sitting by cabinets that contain these free items and helping visitors get what they request. As visitors wait their turn, they can observe other activities at the Health Commons; people having their blood pressure checked, a bandage changed, a foot soak, or hand massage; perhaps, getting some cough drops or foot powder. In this observation, the visitors can decide if they want to risk further interaction and/or if they want to talk with a nurse.

The process of acknowledging a need for nursing students can be uplifted through an undergraduate student's experience. Before coming to the Health Commons, students are asked to name their bias of people who are homeless. One student assumed homeless individuals were "pushy" and "lazy." She was apprehensive of being in a place without more structured barriers or rules to follow. As the Health Commons opened, visitors came in asking for basic human items, raising health care concerns, and building community with one another. During the postpracticum experience, the student expressed her observations of people being engaged, grateful, and struggling to survive. This student recognized that the experience shifted her perspective. She felt called to do more and to volunteer in her local community following this practicum. The faculty expertise in facilitating reflective dialogue following this experience is vital to cultivating self-awareness

and transformation for students. Without the faculty guidance, miseducation could result as stereotypes or bias could be reinforced if context and insights are missing from the discussion.

As the students offer simple supplies to visitors, they become aware of the magnitude of need represented both by the number of people and the reality of waiting in line to get soap or shampoo, often items they use without much thought. They can begin to connect to a common humanity, getting past the markers of exclusion, often noting how the visitors do not look or act like they expected as they reflect on identified biases. These biases contribute to structural violence as they prevent others from recognizing the humanity in the other.

Nursing students slowly become aware of structural violence demonstrated by a lack of access to health care as well as basic needs. In this instance, structural violence is based on the concept described by Dr Paul Farmer. His description represents "a host of offenses against human dignity; extreme and relative poverty, social inequalities ranging from racism to gender inequality, and the more spectacular forms of violence that are uncontestedly human rights abuses."[16(p8)] In stage I of the Health Commons practice model, students begin to explore social injustice in response to their observations. Their *actions* are primarily charitable giving. Therefore, the *role* they assume is that of compassionate caregiver. In the Health Commons setting, this begins to shift their view of nursing practice.

Cultural shift in the rite of passage

As students participate in this stage of practice, they move out of a paradigm of medical-driven health care that focuses on pathology and diagnosis. Through honoring the human story, the student can begin to associate with a culture of nursing that is holistic and healing, not service-based and commodified. Having negotiated the risk of encounter through charitable giving, students must also face the challenge of having something within themselves to offer. Outside the medical structure of care, this challenge becomes important to practice in stage II.

Stage II: Attend to the struggle

The process of participation without intervention is central to this stage. Students need to practice having conversations, rather than rely on interviews or assessments. They must suspend disbelief and withhold judgment. All in all, they must resist "doing" or "fixing" an identified problem from the experts' point of view.

In a cordial introduction, the nurse and the visitor exchange names and perhaps a handshake. The interaction often opens with a simple request from a visitor for a blood pressure check or some item to soothe an ailment. Invited to sit down in one of the comfortable chairs that are arranged in a semicircle, the nurse sits down beside the visitor. Nursing practice in this step responds to a direct request for help framed in a physical symptom and viewed as embodying a struggle to negotiate life. The physical ailment engages caregiving while the sincerity and competence of the caregiver can be observed. The nurse can use this opportunity to open a conversation about a visitor's complex circumstances. The visitor can take this opportunity to gauge a nurse's level of concern and competence. At this stage, questions from the nurse are to be avoided.

Given how health care providers are socialized in a mode of questions, this process can be challenging. Questions can imply judgment about compliance with medications, missed appointments, and/or doctor's orders or advice not followed. Questions can be a means of controlling the dialogue. Requests such as "I'd be interested to hear more about your blood pressure concern" or comments such as "Keeping track of your blood pressure makes sense" are encouraged as they can often elicit larger descriptions of the circumstances visitors face or the attempts they make to manage their chronic conditions. Listening then becomes a vital

tool for practice and a challenge when communication styles and language are connected to different contexts of experience.

During a postpracticum experience, an undergraduate student discussed the difficulty in avoiding questions during his recent interactions at the Health Commons. He said that a young woman came in asking about adult incontinence pads. He thought to himself, why would such a young person need something like this? Exercising constraint in posing questions, the student found the requested items and provided them to the young woman. During student reflections facilitated by the nursing faculty, this request was unpacked. The young woman had shared previously with faculty members, whom she had established trust with, that the adult incontinence pads were means of safety. While this young woman often slept outside to avoid the chaos of staying in emergency shelters, she found that if she urinated in her incontinence pad to produce a notable smell, she was able to ward of sexual predators. The student expressed feeling a sense of disbelief. He said that his experience at the Health Commons was a great exercise in awareness and uplifted the importance of authentically listening.

While nurses must respond to requests for help, a pitfall of this stage is to assume a "therapeutic" role. Too often, these actions are founded on premature conclusions based on inadequate knowledge of a visitor's cultural "idiom of distress,"[17] or suffering that forms itself in a medical alignment, and the predicament they face. Listening closely to visitor narratives, nurses can gain knowledge about specific ways social injustice is experienced. The urge to act as problem solver when visitors are seeking help can actually become useful as advocacy. In stage II, students begin to name structural violence as they listen to visitor stories of their struggles. Thus, *actions* are meant to intervene to fix something in the process of marginalization in the healthcare system. They may implement a *role* as advocate.

Cultural shift in the rite of passage

In this stage, the practice paradigm shifts from nursing defined by the health care culture to nursing mediating medical and marginalized culture. This shift takes the form of advocacy for access to care. Here, a nurse's need to be helpful, to solve a problem, and to make something better can interfere with the process of understanding "the otherness of the Other, the Outsider."[7(p15)] Esteva described this process as complicated, yet essential, to grasp the resourcefulness of navigating in the margins. As this conversation deepens, the practice moves into the third stage of connection.

Stage III: Affirm strength

Socialized in a paradigm of finding and naming people's problems, a step toward relationship, can be very challenging for students. Complicated further by working with people who are defined and excluded from society by "their problems," naming a strength can seem fruitless. Yet, this step is crucial for finding our common humanity, mutual benefit, and common ground in the struggle for a just and equitable world. It is essential for praxis.[15] Trained to intervene and solve problems, this step perplexes nurses by its emphasis on nonaction, on being present, and on "listening a person toward a solution." Two assumptions underpin this step: (1) there is always more to it; and (2) your own ignorance of the circumstances is absolute. Interacting from a stance where you can neither know the complications in others' predicament nor the resources they can rely on, your best option is to name the strength that you can see in their story. A statement such as "You must have incredible inner strength to manage these difficulties" can elicit more self-expression and a visible sense of self-confidence. For nurses, this affirmation builds a sense of common ground, of broader understanding, and a connection to a vitality from which they can also draw strength.

Take, for example, a graduate nursing student's recent encounter with "Jesse." Jesse is a regular at the Health Commons. He often finds himself drifting in and out of homelessness as he struggles with addiction. Over the last year, his blood pressure had

risen to concerning levels. Although he had a prescription for lisinopril, he was unable to afford the $5 co-pay. Students who meet Jesse ask what implications hypertension has on his life. As the student identifies the strength he demonstrates in monitoring his overall blood pressure and tries to understand what resources could help him obtain the medication he desires, complexity compounds the situation. For example, Jesse does not reveal to health care providers that he does not have insurance. He knows that if he were to apply for insurance, there is only one pharmacy in town that would fill his prescription from this prospective insurance. He knows this pharmacy does not take gift cards or checks from local churches or nonprofits, it only accepts cash and he does not have the $5 co-pay. Because of the nature of people's use of cash gifts on the streets, most churches or nonprofits forbid the practice of providing cash donations. So, instead, Jesse does not inform others of his lack of insurance because he has learned that sharing his struggles rarely leads to an outcome he desires. Hence, the graduate student learns to hear his story and witness his struggles, they are able to identify his strengths and the self-preservation demonstrated in his story.

In stage III, students begin to see creative maneuvers that people have used to negotiate margins to solve some of their problems. They recognize behaviors that often frustrate professionals, as noncompliance may in fact be acts of resistance to professional control and assertions of agency on the part of outsiders.[18] Hence, the *actions* in this stage is naming strength. The practice *role* becomes supporter of agency.

Cultural shift in the rite of passage

As nurses listen in witness to narratives that reveal resourcefulness, resilience, and self-reliance, they can be inspired by the creativity in social margins[18] and they can begin to acknowledge their own positions as marginalized in the health care system.[3] Their paradigm shifts from nursing as mediating to nursing as sharing marginal positions. As this mutuality emerges, the process moves into the final stage.

Stage IV: Accompany

This step is not advocacy, although it may emerge from a problem that needs a solution. In its ideal form, this step engages the mētis[9] of the nurse and the visitor. "Mētis" is a term Scott[9] used to call informal knowledge that comes from experience or practical knowledge. It reinforces and builds on the agency of each. Accompaniment is a process that is derived from the teaching of Dr Paul Farmer and Fr. Gustavo Gutiérrez as it means "walking with—not behind or in front—but beside a real person on his or her own particular journey in his or her own particular time, at his or her own particular pace."[19(p6)] When the practical, experiential knowledge of both is brought to bear on what is often a structural problem of inequity or injustice inherent in a marginalized position in society, mutual benefit can result.

Perhaps, this step is best illustrated in 2 stories of APTCN. A graduate student formed a relationship with a woman at the Health Commons who was struggling with a life on the street and many complications of addiction, prostitution, and depression. One day the woman unexpectedly asked the student to accompany her to a child custody hearing at the courthouse. The woman wanted desperately to retain some relationship with her children. The student knew nothing about child custody law, nor court proceedings, but agreed to go with her. It was an act of solidarity and had potential to shift dynamics in a setting that would take notice when a middle-class, white professional sat with a poor woman of color seeking to be heard. Seeing firsthand how structures of inequity function and how much strength and cunning were needed to get a semblance of justice from the system, the student's knowledge about the system and her respect for the woman increased greatly. Although no miracle happened in the courtroom, accompaniment was a small step in a local context at a human scale. The

relationship of trust deepened, and a step toward further reality-based shared problem-solving began.

Another experience occurred with one of the longtime visitors to the Health Commons, "Bob," a middle-aged man who struggled with memory loss that resulted from a head injury several years ago, made great efforts to participate, often working as a volunteer. After being hospitalized for a seizure, his doctor wanted more follow-up support, so he was enrolled in a support group at the hospital. He attended one time but did not return and was worried that his doctor would be upset. He expressed his concerns to a nurse at the Health Commons who offered to go with him to the group, adding that she would benefit from knowing about how it worked. It was agreed that she would accompany him on a date that he chose. "Bob" was very familiar with the hospital and took the lead in finding the unit where the group meeting was held. In the process, he pointed out different areas of the hospital, which was very informative for the nurse. Although the unit staff were very friendly and welcoming, "Bob's" anxiety about what would be expected of him was apparent. He did not trust his memory about how he was referred to this service. After his presence was justified by the system's procedures, the nurse helped him fill out forms that were also needed to justify his eligibility for this service. When he was finally invited to the group activity, the nurse stayed until he felt comfortable for her to leave. From that initial meeting, "Bob" did not miss another session and expressed appreciation for the activities he found there.

On the surface, this may represent a simple example and common knowledge. It was a small step, but in a larger context demonstrated how efforts for follow-up care through referral within the same care system can be intimidating and confusing and a waste of effort. The nurse could be helpful on many levels, certainly as a support to an independent person struggling to maintain his agency in a hospital setting he knew well. She was comfortable negotiating procedures of health care organizations and could make connections in the process that he would not know. The staff of the hospital would not know much about "Bob's" circumstances, nor the street life he had to negotiate in following through on his doctor's advice. Set up for general support to people with mental health struggles, the staff would not be aware of "Bob's" memory loss and motivation to participate.

This example illustrates how interpretation and mediation works in APTCN. It was also a step in collective problem-solving as the nurse became aware of a potential ally in a nurse working in the hospital setting. This introduction helped establish a connection between marginalized people in the community and an advocate within the health care system that was often utilized by people coming to the Health Commons.

Shared experience of challenge can lead to creative action that requires and builds on the agency of both the nurse and the marginalized individual. It engages the mētis of both—the practical knowledge that is often not articulated. In stage IV, a nurse begins to clarify the knowledge that one has gained through their own professional and personal experience.[9] As Camus stated, "You cannot acquire experience by making experiments. You cannot create experience. You must undergo it. . . . It is all practice: when we emerge from experience we are not wise but we are skillful. But at what?"[20(p5)] Thus, practice *actions* are shared risk in solidarity facing injustice. The *role* is to honor mētis.

Cultural shift in the rite of passage

As human connections expand and cultural knowledge deepens, mutuality of the relationship can be acknowledged. This step requires common sense and common ground. It reflects action based on solidarity and mutual problem-solving. Building on the mētis of both nurse and the visitor, this shift creates a paradigm of synthesized care, as both the marginalized and health care cultures become one as shackles constraining the origins

of knowledge are dismantled and the voice of the marginalized is viewed as the expert.

A foundation in hospitality

When faculty members and students of the DNP in Transcultural Nursing Leadership program at Augsburg University collaborated during coursework, the Health Commons model of nursing practice took new form. DNP students openly critiqued the model following practicum experiences at the Health Commons. The stages to acknowledge the need, attend to the struggle, affirm strength, and accompany suggested a linear process that had a beginning and end, but after critical reflection it was determined that relationships and practice are best depicted as a circle, thus suggesting that the center of practice model should be the practice of "hospitality" and that people should not just tolerate difference but welcome and promote diversity.[7] Rather than working from the outer rim of the circle to an inner base of "common ground," the model starts from a core of "hospitality" that is aptly symbolized by the Celtic knot. As an ancient art form, the Celtic knot incorporates the design elements of spirals and interlacements portraying the beauty and complexity of human interconnectedness.[21] Concentric circles represent the practice and imply the space that is safe, free, and sacred. The movement is from the center outward. In the first circle around the hospitality center, the stages of relationship revolve. In the second circle, principles of action reside. As the circles move out from the center, connections with the dominant society are sustained as ultimate efforts at social and cultural changes.

CONCLUSION

This article described how nursing skills that focus on means of inclusion allow the advanced practice transcultural nurse to address issues of equity and social justice through methods of direct, collective action. The Health Commons practice model serves as a guide for nurses to reduce stereotype, stigma, and discrimination that surface in US health care settings. The process of decoding allows faculty, students, and volunteers to engage with people who are marginalized and learn from the wisdom of those who survive living life without a permanent place to call home. Students are able to begin to understand the complexity of health and the social constructs that limit it, which can produce a call to action. The future of nursing depends on innovative methods of caring that address health inequities through approaches that move from need-based to accompaniment.

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