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Caring in the Margins: A Scholarship of Accompaniment for Advanced Transcultural Nursing Practice

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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, transcultural nursing 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 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 socio-cultural 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 the other. These stages require an APTCN 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. Becoming a member of a marginalized cultural collective is essential to the accompaniment of persons from that collective. Familiar with the use of stealth and cunning[2], 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. It is in the cultural collective that nurses learn about the mindset 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, 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 are drop-in centers 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." Further, "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 transcultural nursing.

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 mainstream U.S. society.

Social marginalization can threaten health by increasing social isolation, alienation, and generalized distrust of others. The 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 or even give their name. They do not have to name a problem or concern to be

unconditionally welcomed.

The Commons is organized and staffed by 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 Commons. Students of the nursing program at Augsburg come to the Health Commons during their Baccalaureate completion program, in addition to students in the Master of Arts in Transcultural Nursing and Doctor of Nursing Practice students in their APTCN doctoral program. The Health Commons is a twenty-five 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 are unique. Faculty traditionally have practiced transcultural nursing in a variety of settings with an emphasis on engagement as scholarship. Not only is cultural knowledge relevant and policy awareness important, but 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 to have learned how to care for those who are marginalized through accompaniment.

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 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 lab 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 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 are tallied in order 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 Commons staff view structured assessments as establishing power differentials between provider and patient in the health care system. Foucault described this process incisively as "hierarchical surveillance and normalizing judgment." [3(p192)] Acknowledging the process is a barrier to mutuality and hospitality. Thus the 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 Commons come from social margins, which carry a weight of stereotype and prejudice, stigma and discrimination. They may be situated as addicts, ex-cons, transients, 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 be traverse to get to the 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 non-clinic 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 Commons community at an inner-city church is unique. At the Commons, tasks are de-emphasized and students are urged to take time to listen, to sit down and spend time with people. Introductions using first names are encouraged. Conversations in the moment that offer

meaning are considered more important than inscribing peoples' problems and responses in records. In short, expectations of practice are very different at the Commons compared to the culture of health care.

A ritual of simple tasks that offer familiar cultural practices could help to ease professionals' encounter across this threshold. The initial ritual was shaped by the experiential knowledge shared by some individuals of the marginalized community. The Commons staff do not perform a "community assessment" to determine "needs." "Satisfaction surveys" are not completed. Rather, relationships are built with people who came to the 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 Commons made it clear to nurses that people negotiating scarce resources value new, clean socks, diapers, menstrual pads, and small size 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, 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 transcultural nursing work.

This practice model is structured as Gustavo Esteva admonished "humble actions, in a local context, at a human scale." (G. Esteva, oral communication, October 2016)[7] 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 co-created based on

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 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, it 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. By contrast, innovation and action that come from people living in the margins can be minimized by professional staff "providing service" to them. Acknowledging the benefits nursing faculty and students receive from marginalized individuals who come to the 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 continues in some form within a person. If personal history is grounded in experiences of mistreatment, anti-social 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 re-defined 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 three phases that are common to this ritual

process of social role change: 1st separation, when the initiate moves away from a social role

and status; 2nd liminality or transition, when the initiate enters a space of ambiguous identity

where they are to reflect on and question all that they have learned before and where they are

taught by other members of the society what will be expected of them in a new role, with a new

identity; and 3rd incorporation when they re-enter society with a new identity and role. Nursing

students experience at the 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 right 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, 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 either a Bachelor's of Science in Nursing, a Master's Degree in

Nursing, or a Doctoral Degree in transcultural nursing.   The principle aim of the ritual is to

establish a non-threatening 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 an ability to acknowledge express felt needs.

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 support developing a ground of mutuality and reciprocity.

As people come to the open door of the 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 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. Prior to coming to the 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 post-practicum 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 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 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.

In a cordial introduction, the nurse and 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 semi-circle, 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 care-giving 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 like, "I'd be interested to hear more about your blood

pressure concern," or comments like, "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 post-practicum experience, an undergraduate student discussed the difficulty in

avoiding questions during his recent interactions at the 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 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 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, 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, in order 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 towards

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 non-action, 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 another's 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 the nurse, 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 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 pay 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 non-profits, they only accept 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 non-profits 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 which often frustrate professionals as non-compliance may in fact be acts of resistance to professional control and assertions of agency on the part of outsiders.[2] 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 even though 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, as his or own particular pace."[19(p6)] When the practical, experiential knowledge of both are 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 two stories of APTCN. A graduate student formed a relationship with a woman at the 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 first-hand how structures of inequity function and how much strength and cunning[2] was 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 long-time visitors to the 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 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. 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 to 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 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 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 are viewed as the expert.

A Foundation in Hospitality

When faculty members and students of the Doctor of Nursing Practice (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," 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, connection with the dominant society are

sustained as ultimate efforts at social and cultural change.

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 U. S. 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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Supplement Digital Content 1. Table that illustrates the Health Commons Practice Model. pdf