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Canada

Caring and Culture: The Practice of Multiculturalism in a Canadian University Hospital

by

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The Practice of Multiculturalism in a Canadian University Hospital

Abstract

This thesis examines how cultural understandings are generated and transmitted in a Canadian multicultural teaching hospital. It explores how issues of 'culture' are addressed formally and informally in the experiences of patients and practitioners. Using the approach of an institutional ethnography, emphasis is placed upon informal strategies of cultural care as a taken-for-granted practice in clinical life. It illuminates how pressure to learn culturally sensitive care seeps into the fabric of daily clinical life, and how cultural practices are constructed within a complex set of organized social practices.

The study concludes that advocacy of multicultural policies, must consider the dominance of existing western health care paradigms. It advocates culturally responsive care as a parallel force that can collaborate with the regimes of formal health practices. It argues that providing effective health care to all segments of Canadian society requires structural changes in health education which need to address existing disjunctures between 'effective ideals' and ideological knowledge, in order that all are ensured optimum health care.

Résumé

La présente thèse examine comment naissent et sont transmises les interprétations de nature culturelle dans un hôpital d'enseignement multiculturel. Elle explore, à partir de l'expérience des patients et des praticiens, comment les questions de "culture" sont traitées officiellement et de façon informelle. Par le biais d'une approche fondée sur l'ethnographie institutionnelle, on y met l'accent sur les stratégies informelle en matière de soins adaptés au contexte culturel qui sont tenues pour acquises dans le milieu clinique. Cette thèse illustre comment des pressions visant l'apprentissage de techniques de soins qui tiennent compte des différences culturelles s'exercent quotidiennement dans le milieu clinique et comment s'élaborent des pratiques à caractère dans le cadre d'un ensemble complexe de pratiques sociales organisées.

L'étude conclut qu'un plaidoyer en faveur de politiques multiculturelles doit tenir compte de la dominance des modèles de soins de santé officiels. Elle fait valoir que, pour fournir des soins de santé efficaces à tous les segments de la société canadienne, il est nécessaire d'apporter des changements structurels dans le domaine de l'enseignement des soins de santé afin de combler le fossé que existe entre les situations idéales et la connaissance idéologique, de manière à assurer des soins de santé optimaux.

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Introduction

This thesis examines the way cultural understandings are generated and transmitted in a large Canadian multicultural university teaching hospital. In particular, it explores how both formal and informal activities contribute to the learning and practice of cultural care in and through a set of socially organized relations.

In Canada, both federal and provincial multicultural policies encouraging cultural diversity have important implications for effective health care practices. While the intentions of these policies are to ensure that patient populations receive culturally sensitive care, there has been little systematic understanding of whether or how this objective is realised in practice. These concerns form the central focus of this thesis, which will investigate the learning and practices of nurses and physicians involved in the care of a large multicultural client population in a Canadian university hospital.

Multicultural policy objectives have been given considerable attention in the literature in relation to health professional practice in Canadian service settings (Masi, 1988). Moreover, proposals to expand current medical and nursing education to include greater multicultural content have received substantial attention by nurse academics, physicians and the health profession at large (Branch, 1976; Leininger, 1978; Masi, 1989).

Medical academics have argued that the western medical orientation, which informs much of the content of contemporary medical and nursing knowledge, has had a 'deterministic' effect on learning and practice in that it fundamentally overrides alternative health care systems. These writers argue that alternative health care

orientations are in fact, 'anathematized as false beliefs' (Kleinman, 1992) by the orthodox medical paradigm as a whole. Medical and nursing academics have argued for the teaching of other views, such as transcultural and anthropological clinical sub-specialisations, in an attempt to anchor and situate health care alternatives within a realistic framework of clinical practice. Despite these arguments, very little is known about how or whether these alternative paradigms are reflected in daily clinical practice. This thesis will examine these questions and issues which surround multicultural health care learning and practice, and will attempt to situate them within a sociology of knowledge.

Multiculturalism, Health Care Learning and Practice

Explanation and advocacy of culturally sensitive health care within hospital settings has been given a great deal of attention in the Canadian health care literature (Anderson, 1986, 1988; Clarke, 1993; Masi, 1988, 1989; Stephenson, 1991). Yet how culturally sensitive practice actually works or how its varying definitions become translated specifically into the education and daily activities of Canadian health practitioners remains largely unexplored. Thus the purpose of this investigation is to explore cultural understandings from the standpoint of practitioners in their everyday world and the way in which these understandings are constituted within the social organization of the health care system.

In particular, this study situates the problem of managing cultural care and practice within a sociology of knowledge. Using the approach of an institutional ethnography,

everyday strategies of learning about and managing the needs of patient care will be illuminated in order to show how health practitioner learning and practice are constructed within a complex set of social, political and economic relations. This analysis will draw heavily on the words of both practitioners and patients, both of whom are highly vocal about their experiences. Their words reflect many features of their experience within the hospital setting. They reveal not only how the pressure to learn treatment and culturally sensitive care seeps into the fabric of clinical working life, but also how cultural learning is understood and defined within a set of informally sanctioned work practices. Thus we can see how what constitutes multicultural health care evolves as a product of daily practices.

This investigation aims to shed new light on the familiar theme of tension between orthodox medical knowledge and culturally sensitive practice. It explores the daily dynamics between the routine knowledge and decision-making of practitioners in the context of accountable care, and the forms of understanding commonly used by patients to interpret and manage their own illness experience. It points to some contradictions in decision-making around learning and practice of culturally sensitive care and to the need to reframe some of the issues involved in managing the delivery of care in the context of a formal commitment to cultural sensitivity. It examines the orthodox paradigms and routine professional practices that make up the daily substance of culturally sensitive practice in hospital life, including events like finding a translator, accommodating special illness needs, modifying treatment regimes, meeting special family needs. Moreover, it illuminates how these elements of individual practice are embedded within a complex set

of institutional relations of entitlements, resources and legitimate claims within the current health care system. Thus it explores the requirements of culturally sensitive care at both the individual and institutional level of action.

The epistemological and ontological grounding underlying this method of analysis does not primarily start with traditional sociological, anthropological or cultural theory. Rather it begins with the actual experiences of ordinary people, in this case health practitioners and patients. Thus the investigation takes up the standpoint of practitioners, rather than beginning with the attempt to examine the formal 'meanings and formulas' underlying sociological and medical anthropological disciplines. For example, much attention has been given to the study of culture and health care in relation to formal knowledge of differing cultures and their specific health/illness pathology. (See Kleinman, 1981; Leininger, 1985). The work of transcultural psychiatry epitomised in the contribution of Raymond Prince, medical anthropology in the contributions of Arthur Kleinman and the transcultural nursing of Madeleine Leininger, are three widely known approaches to cultural understanding in health care practice. The aim of my work is not primarily to investigate these formally defined frameworks of cross-cultural scholarship. Instead my inquiry places emphasis on a less visible aspect of multicultural health care. It is primarily concerned with culturally sensitive care as an outcome of socially organized practitioner knowledge on the hospital unit itself. To this end, my analysis is more properly concerned with the provision of institutional arrangements through which multicultural health care learning comes about and is made operational in practice in the hospital. As such, the investigation then moves away from the generally known world of

formal concepts and explanations to focus on the everyday world of nurses and physicians' actual practices and actions.

Following this approach to investigation, this thesis will explore how "cultural understanding" comes into being as a social practice of nurses, physicians, administrators and patients in their everyday world in and through a set of social relations which "organizes the worlds of experience" (Smith, 1987).

Overview of Chapters

Chapter One examines Canadian multiculturalism and its relation to Canadian health care education and practice. It reviews the ideals and intentions underlying multicultural policies and discusses the accompanying body of knowledge and debate underlying these policies in the context of their relevancy to health care. Here the need for medical and nursing knowledge addressing cultural factors has been voiced as an important concern in light of clinical research evidence which reveals instances of misdiagnosis, lack of agreement with prescribed treatment procedures and discordant patient-practitioner communication in multicultural health populations. In particular, current debates and concerns around the relative absence of culturally sensitive training opportunities for health practitioners in Canada in relation to multicultural health practices are discussed.

Chapter Two explicates theoretical principles for an approach to methodology informed by the social organization of knowledge. In particular, the aim is to provide an understanding for an institutional ethnography and to present central epistemological and

ontological arguments for this approach to research. In this chapter, four central issues are addressed: (1) the rationale underlying the choice of research questions; (2) the principles of phenomenology as important theoretical contributions to the tenets of institutional ethnography; (3) the concept of 'reflexivity' as a central component of institutional ethnography; and (4) two essential processes with respect to the mode of inquiry, talk and documentary data. Finally the research setting and the process of data collection is described.

Chapter Three furthers the discussion of multiculturalism and health care from a broad critical and theoretical perspective of health education discourse. It attempts to account for some of the controversies and ambiguities surrounding multiculturalism and health care training and practice outlined in Chapter One. It draws on the theoretical work of Dorothy Smith on the sociology of knowledge, of Michael Polanyi on the philosophy of knowledge, and on the theoretical positions of medical anthropology epitomised in the work of Arthur Kleinman. In this chapter it is argued that the way current health care curriculum is organized renders education and training accountable to science-based models of practice. For example, the increasing efficiency of science-based practices ensured by stringent health care training and policy demands, relegates culturally responsive care to the status of *ad hoc* experience and common-sense acquisition rather than to a place in the legitimate teaching program.

Chapter Four begins the exploration of multiculturalism in learning and practice through the everyday experience of patients in University Hospital. It attempts to make visible through their talk their expressed assumptions concerning health care and their felt

experiences in relation to health practices in the hospital setting. In particular, the chapter explores multiculturalism through pervasive changes in the patient care climate at University Hospital. It attempts to make more visible the evolving needs of patients and family clientele and how this development which creates pressure for change in the hospital also creates pressure for practitioners to attain differing knowledge and decision-making practices.

Chapter Five analyses phenomena outlined in Chapter Four in the context of the experiences of practitioners and their views as on the learning practice of 'multicultural health care'. Through an exploration of the learning and practice understandings of nurses, it shows how nurses informally *work into* their practice demands for culturally responsive care. And it highlights the impact which western health care policies and frameworks of practice have on nurses' daily practice experiences at University Hospital.

Chapter Six examines current contradictions and ambiguities with on-going facilitation and development of contrasting paradigms to those informed by science-based models of care. It shows that while new theoretical parameters have been presented in the context of medical anthropology and transcultural nursing, nurses' sense of 'practice competency' is brought about by rewards for actions based on scientific frameworks for quantifying patient and family care. This not only renders a pervasive accountability to practices exclusively informed by those models of care, it inserts a disjuncture in the cultural practice relations in the day to day encounters between nurses and patients.

Chapter Seven explores through physicians talk, their expressed ambiguities concerning orthodox medical paradigms. Prevailing assumptions that universalist models

of medicine pervade in practice are explored through the voices of physicians. These assumptions are further explored in the context of the concepts of 'clinical modification' and 'cooperative practice' which shape informally the day to day clinical activities of physicians' work.

Chapter Eight explores through the voices of nurses and physicians their concerns and aspirations in relation to clinical competency, cultural understanding and language proficiency. In particular, these concerns and aspirations are explored through the concept of "collaborative linguistic exchange" and an attempt is made to explicate the organized social practices within which practitioners' linguistic practices are embedded.

CHAPTER ONE

CONCEPT OF MULTICULTURALISM

Canadian society has always included people from varying linguistic, racial, cultural groups and communities, however the perception of Canada as a multicultural nation is associated largely with the immigration movements of the late nineteenth and early twentieth centuries (Burnet, 1988; Clarke, 1992; McAndrew, 1991). Canada must recognize and affirm the rights, needs and aspirations of people from many different communities, regardless of their racial, linguistic or cultural affiliations. Canada, as well as many other countries throughout the world, must also respond to the fact that contemporary society is increasingly mobile.

What is unique about Canada is that it has formally established a multicultural policy which acknowledges and confirms the nature of its multiracial, multilingual society, thus affirming Canada as a pluralistic society (Masi, 1988). In Canada we are guided by the 1971 federal policy of multiculturalism which recognizes the multicultural reality of Canadian society and accepts responsibility for protecting and promoting cultural diversity. Subsequent efforts to implement this policy have concentrated primarily on the provision of measures to ensure equality of opportunity and rights for Canada's culturally diverse population. These are, the Canadian Human Rights Act (1977), entrenchment of the Charter of Rights and Freedoms (1982), and Bill 93-C, the first Multicultural Act (1988).

The Multiculturalism Act (Bill 93-C), the first national Multiculturalism Act in the world, builds upon the equality and Multicultural commitments of the Canadian Charter of Rights and Freedoms. It commits the federal government to promoting the full and equal participation of individuals and communities in shaping Canadian society. The intention of all federal legislation concerning Multiculturalism has been to foster integration and pluralism and to create optimum conditions for Canadians to maintain their individual heritage, language, customs, and beliefs.

In the province of Québec a number of acts support the principles of multiculturalism: First, the Ministère des communautés culturelles et de l'immigration Act (1981); second, the Québec Human Rights Charter (1982); third, the Conseil des communautés culturelles et de l'immigration Act (1985). The expressed aim of Québec legislation is to achieve equality for all and to respect Québec's cultural diversity.

In Québec although the federal concept of multiculturalism creates a problem from the perception of Québec society, since its policy ideals do not outline or specifically affirm a special status in Canada for Quebec (Berry et al., 1977; McAndrew, 1991), the Québec government nevertheless has made clear its intentions to promote and foster cultural exchange according to the Quebec Human Rights Charter (1982). This charter ensures the recognition of the dignity and value of all human beings without discrimination or preference based on race, colour, sex, religion, language, national extraction, social origin, customs and political conviction. These latter intentions are visible in two particular areas of documented Québec legislation, provincial education and health care.

1.0 Multicultural Reality in Canada and Quebec

The number of persons immigrating to Canada from foreign countries has varied from a low of 84,331 in 1985 to approximately 152,000 in 1987 (Statistics Canada, 1988). In 1988, one in six Canadians was born outside of Canada. The ratio of people born outside Canada to people who are Canadian-born has never since Confederation been less than one in six and has sometimes been as high as one in five (Census of Canada, 1988).

Populations in Canada have become increasingly diverse, and currently there are reported to be more than 80 linguistic groups (Masi, 1989). Emigration between 1956 and 1971 was dominated by movements from Europe. However, during the last two decades the proportion of immigrants from Europe has decreased by 40 per cent, whereas the number of immigrants from Asia and Latin America has expanded by 60 percent (Statistics Canada, 1989, pp. 93-150).

In Québec 13 per cent of the population in 1986 were of nationalities other than British or French origin. The population has also become increasingly diverse with more immigrants from Haiti, Vietnam, Asia, Iran and Central America.

Montreal has an increasingly diverse ethnic population who are neither English nor French, with an increase of seven percent since 1981 to a total of 30.1 per cent in 1986. The largest ethnic groups in the city in 1986 were Italian, Greek, Haitian and Chinese (Census Canada, 1986). According to the 1991 Census, immigrant communities in Montreal comprise French, English, German, Scottish, Italian, Irish, Ukrainian, Chinese, Dutch, Polish, Haitian, Greek, North American Indian, Métis and Inuit. The Chinese community has increased significantly in numbers since 1986, from 21,240 to 34,350 and

is currently considered to have grown the most of the ten largest groups in the city (Statistics Canada, 1991).

Québec has established policies which address equal rights and respect for cultural diversity in health care. The *Loi sur les services de santé et les services sociaux Quebec,* (1989), is intended to ensure that everyone receives personalized care that is ethically, socially, and humanly sound. It also provides for measures against discrimination with regard to race, colour, sex, religion, language, social origin and political convictions. In 1989, the aims and objectives of the Ministère de la santé et des services sociaux of the Québec government outlined the following major provincial health care objectives. These objectives were primarily aimed towards promoting the increased presence of cultural communities in the health and social services network through partnership and the development of accessible and adequate, culturally aware services.

1) To ensure that all Department programs take our multicultural reality into account;

2) To identify, establish and ensure that a base of accessible services adapted to cultural community needs is established in regions with a sizeable multi-ethnic population;

3) To promote the presence of cultural communities within the health and social services network so as to bolster ethnic and cultural representation at all levels of the system;

4) To recognize the partnership role that may be played by cultural community organizations working in the area of health and social services;

5) To disseminate adequate information on the services and their operation to cultural communities;

6) To promote research into the various aspects of cultural community services. (Québec, 1989, pp. 12-16)

The criteria by the *Bureau de coordination des services aux communautés culturelles* for ensuring that the preceding objectives were carried out would be based on evidence of the number of files processed relating to the issue, the number of joint initiatives undertaken and the number of projects and programs undertaken within an immediate two year period (Québec, 1989, pp. 12-16).The most recent health care policy in Québec, Bill 120, states that "cultural communities must have access to services that take into account their particular situations" and the policy advocates "special health care access programs to account for cultural diversity in patient populations" (Quebec, 1991, p. 145).

1.1 Multicultural Policies and Health Care Practice

The policies and legislation outlined in the preceding sections here have important implications for health care practice in Canadian multicultural health settings. They suggest evidence of practices with a commitment to knowledge and health care which recognizes fairness, compassion and freedom (Secretary of State, 1987, pp. 23-24), and thus an openness to the concept of pluralism in the acceptance and full recognition of the many immigrants who seek Canadian health care.

To this end, the Canadian Council on Multicultural Health has defined multicultural health care as:

> Health care which is provided in a culturally sensitive appropriate manner ...; it is equally accessible to all persons regardless of their racial or cultural background. (Canadian Council on Multicultural Health, 1992)

Therefore a multicultural approach to health care would require that the policy makers who structure and order the content of health care education and practice acknowledge the varying needs of health care by Canada's immigrant population. It would also acknowledge their right for an equal opportunity to participate in the political, social and economic realms of everyday life in terms of decision-making and health care practices. In turn, health care educators as disseminators of knowledge would assume a commitment to practice which recognises, accepts and legitimates the full magnitude and potential of Canada's multicultural and immigrant communities.

Thus a multicultural approach to health care would formally incorporate learning models which fully acknowledge Canada's immigrant communities. Within this ideal, there is also the assumption that there is no singular body of knowledge that is selectively predominant. Therefore the stated intentions of multicultural legislation have significant implications for effective health practitioner education. There is an assumed willingness to recognize the distinctiveness of health knowledge and life experience of cultural communities, which may differ from knowledge informing western models of health care.

This would mean that cultural knowledge and assumptions about health education and practice would inform Canadian health practitioner curriculum and policies. Moreover, policies which direct the development, implementation and evaluation of Canadian health practitioner curriculum would reflect a model for practice which legitimately recognizes alternatives and which is not exclusively informed by the current mainstream orthodoxy of science-based care.

1.2 Multiculturalism and Health Practice

While Canada's policy of multiculturalism creates optimal conditions for training programs for health professionals, there is little existing evidence of cultural awareness and sensitivity to differing life-world experiences in health care practices.

The experiences of many immigrants facing hospitalisation in a foreign society, in which cultural values and illness beliefs are antithetical to their country of origin, create tremendous stress on patients and their families. Some case studies have revealed that treatment and care planning is often based on western models of health care and does not include alternative methods of healing. As a result, it does not always lead to effective outcomes (Boston, 1992). Health professionals frequently care for patients from cultures which are unfamiliar to them. Numerous quantitative studies indicate that the day to day experiences of immigrant patients and families in a western health care system are complicated by differences in experiences, knowledge, beliefs and approaches to health and illness (Dyck, 1989; Jung, 1984; Kagawa-Singer, 1987; Shon & Davis, 1982; Sue, 1977).

A number of ethnographic studies have used interpretive analysis to understand the cultural and social meanings of health and illness. Through observation and in-depth interview techniques, researchers have discovered the varying ways in which people make sense of illness and health behaviours. All of these studies reported the use of cultural remedies and cultural explanations of illness, in conjunction with orthodox western models of care (Anderson, 1986; Cornwall, 1984; Donovan, 1986).

One in-depth, qualitative study using semi-structured interview techniques with Chinese families in a large university teaching hospital in Québec, has addressed cultural perceptions of illness, decision-making and coping responses in relation to the hospitalisation of a family member for a psychiatric illness. Although this work was limited to retrospective clinical observations, the researchers reported that subjects consistently used traditional healing remedies which were often discreetly substituted for orthodox treatment measures (Sun Li & Boston, 1989).

There has been voluminous work done in an attempt to understand traditional healing practices in the field of transcultural psychiatry. Much of this work has demonstrated that health and illness knowledge is constructed in local contexts, away from the mainstream culture. Much attention has been devoted to the understanding of traditional healing practices in relation to western, orthodox medical knowledge (Prince, 1987, 1993). There has been some recent concern in this field, about the universality of diagnostic categories across cultures (a phenomenon associated with western orthodox models of practice), with the assessment of psychiatric disorders. Prince (1987) has argued that diagnosis of illness across cultures must depend upon signs and symptoms (not local meanings) since this is the only phenomenon that is likely to be constant (Prince, 1987, pp. 1-49). And in contrast to what has been criticised as the dissociative phenomenon of biomedical categorisation, problems are perceived in evaluating the nature of consciousness and the social construction of the person (Kirmeyer, 1992). Moreover, it is also argued that cultural knowledge or traditional ways of experiencing illness are embedded within indigenous conditions, which do not always fit the mainstream

orthodoxy of assessment through diagnostic categorisation (Lewis-Fernandez, 1992, pp. 301-317). Recent work in the field of family therapy has attempted a theoretical synthesis between the practical application of family therapy and the broad research orientation of transcultural psychiatry (Di Nicola, 1985).

In the field of nursing, an entire theoretical sub-field of transcultural nursing has evolved, which argues that cultural care often involves nursing decisions and actions which are acceptable to the patient and the caregiver, yet are in direct opposition to the mainstream orthodoxy of care (Branch, 1985; Leininger, 1988[a], 1988[b], 1991). In fact there is much evidence in both the theoretical and empirical literature to support the value placed on traditional practices. Some studies have revealed that healers and lay mediators from cultural communities are informally called upon to assist practitioners towards illness and health explanations (Anderson, 1986; Dyck, 1989; Sankar, 1991).

There is some evidence which reveals that cultural and ethnic differences are often directly related to particular chemical compound responses in treatment regimes such as those of drug therapy. For example, many clinicians affirm cultural/racial differences in clinical practice with respect to psychotropic drugs (Joyce, 1980, p. 131). In a similar vein, Prince (1982) suggests taht some of the marked cultural differences in alcohol abuse (Chinese versus Irish, for example) may result from biological differences. Chinese, in high proportion react to alcohol with an unpleasant biological flushing response which may inhibit use ina manner similar to Antabuse. In this argument it is held that the actual way of physiological and biological processing whereby for example, alcohol is converted to acetaldehyde (ADH) may account for cultural differences in acetaldehyde levels

(Prince, 1982, p. 598) and that therefore, drug tolerance or intolerance of toxic substances cannot be reduced to therapies based on notions of cultural "similarity" and "uniformity". Similarly, Ralph Masi has argued that among the need-to-consider variables are the cultural factors in the health assessment of a person (Masi, 1989). For example, Masi reports evidence of high nutritional variations in the ability to tolerate lactose. Masi observes that lactose intolerance in people from Asia, is often as high as 80%-90%, which differs strikingly from people living outside Asia (Masi, 1989, p. 69). Other areas for concern are the possible physiological or metabolic differences that can be caused in different people by chemical substances. There has been further evidence to suggest that metabolic response to drug therapy such as Sparteine, Debrisoquine Mephyenytoin, Debrisoquine and Caffeine may be culturally related (Masi, 1989, p. 70). These findings would seem to imply that diet and nutritional lifestyle may vary by a wide margin and therefore may not be compatible with standard regimes of drug therapy.

Other studies have indicated that differing perceptions of treatment related to health and illness have resulted in problematic outcomes for both health practitioner and patient. These studies have specifically considered cultural variations such as migration, family dynamics and cross-cultural exposure. They observe problems for immigrants, in a society which is antithetical to their country of origin, which include perception and communication difficulties related not only to language, but also to culturally embedded meanings attached to illness (Garro, 1990; Gorlin & Zucker, 1983). Other problems which have been identified include caregiver misinterpretation related to illness, differing

expectations of behaviour by practitioner and patient, and misdiagnosis (Kleinman, 1981; Molzahn & Northcott, 1989; Zola, 1966, p. 23).

An early qualitative study of 200 patients from Italian and Anglo-Saxon groups found that the decision to seek treatment was related to socio-economic factors rather than to the degree of illness and that the language of "distress and suffering" differed by a wide margin (Zola, 1966). Misinterpretation of suffering has been illustrated in a number of studies and has been found to be marked particularly when the patient and health professional come from differing socio-cultural backgrounds (Garcia and Lee, 1988; Kleinman, 1985; Zola, 1966).

Another more recent qualitative study conducted in Victoria, British Columbia by Peter Stephenson (1991) assessed the manner in which the formal health care system was used by Vietnamese, El Salvadorans and Indo-Canadian people. This study was based on a total of 135 qualitative interviews involving 30 key informants, 30 health care workers and 90 community members. Findings revealed that the most common barrier to health care was identified as language understanding and interpretation around illness meanings. Language was believed to compromise care, the failure to communicate effectively was perceived to impede quality health care by members of all three ethnic communities.

A qualitative study reported by Lipson, Reizian and Meleis (1987), which explored the help-seeking behaviours of Arab-American patients in a university hospital in a Canadian west-coast city explored the way in which health providers characterised patients from a cultural perspective within the recording process. The researchers used a chart audit of 106 hospitalised Arab-American patients and explored all recorded data that

focused upon culturally sensitive care. While the reported results did not reveal overt stereotyping within chart documentation, this study revealed interesting findings in terms of the priority and focus on the kind of data actually recorded. For example, the researchers noted that diagnosis and treatment constituted the central focus of the practitioners written documentation and moreover, patient problems were frequently described in the medically based language of the health practitioner rather than in the patient's own words (Lipson, Reizian & Meleis, 1987).

Considerable research is evident (in the literature on the care and treatment of cancer) about the varying perceptions and expression of pain. The issue of language as the means by which cultural reference to bodily changes, sensations and other factors attributed to disease has been given considerable attention in the nursing literature. Garro (1990) argues that pain cannot be directly measured and observed, but is a perceptual experience which is communicated through verbal means or through non-verbal expressions which the person indicates to be pain (Garro, 1990, p. 34). Pain language often has distinctive terms which show a wide variation in description (Garro, 1990; Melzack & Torgerson, 1985). For example, Melzack and Torgerson collected 102 pain descriptions in the English language but cited difficulty in the adoption of cross-cultural comparisons. Translation was perceived to be over-simplistic and not meaningful. For example, in trying to arrive at an Italian translation of the McGill pain questionnaire, two independent linguistic researchers arrived at two entirely different sets of pain questionnaires for the use of Italian patients (Garro, 1990). These observations illustrate

the complex difficulties of understanding and perception and the need for a high degree of language understanding in relation to the nuances of cultural care (Garro, 1990).

Anderson (1987) in a qualitative study comparing perceptions of 'normal' illness between Chinese immigrant mothers and Canadian English mothers found the ideology of western "normalisation" problematic with respect to the Chinese mothers' views of illness. These mothers felt compelled to follow discharge plans concurrent with western models of 'normal' care and as a result expressed confusion, inadequacy and distress in relation to the health care team.

These studies have concluded that subjective views of treatment and care, knowledge of pain and suffering, and illness understanding, need to be recognized if 'cultural understanding' in health and illness treatment is to be effective. They conclude that alternative knowledge of health in relation to culture needs to be freed from the professional, unicultural, westernized models associated with illness and health care practices (Bickel, 1987; Cali, 1991; Kleinman, 1980; Weaver & Sklar, 1980).

In all of these studies, the most consistent practical proposal for resolving the communication gap has been to encourage health professionals to treat seriously the lay knowledge of their patients and their families (Helman, 1990).

1.3 Multiculturalism and Formal Training of Health Practitioners

Despite the empirical value of the above studies regarding multiculturalism and health care, these research concerns are seldom reflected in formal medical and nursing curricula (Masi, 1989; Moffic, 1987). Existing curricula maintain high standards of

evaluation and accountability compatible with orthodox training models in the field of health care. These are seen as the only tools by which to produce appropriate explanations for cultural manifestations of health and illness. There has been some concern expressed regarding the current content of health practitioner knowledge, particularly that it has largely ignored cultural considerations in favour of biological content in curricula (Pfifferling, 1981). Research reported by Stephen Moffic (1987), reveals a notable absence of cultural content in psychiatric residency curricula. Moffic (1987) argues that:

> ... most residents are not as naturally interested in cultural psychiatry as in such publicized areas as psychotherapy and psychopharmacology. As biological psychiatry has grown in influence, time and concern for cultural issues may have decreased (Moffic, Kendrick, Lomas & Reid, 1987, p. 174).

What this seems to confirm is that the 'decrease in cultural concerns' reduces the notion of cultural inclusion in curricula to an ad hoc alternative which is not given equity to the mainstream orthodoxy of knowledge. Sole inclusion of the dominant mainstream orthodoxy clearly constitutes a selective transmission of knowledge and practice.

While many Canadian colleges and universities offer instruction on consciousness-raising and cultural sensitization, there is no mandate for nurses or physicians to participate in this type of learning activity (Canadian Task force, 1988). Moreover, health institutions offer little in the way of multicultural training (Leininger, 1985; Masi, 1988; Moodley, 1986). Another problem in training, which Schmidt, Dauphinee & Patel (1987) have pointed to, is the current challenge for community-oriented medical schools whose goals are to prepare physicians for community practice. These researchers report a

growing tendency for career preference to shift between enrolment and graduation, from primary specialty care to non-primary specialty care.

Thus as the recipients of practice, patients and families often face treatment modalities which are in direct opposition to their own mores and values. A report by the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees found that "initiatives in cross-cultural training are usually undertaken by interested individuals who may not always have ongoing administrative support" and it reported the "need for cross-cultural training for specialists in a variety of services; nurses, educators, family therapists, general practitioners, public health personnel and social workers" (1988, p. 54).

The requirements for specialization of Canada's Royal College of Physicians and Surgeons include knowledge about "psychosocial reactions to disease" (Beiser, 1990). However, training programs do not specify a structural component in cultural awareness, and training in cultural sensitivity is not listed among its requirements (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988, p. 54).

Out of a calender survey I did of the content of ten university departments of psychology, five actual courses relating to cultural sensitivity were identified. Course content included cross-cultural study of human behaviour, intercultural issues in counselling, race, ethnicity and linguistic issues. None of the identified courses dealt specifically with human rights, biases or issues of discrimination. Similarly, in a calendar survey for multicultural content in twenty Canadian baccalaureate nursing programs, findings reveal that nine nursing schools offer courses with multicultural content. These include cultural traditions and heritage, cultural sensitivity to differing lifestyles, dietary

habits and (western) models of nursing care in cross-cultural settings. While two nursing programs deal specifically with the law, ethics and philosophy of the nursing profession, there is no specific emphasis given to human rights issues or discriminatory practices (Boston, 1991).

Literature on nursing education emphasizing cultural issues has come largely out of the United States. The earliest nursing writer to advocate transcultural nursing, Leininger (1985) has argued that less than 10 percent of graduate nursing students in the United States receive cultural content in their training. She notes that the nursing profession has taken limited steps in education and service to change past practices of uniculturalism or to reduce ethnocentric practices (p. 694).

Marciniak (1990) studied the perceptions of nursing students and nurse educators with regard to the concept and content of multiculturalism in two Montreal inner-city nursing education programs. One of the findings revealed that incongruencies existed between government policy ideals of multiculturalism and multicultural inclusion in the content of these programs. Marciniak states:

> . . . despite both faculties believing that cultural diversity and discriminatory issues must be addressed in nursing education ... major aspects concerning societal and institutional barriers were lacking in both programs. (Marciniak, 1990, p. 89)

Studies by Colette (1982) and Chunn (1983) have argued that there is a resultant need for nursing research regarding issues of stereotyping and cultural biases in health care. They have noted serious deficits between the ideals of multiculturalism and inclusion in practice. These writers have noted the lack of, and urgent need for, research into cultural factors and health care practices. A study by Glynn (1985) which examined

nursing curricula in the states of Alabama, Florida and Georgia to identify perceptions concerning key cultural concepts and their inclusion in nursing school curricula, showed a discrepancy between what was desired and what was practised. Demographic data were examined to identify factors that might contribute to reported perceptions of administrative and faculty personnel. Patterns of homogeneity were revealed which were believed conducive to the maintenance of a unicultural perspective rather than a multicultural one (Glynn & Bishop, 1985).

Formal multicultural training in health care settings is often initiated on an individual basis by interested practitioners in response to particular case needs (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988). Many practitioners in multicultural settings claim immigrant status or are first generation immigrants, and are aware of alternative life views and traditional illness and treatment explanations. Yet frameworks for health care are informed by the formally legitimized models of care which are carefully learned and practised (Cali, 1991; Lakhani, 1989; Masi, 1988). Thus it would appear that the notion of negotiated care, compromise and full recognition of cultural knowledge in relation to health care, is restricted to an ad hoc or informal system of practices.

Other reports assessing the training needs required for understanding of cultural communities in hospital care have revealed that many hospitals do not fully recognise or act on the fact that Canada has become a multicultural society (Head, 1985). Based on Human Rights Commission reports, Masi (1988) has argued that the existence of cultural

bias in institutions and health care centers needs to be addressed both at the personal level of the health practitioner and at the institutional level.

Some health care organizations have developed multicultural committees while others have sponsored multicultural awareness programs. Ralph Masi has reported that some hospitals, such as the Regina General Hospital, Mount Sinai Doctors Hospital and Central Hospital in Toronto have taken positive actions to respond to specific community needs and to facilitate multicultural awareness programs (Masi, 1988, 1989).

1.4 Current Problems and Research Concerns

The concept of multiculturalism has significant implications for everyday Canadian health care practices. While the ideals of multiculturalism would appear to recognise the full potential of life experiences brought forward by people from varied and differing life worlds, there is very little known about how these ideals are realised in Canadian multicultural hospitals or what the everyday practice experiences are for patients and practitioners experiencing care in multicultural hospitals (Beiser, 1990; Head, 1985; Sue, 1981). There has been a call for more formal preparation of health practitioners in relation to multiculturalism in North America (Bickel, 1987; Constable, 1984; Giordano & Giordano, 1977; Moffic, 1987). In the United States, while there has been considerable emphasis placed upon the development of the transcultural nursing practitioner role in hospital settings, it continues to be argued that there has been very little progress in the development of transcultural specialists of curricula in nursing school programs (Leininger, 1988). It is also argued that health care knowledge is not well defined with

respect to the potential for shared cultural understandings in health care institutions (Beiser, 1990; Leininger, 1985, 1990; Masi, 1988). In numerous studies, it has been argued that the experiences of immigrants facing hospitalisation in North American society create tremendous stress on patients and families, and that treatment and care planning is often not in agreement with models of care and the illness understandings of multicultural populations. These studies have indicated that the experiences of immigrant populations are complicated by different perceptions of life style, beliefs and approaches to illness (Dyck, 1989; Garro, 1990; Molzahn & Northcott, 1989; Shon & Davis, 1982; Sue, 1977). A number of writers have discussed traditional assumptions in relation to western medical knowledge and its unchallenged status in the health professions (Eisenberg & Kleinman, 1981; Helman, 1990; Lock, 1988; Wright & Treacher, 1982). It is argued that orthodox medical knowledge assumes an increasingly scientific status, defines health and illness within strictly physical parameters (Helman, 1990), functions with a "special technical status" (Wright & Treacher, 1982), and is arranged in segmented hierarchies of knowledge within the profession (Foster & Anderson, 1978; Helman, 1990). These issues remain a pervasive concern in the theoretical literature.

Given the large number of these preceding research concerns which show both discrepancies in clinical findings and the absence of formal culturally responsive training, there is surprisingly little research evidence on how North American practitioners in hospitals actually go about daily practising and learning, (within the limitations which have been outlined in the research literature). In particular, there has been little emphasis on the way in which knowledge is organized in and around health settings with respect

to Canadian multiculturalism. While the intentions and aspirations of multicultural policies would appear to embrace a legitimate space for culturally responsive health practices, little attention has been given to how this actually happens and how these practices work from the day to day standpoint of the Canadian practitioner.

CHAPTER TWO

METHODOLOGICAL FRAMEWORK FOR AN INSTITUTIONAL ETHNOGRAPHY

Before considering an approach to research on multiculturalism, it should be emphasized that there is much perceived ambiguity in the literature in relation to the defining of policy and for our purposes here, this needs to be understood. It has been vigourously argued that the notion of policy is neither a fixed entity nor a concretely understood phenomenon and that it has much ambiguity of meaning. (Guba, 1984; Prunty, 1984; Wildavsky, 1979; Yeakey, 1983). Egon Guba has argued that people's definitions of 'policy' are within their own personal constructions and thus none can claim a tangible reality[1] (Guba, 1984, 70). In my approach to a research methodology this notion of policy as a phenomenon which is experienced - a set of assumptions which Guba terms "policy-in-experience" (Guba, 1984) is of particular interest[2]. In Guba's view, this notion of policy becomes a set of assumptions which are borne out in people's experiences and practices. These assumptions may not become immediately visible to people in their everyday practices, yet they are constant within their everyday world. Thus in applying this approach to research which is concerned with multicultural policy, the objective is not to examine policy as a formal concept in a traditional sense (a positivist stance)[3] but more to explore how experiences and practice within a multicultural setting work for practitioners and patients. Such an approach is more properly concerned with how these

practices work in daily talk and action within the context of the local and broad relations of the setting.

In an attempt to gain an understanding of the experience of multicultural ideals and the perceptions of learning and knowledge related to these ideals, I have undertaken a research inquiry to investigate the perceptions of knowledge by multicultural health practitioners and patients, the concerns that are most important to them and their experiences in practice.

The primary focus of research is on how health practitioner and patient learning experiences are organized in everyday health care practices, and what kinds of social relations serve to generate them.

The purpose of this chapter is to explain the theoretical principles for an approach to methodology. In particular, the aim is to provide an understanding of the central tenets for an institutional ethnography and to present central epistemological and ontological arguments for this approach to research.

Broadly, four central areas are addressed here: (1) the rationale underlying the choice of research questions; (2) the principles of phenomenology as important theoretical contributions to the tenets of institutional ethnography; (3) the concept of 'reflexivity' as a central component of institutional ethnography and (4) the two essential processes with respect to the mode of inquiry, talk and documentary data.

The rationale underlying the formulation of research questions in the present approach to research takes a non-positivist and non-naturalist stance which is specifically

concerned with questions about "how things work" and "how things are actually put together" (Smith, 1987).

This way of approaching research is conceived within a framework described as institutional ethnography. The central idea informing this approach is that personal life experiences, in whatever contexts they are described, are embedded within complex social relations which are not always immediately apparent or easily articulated in the setting. The approach draws heavily on the traditions of ethnomethodology and phenomenology. All acknowledge the notion of a taken-for-granted understanding of the everyday world and the idea that people rely on a set of "stock knowledges", and all acknowledge the existence of multiple interrelated realities of intersubjective experience. It will be seen that in this way of approaching research, inquiry begins with the subject as "knower", a subject whose everyday world is determined and shaped by complex social relations which extend beyond the immediate experience. In the same vein, the concept of reflexivity gives acceptance and full recognition of a self-conscious engagement of the researcher with the world she or he is investigating. Moreover, "reflexivity" positively 'reframes' reactivity on the part of the researcher from being a source of 'bias' to giving full recognition of the researcher as an integral part of the research process and product (Hammersley & Atkinson, 1983).

The fourth and final issue to be discussed is that of communication in relation to an institutional ethnography. Two kinds of communication are discussed here, verbal accounts and documentary data. Here the approach to inquiry presumes these processes as products of textually-mediated organization. That is to say that texts - talk and

documents are products of complex institutional processes which structure and order the everyday world of experience.

2.0 Research Questions

The research questions have been broadly designed to allow for an understanding by the researcher of the ways in which a specific health population perceives and experiences multiculturalism, and the concerns regarding knowledge of health care in this regard that are most important for them. The focus of analysis is on the ways in which members of a hospital community characterised by many differing cultural and immigrant experiences, go about seeing, describing and accounting for their experiences. The following research questions serve as a broad guide to the study.

1. What are the perceived ideals/policies of the study setting in relation to multiculturalism?
2. How is knowledge defined and claimed by patients and practitioners in a multicultural health care setting?
3. What are the culturally related practice experiences of patients and health practitioners?

In the broadest theoretical terms, the concepts of cultural learning, health practitioner knowledge and policy are approached here from a non-positivist perspective. These concepts are all viewed as having their existence in a dynamic social process which is embedded in the social organization of health care practice manifested in Canadian multicultural settings. Knowledge and understanding in this view, are embedded within dominant academic standards and within family, community and work relationships. The effect of such knowledge and understanding however, is manifested in everyday local

practices. It is within these definitions that ideals and practice experiences in relation to culture are being investigated.

It must also be emphasized that these ideals and practice experiences are also analyzed within the broader context of health care as a set of complex social relations. In this context moreover, the notion of cultural learning and practice experience, while conceived within a notion of the Canadian multicultural policy ideal, also refers to culture as an ideological mode of thought. Thus the distinct experiences of health practitioners and patients are not viewed as being generated only by multicultural experience in the hospital, but also by the ideological structures or ideas that underlie knowledge and experience within the health care system. This concept of ideology is derived from the formulation by Dorothy Smith. As she puts it,

> This production of 'ideas' or images are produced for others to analyse, to understand and to interpret their social relations (Smith, 1975, p. 354).

Thus the ideals which practitioners hold, and the assumptions about their daily work of caring for and treating patients, are produced for them in order that they may understand and interpret what is happening to them. In this way knowledge and practice come to be determined within an organized set of social relations.

2.1 Principles of Institutional Ethnography

The purpose of this part of the chapter is to explain the central principles of an institutional ethnography in order to support its choice in a study of multiculturalism and health care knowledge and practice.

The research approach is grounded in the social organization of knowledge, the method of which is institutional ethnography. It is a method which has been pioneered by Dorothy Smith (1987) as a way of doing research in the social sciences. This approach allows a bridging of the gap between micro-analyses and macro-analysis of society. Taking individuals' ways of 'knowing' as a starting point, an approach informed by institutional ethnography allows both an understanding of the experiences of local and particular events and also an understanding of the broader social relations within which these experiences are embedded. The central aim of this method is explained by Dorothy Smith:

> The idea of an institutional ethnography emphasizes that the inquiry is one of discovering "how things work", how they are actually put together. The notion of an ethnography lays stress on the project of being faithful to the actualities of social organization and relations (Smith, 1987, p. 147).

The emphasis in this approach is not to:

> . . . transform subjects into objects of study or make use of conceptual devices for eliminating the active presence of subjects. Its methods of thinking and its analytic procedures must preserve the presence of the active and experiencing subject (Smith, 1987, p. 105).

So, in the case of my study of health care, this approach takes as its starting place, the ways of knowing of practitioners and patients, and strives for an understanding of these experiences in the context of the broader social and institutional relations in which they are embedded.

2.2 The Socially Organized World of Experience

While there is a significant absence of documented research on the use of an institutional ethnographic approach in relation to multicultural health care in Canada, a notable exception can be seen in the work of Joan Anderson (1985, 1986) in relation to illness and health concerns of specific immigrant patient populations. Two such examples serve to illuminate the way in which an institutional ethnography is used to understand illness experiences in the context of complex social relations.

In the first example, in an attempt to understand the differential construction of illness in the context of daily life, Anderson analysed and compared the experiences of Anglo-Canadian and immigrant Canadian-Chinese families with a chronically ill child at home. Beginning with the theory of a sociology of knowledge formulated by Dorothy Smith, which informs institutional ethnography, Anderson began with the argument that immigrant families' subjective accounts of health and illness are rooted in complex social and historical relations. This served as an epistemological guide to analysis. Six Chinese and seven Anglo-Canadian families were interviewed at intervals of 4-6 weeks for 2-5 hours using audio-tape procedures and comparative field notes. Following analysis of emergent themes in the data, the study revealed that the Chinese immigrant families found the ideology of health services offered to them dissonant with their beliefs and values around managing illness, and therefore were unable to understand the treatment offered to them. Moreover, the disjuncture between practices of the families and those guided by the dominant health care ideology actually led to a lack of cooperation by the immigrant families, and thus unsatisfactory treatment. Anderson noted also that health practitioners

explained the lack of cooperation by the "obvious facts of cultural differences", but concluded that institutional 'ideas' (ideological knowledge structures within health care) excluded the Chinese families from effective decision-making and participation in satisfactory health care (Anderson, 1986, pp. 1277-1283).

The second example of Anderson's research work focuses on the health status of two groups of immigrant women and their experiences surrounding help-seeking (Anderson, 1985). In an attempt to understand issues facing immigrant women in their everyday life, Anderson examined the subjective experiences of six Indo-Canadian and eight Greek women, as these experiences were described by them from their own perspective within the broader social context. Open-ended interviews were tape-recorded and analysis was derived from the perspective that subjective experiences of individual members of society are determined by the objective organization of society. The study concluded that the illness understanding of particularly, Indo-Canadian women, are not always addressed by health care providers and the "the organizational features of the health care system and the sociocultural distance between women and caregivers influence the subjective experiences of women" (Anderson, 1985, p. 74).

Most of the research by Anderson using an institutional ethnography approach has been specifically concerned with the meaning of health for immigrant women and chronic illness management. This work has illuminated issues and problems that specific groups of immigrant women have to face which are located in historical, political and economic contexts (Anderson, 1987, 1989, 1991). What becomes apparent in light of the preceding accounts is that illness experiences are understood within an ideological process which

orders and structures everyday subjective experiences. Moreover, these experiences are not always conscious ones.

Dorothy Smith explains this further. She tells us,

> We have the sense that the events entering our experience originate somewhere in a human intention but are unable to track back to find it and to find out how it became and how it got further from here (Smith, 1987, p. 87).

In this type of research then, the aim is to analyze people's ordinary accounts of their experience, their interpretations of their experience and to explicate that experience "in ways in which it passes beyond what is immediately and directly known" (Smith, 1987, p. 87). The aim is not to *explain* behaviour but to explain the social relations of the experienced world. As Dorothy Smith puts it:

> Rather than explaining behaviour, we begin from where people are in the world, explaining the social relations of the society of which we are a part, explaining an organization that is not fully present in any one individual's everyday experience (Smith, 1987, p. 87).

Taking this approach to research investigation begins with the subject as knower, a subject whose everyday world is determined, shaped and organized by social relations beyond the immediate experience, which in turn is shaped by the intersubjective experiences of that world.

In this way of doing research in the health care field we become aware that the experience of health care for immigrants cannot be separated from the many other aspects of their lifeworlds: looking after parents in another county; supporting families unable to enter Canada like themselves; trying to get work without proper authorization; trying to maintain 'illegal' family members; fear of refusal on return to their country; trying to

make ends meet; trying to cope with differing political ideologies both in their home country and in their Canadian lifeworld. Moreover the experience of health care knowledge cannot be separated from alternative knowledges of treatment and cure and from alternative views and realities on rehabilitation and health. What is meant by this is that the everyday practices in the hospital life of immigrant communities cannot be separated from other aspects of their life worlds. Thus doing research using the method of institutional ethnography involves inquiry into the everyday life experiences of a multi-cultural society. It is also concerned with the wider social relations in health care systems that determine and organise these experiences.

This approach to investigation aims to explain everyday experiences by starting with the subjective perspective of respondents and working to discover those practices that organize experience in the everyday world. This type of research then, begins with the description of everyday experiences of health practitioners and extends to the wider social relations that organize knowledge and practice. As Dorothy Smith explains,

> Inquiry starts with the knower . . . Activities, feelings, experiences hook her into extended social relations linking activities into those of other people and in ways beyond her knowing (Smith, 1991, p. 21).

Thus this type of research is concerned with the subject as "knower" in the understanding of his or her lifeworld, within an organised set of complex historical and social relations. It is this relationship between the underlying social relations and everyday local understanding that is fundamental to the methodological approach. Practitioners' experiences of the knowledge that they have acquired through formal education and through the various ways of learned phenomena, are embedded within complex relations

of the educational process. In this way the method of focusses not only on the seen and objective factual entities of the social world but also on past, or beneath the surface social relations and life understanding unique to the individual. Roxana Ng and Judith Ramirez describe the process of analysis in this approach to inquiry:

> Analysis proceeds on the understanding that the subjective experiences of individual members of society are determined by and are part of an objective organization of society. What people may experience as inexplicable ... (arises) out of a context, in an objective social organization which is discoverable although not immediately visible (Ng, R. & Ramirez, J., 1981, p. 18).

The social organization which is manifested in the experience of the everyday world may not become immediately apparent to informants such as practitioners and patients, and they may not be able to consciously articulate that their experiences are rooted in complex historical relations. Moreover, these relations may constitute a form of 'observed' knowledge by informants. Nevertheless they exist as ideological processes as organized ways of knowing, which order and dominate people's thought. The focus of this approach then, is on the factual or concrete content of practitioners' accounts, but more on what is termed as taken-for-granted understandings.

2.3 The Phenomenology of Alfred Schutz: The Common World of Experience

It is perhaps important to understand what is meant by taken-for-granted understanding, since this notion is fundamental to the idea that the social world cannot be understood by the tenets of positivism or systematic science. The basic assumption is that all perspectives of the external world are experienced through the senses. This assumption is rooted in the ideas of Edmund Husserl[4], later developed by Alfred Schutz.

Husserl emphasized that humans operate in a taken-for-granted world which, while not the topic of conscious reflective thought, nevertheless shapes people's thinking. Moreover, people presume that they experience and share the same taken-for-granted understandings. These ideas which were later elaborated on by Alfred Schutz and which inform ethnomethodology, presume that people act as if they live in a common world of experience and construct shared meanings. Thus we cannot measure the world as something objectively ordered and separated from our own lifeworld[5]. As such, people retain and share what Schutz terms "stock knowledge", which is not an object of conscious reflection but rather an implicit set of beliefs and practices that are silently used by individuals as they construct meanings and share in each other's everyday world.

For the present purpose, what is meant by the taken-for-granted understandings of health practitioners are not the objectively seen facts or formal rules, values and common definitions of practice. Rather taken-for-granted understandings are found in the conscious and unconscious processes of constructing people's everyday sense of reality. In fact, 'stock knowledge' or taken-for-granted knowledge may in fact be information that people "silently work", to keep from questioning the formal, day to day issues in the everyday world (Turner, 1991).

A research approach using institutional ethnography necessarily includes these theoretical notions of 'stock knowledge' or taken-for-granted understandings in its investigative pursuit. For example, nurses in contemporary health care settings often talk to each other about 'going back to school', a taken-for-granted understanding which affords special ways of knowing. When a nurse says to another, "I'm hoping to get my master's",

the process of learning to which she is referring and the notion of nursing education is clearly couched in an administrative process of decision-making known only to contemporary nurses. The nurse doesn't fill in the gaps to other nurses. In fact her utterance is incomplete to an outsider. But what other nursing members have is a basic inner knowledge of contemporary nursing education - knowledge of a historical process leading up to current political and educational concerns in nursing, and past and present administrative priorities with respect to accountability and hiring procedures.

An analysis using an institutional approach takes the notion of 'stock knowledge' or taken-for-granted understanding much further. There is agreement with the philosophy of Schutz, on the premise that all time perspectives and space perspectives encompass the everyday world which is within the circle of the knower (Smith, 1990, p. 53). There is a similarly understood notion of 'knowing' within the sensed world of experience.

But what is significantly different in an approach using institutional ethnography, is the fundamental premise that there is a socially organised presentation of time, space and distance rather than a 'locally embodied experience' (Smith, 1987, p. 58). For example, Smith analyses on two levels, the micro-politics of an academic meeting at which a paper was presented. In her analysis, she explicates the local organization of subjectivity, or what Schutz terms 'intersubjectivity' or constructed local meanings, as the various 'housekeeping' pieces which attend to the organization of an academic meeting. Issues such as where microphones are situated, how the discussion period is recorded and confidentiality of panel discussions, are phenomena which can be observed at one level. And at another level, there is the academic presentation itself. The phenomenology of

Schutz would acknowledge these two levels of reality: the passing from the local to the 'textual,' with the shift from the 'local operative social realities' to a detached objective mode (the presentation of the paper). His analysis would constitute two levels of consciousness which exist paralleling each other: the presentation of the account as one level of consciousness or reality, and the local cognitive personal account as the other. Whereas the phenomenology of Schutz would argue this as a phenomenon of multiple realities of intersubjective experience[6], an institutional ethnographic approach would view the first reality (the inner workings of the meeting such as where the microphones are), as the *paramount reality* which fades out of attentional focus. Analysis would then focus not on the two phenomena as two separate but interrelated realities but as one reality - the structural order of the meeting as a 'nested' reality within a socially organised practice. Participants at the meeting are shifted from a locally organized world, a taken-for-granted world, to a theoretical world (the world of formal presentations). An institutional ethnographic approach would focus upon this reality of stock knowledge and its relationship to the socially organized practice of academic discourse.

Following on with this idea, a data excerpt from my study taken from a meeting which the researcher attended illustrates the way in which one reality, 'the paramount reality', is embedded within another complex process. Here we are observing a committee meeting in which the primary agenda is to design multicultural objectives in a large hospital:

> **Chair:** I know we all have a very tight schedule so I'm going to try and finish our agenda before 3. I hope we don't get any more interruptions (laughing in room) on the phone this week. Well today I asked K to present to us some of the things that are being done at X hospital. So I

> think we could start. I see there are some nice goodies they sent from the kitchen and I think if anyone wants coffee it is coming very soon. Anyone here who did have lunch? (laughing). Did anyone have lunch? Well I think we should start with K. S has offered to take minutes, so that lets us off the hook for today (October 1992).

Analysis of this data excerpt using an institutional ethnography allows us to see that K's presentation is an integral reality in the meeting, but it does not fully belong to what is actually happening at the 'occasion'. It exists as a separate reality or a separate "we" to the local reality which is defined by the incidental pieces, such as the "schedule" and "time constraint" concern factors.

The "now' of the perceived incidental pieces such as food from the kitchen and the taking of minutes, are disengaged from the "now" of the formal presentation. But what the Chair of the committee knows and what the committee members know, is that the two aspects of "we" as committee members are not separate. An institutional ethnographic analysis would argue that K's presentation "establishes a transition within and from the local order into an extra-locally organized province of meaning overriding it" (Smith, 1990, pp. 80-81).

Thus we might say that the form of the meeting, the presentation, overrides the underlying, "hidden" issues of time management, stressed work schedules - all of which fall within a complex set of administrative relations controlled by budgetary considerations managed at provincial and federal government levels.

Such activities, tasks, relations and intentions are not always apparent to participants as such in the concreteness of the everyday world, yet they are often taken as a 'given' by people. They are not defined as 'stock knowledge' or taken-for-

grantedness but, as can be seen in the example of the multicultural committee meeting, these 'stock knowledge' experiences are embedded within the account of the meeting.

Health practitioners for example, are able to relate to experiences which hold within them a social embeddedness relating to time - accountability and budgetary requirements which must form an integral part of their knowledge in caring for patients, but which are not part of their actual descriptions to the researcher. One particular example of this phenomena can be seen in the work of nurse practitioners in outpatient clinics where there are large volumes of patients, many of whom are from differing cultural backgrounds and who must undergo strange and unfamiliar procedures. Here, if we look at an example from the talk of nurses, we see that "care" is constituted within a 'time frame'organized by a western scientific model of care which in turn constitutes accountability to budgetary, accountable tasks.

> **Interviewer:** How does it work with so many patients at one time and from so many differing cultural backgrounds? How does it work for you?
>
> **Nurse:** Well yeah, if I come out of endoscopy, there it's all diagnostic and its important (to) get rolling with the numbers - the next patient and the next patient ... get the patient ready ... Let's get the vitals, do the 'stats'[7], bloodwork, E.K.G. and that's it.
>
> And later:
>
> You get really frazzled ... you need more equipment, more space ... can only deal with what's necessary (laughs). Chatting with the patient, well (laughing) that has to stay in the cracks (January, 1993).

These accounts can be understood in different ways. They may be taken as evidence of a keenness to get on with the most fundamental and basic tasks of care or to deal with what is most vital for the patient. This is a view commonly held by nurses. But

nurses are also aware of the circumstances of 'accountable care', which fall within the time managed conditions. Within these time managed conditions, instrumental tasks such as doing the vitals, the EKG and the technical procedures must have measurable outcomes which can be held accountable. This condition of accountability, has a significant impact on the working practices within the health care environment and thus on the priorities which often determine care. It is a vital factor in determining budgetary decisions at both the local institutional and government level. Similarly, in the context of historical relations, working conditions are determined by such factors as the rationale and justification for health care deficits and budgetary requirements. This means that nurses, although knowledgeable and well-practised on the kinds of skills which 'fall between the cracks' in a routine clinic day, must situate their care so that tasks such as arranging for the EKG or the lab work can be rendered accountable. While nurses know this as a taken-for-granted feature of their work, it is not immediately focused on in their experience. Thus this process of showing the relationship between people's experience and the social and historical process within which it is embedded, is central to an institutional ethnography.

In the next section of this chapter, a discussion of the concept of reflexivity will be presented. This concept is particularly important in view of the discussion to this point since it deals with the important issue of the relationship of the researcher to the subjects he or she is investigating as one important feature of the research inquiry.

2.4 The Concept of Reflexivity

Hammersley and Atkinson (1983) have in their theoretical analyses of ethnography, presented some useful theoretical distinctions between the naturalist perspective on ethnographic study and an approach to ethnographic research which acknowledges the concept of reflexivity. One of the problems with doing ethnographic work and taking a naturalist perspective they argue, is that its primary goal is restricted to pure description; moreover, the approach assumes a form of objectivity which is closely related to an approach informed by positivism. This form of objective reasoning occurs within the actual process of describing data by the researcher, and they argue that the researcher rather than accepting herself as 'knower' in the research process, is required to treat the phenomena as anthropologically strange even when the 'culture' is familiar to her. Hammersley and Atkinson explain:

> Ethnography exploits the capacity that any social actor possesses for learning new cultures and the objectivity to which the process gives rise. Even when he or she is researching a familiar group or setting, the participant observer is required to treat it as 'anthropologically strange' in an effort to make explicit the assumptions he or she takes for granted as a culture member. In this way the culture is turned into an object available for study (Hammersley & Atkinson, 1983, p. 8).

The problem with this naturalistic approach to ethnography is that it assumes the possibility of separation of the researcher from her data and the feasibility of doing description 'without inferences' (Hammersley & Atkinson, 1983). Moreover, it restricts the research enterprise to the level of description of surface features of the setting. Thus in setting out to study health practitioner' experiences of health care in a Canadian multicultural hospital in Eastern Canada, even as a knowledgeable nurse practitoners, I

would have to begin with the assumption that there are no relevant political factors involved, no relevant federal or provincial issues of language concern and no issues of budget allocation and administrative control.

In the naturalist perspective, the beginning assumption is made that the researcher has a different method of seeing the world to that of informants and reality would be distorted if they check their views with each other. Thus, in this method, as a nurse researcher, I would ask people about their views on education and their perceptions of learning and practice. I would engage in a conscious process of eliminating that knowledge which I already possess as a nurse educator. If a nurse tells me that she is hurrying to get her procedures completed so that she can get to coffee on time, I must simply describe that, without drawing on my own understanding that her procedures are scientifically accountable and must be documented before unit rounds are done, when important patient decisions are made within a particular social process.

Thus the naturalist approach assumes a dichotomy in that it conceptualises science and common sense in different ways. The researcher becomes separate in an attempt to eliminate his or her *effects* on the research. The researcher standardizes the social world and the informant directly experiences it. Thus this approach closely resembles many of the central tenets of positivism.

The resolution of this dilemma is found in the concept of reflexivity which recognizes that we are part of the social world we study (Ball, 1990). Hammersley and Atkinson argue:

> This is not a matter of methodological commitment, it is an existential fact. There is no way in which we can escape the social world in order to

> study it; nor fortunately is that necessary. We cannot avoid relying on common-sense knowledge nor, often can we avoid having an effect on the social phenomena we study (Hammersley & Atkinson, 1983, p. 15).

The concept of reflexivity reframes "reactivity" on the part of the researcher from being a source of bias, to being an integral piece in the research process, which must not only be seriously considered but also 'exploited'. Just as the notion of subject as 'knower' becomes a starting point in an institutional ethnography, so must the researcher as 'knower' become a fundamental part of the joint production of the speaker and hearer within the research process. Hammersley and Atkinson explain this further:

> The fact that behaviour and attitudes are often not stable across contexts and that the researcher may play an important part in shaping it, the context becomes central to the analysis. Indeed it is exploited for all it is worth (Hammersley & Atkinson, 1983, p. 18).

In this way of approaching research and in fully recognizing the concept of reflexivity, research undertaken as a 'knower' of health care practices and of the everyday world of hospital life, necessarily includes a self-conscious engagement with that world. As a nurse, my reflective involvement with practitioners will involve myself as 'knower' in the clinical *milieu*, as I know and understand it. As I interpret people's accounts, I know that I think as a practitioner, use similar language and understand many clinical practices. I am also aware that I am viewed by informants not only as a 'knowing' researcher but also as a nurse teacher. What is advantageous in this way of approaching research is that since I think like a practitioner, certain sets of data are made readily more available, both in that which I observe and in that which is presented to me.

Stephen Ball (1990) defines reflexivity in this regard as a consciously thought out process by the researcher which provides rigour in the research process. He tells us:

> This self-conscious engagement with the world is what defines the process of ethnography. In microcosm, such engagement allows the researcher to connect the processes of data analysis and data collection. It also provides the possibility of technical rigour in the ethnographic process. The basis of this rigour is the conscious and deliberate linking of the social process of engagement in the field with the technical processes of data collection ... I call that linking reflexivity (Ball, 1990, p. 159).

Thus however effective an 'external' interviewer might be at getting practitioners to describe their views on education and learning in relation to multicultural patient health practices, the fact that I "know" the common-sense meanings which are necessarily embedded in their accounts, allows special features of data exposure which I am privileged to access.

Let us consider this form of reflexivity in one practitioner in my own research. Here I am talking with a nurse about her work with a terminally ill patient and her family:

> **Interviewer:** What are the things that are most striking for you in taking care of the family?
>
> **Nurse:** Striking? *Uh, well as you know, I think we all have this problem for a start with getting to know them and then having to face the idea of our own death. You take care of the patient and get to know them as people but ... yeh, I guess you have the feeling you know what if it was my young sister or what if it was me ... you know what I mean?* (January, 1993) (emphasis mine)

This point of access is what Ball calls a deliberate linking of the social process with data collection (Ball, 1990). The nurse knows that as a practitioner and teacher of family therapy I have stock knowledge or a taken-for-granted understanding about some of the everyday world of working with people who are dying, and she makes this

assumption of my 'knowing' this in her account, and possibly speaks more freely as a result.

The concept of reflexivity also features as an integral part of the on-going interpretative processes, in that it makes the assumption that people's accounts are in fact, accounts about accounts. This feature of reflexivity is explained by Warren Handel:

> All accounts have a reflexive relationship with themselves, regardless of their content and regardless of the medium in which the account is expressed (Handel, 1982, p. 35).

What is meant by this is that accounts cannot be taken literally or treated in a singularly logical way, since they establish what is accountable in the setting in which they occur. Whether or not a practitioner's account is correct by definition of its reality to others, his or her account defines reality for all practical purposes in that he or she acts on the basis of what is accountable in the description of the situation.

For example, nurses and family therapists do family assessments when a problem in the family is seen to justify it. The accuracy of this account is effectively judged on whether the family is helped or not. *Regardless* of the success of the interview however, the probable success is accountable and it is *that* judgement that people act upon. If at some point, the family doesn't respond to the practitioner's intervention, the practitioner will decide that the probable success of the interview is not an accountable basis for action.

Family therapy can be accountable when "in reality", therapy is no longer useful for the family or the practitioner. The account provides the basis for action, a definition of what is real or normal, and it is acted upon as long as it remains accountable. Thus if

health practitioners define things as real, the definitions are real for them in their consequences. As Handel explains:

> Whatever the content of an account, whatever it seems to be about, the effects of the account are to provide a definition upon which action can be based (Handel, 1982, p. 36).

Thus the account of the practitioner about her family therapy interview establishes what she believes to be "sound and proper" - that is, she establishes what is accountable. It is not that she is aware of 'accountability' as an issue in itself. She believes she is defining her description for the situation - the norms for that family assessment rather than attempting to reach a 'hidden truth' about it. The point is made by ethno-methodologists that from the researcher's perspective, this awareness of how accounts are delivered is an evaluation of what accounts accomplish from a researcher's perspective. "We need to connect this assertion about the function of accounts with what the researcher actually observes" (Handel, 1982, p. 36).

When health practitioners construct accounts of family interviews, they do it in such a way that the accountability of care in terms of success is presumed by the hearer. They thus provide expression for one of the most fundamental tenets of modern health care - that when treatment is administered, it is presumed within an accountably perceived notion of success and failure. Warren Handel explains this:

> Technically then, situations are made up of people's accounts, rather than as the objects themselves ... To understand how accounts work, we do not need to know what is true in some final sense. Rather, we need to know what is accountable or accepted as true (Handel, 1982, p. 39).

Thus a particular vision of reality is put forward. Reflexive action in fact works to maintain or uphold a belief, even when opposing information would deem the belief incorrect. John Turner explains this process of maintaining a set of beliefs.

> Even in the face of evidence that the belief might be incorrect - even when the facts would seem to contradict a belief, the face to face rituals uphold the contradicted belief (Turner, 1979, p. 410).[8]

An example of this form of upholding belief in the face of possible contradiction, can be given from this researcher's work with health practitioners on the issue of language translation in a multicultural institution. When health practitioners talk about "managing ok" with getting translations done on a casual or "adhoc" basis, they make explicit their vision of reality or norm which uphold the "facts" of their belief that they are "managing ok". Even though, for example, the person available to translate may be unfamiliar with clinical knowledge or the particular emotional circumstances of a patient's case, health practitioners believe that paging over the hospital loudspeaker for "anyone who can translate" constitutes a 'normal' vision of reality. Moreover, when such a system appears to work badly, the response or justification is "well, we would need to call again for someone else." Let us consider the following example from the talk of one practitioner:

> **Interviewer:** How does it work when there are differences in language and understanding between yourself and the family?
>
> **Informant:** Actually, like, I'd say we have a pretty good system. Usually you can get a family member to translate and really there is always at least one person in the hospital who speaks the same language.
>
> **Interviewer:** Can you give me an example?

> **Informant:** Sure, uh, well just the other day there was a Greek lady who di - had just been diagnosed with breast C.A. She didn't speak any English or French and her sister who came with her spoke a bit of English ... Anyway, it wasn't really a problem that way - we just called on the loudspeaker and it was very fast, and we got an orderly from - unit and he translated for us.
>
> **Interviewer:** And he was able to translate everything?
>
> **Informant:** Well yes, yes. Well I'm not sure if he understood all of the case but it worked out okay and even if there was a problem, you know, we could always page somebody else (September, 1992).

The preceding data excerpt reveals how the 'reality' of the translation system is sustained. The practitioner's response to the 'problem' is reflexive in that it reinforces the belief in the system, even though another reality may deem it incorrect. Even when contradictory knowledge is illuminated, it is reflexively interpreted to maintain a body of belief and knowledge.

In the next section of this chapter, discussion will be primarily concerned with two essential features of an institutional ethnographic analytical approach to research: talk and textual processes. While reflexivity is not specifically focused upon as an illuminated feature of these forms of communication, it will be seen that it remains an integral component in doing this kind of research.

Of primary concern in the discussion following is the notion that communication, as it is manifested in everyday talk and textual processes, is embedded in a set of particular social relations. Here we return to an earlier discussion on this idea, but give emphasis to some essential methods of investigation: talk and documentary data.

2.5 Talk and Documentary Data

Central to analysis of people's talk using a method of institutional ethnography, is the notion that social relations are present in its organization. The question then arises as to how features of social relations may be found in the ways that informants speak while giving their accounts in the course of an interview. For example, we do not expect or hear accounts of practitioners consciously describing the formal educational processes which dominate their everyday practices, and yet their talk often expresses these, just in the ordinary ways in which they speak of their experiences.[9] Dorothy Smith explains that this way of analyzing talk assumes that "the ways terms are used in their original context including their syntactic arrangements, is controlled or governed by its social organization" (Smith, 1987, p. 18). Wittgenstein explains this approach further. He tells us:

> To understand a concept we must understand the role it plays in an entire system of social practices, for the speaking of language is part of an activity or a form of life (quoted in Rubenstein, 1981, p. 134).

Rubenstein (1981) argues that Wittgenstein illuminates the fact that meanings in statements must be understood and interpreted within the relevant social context. For example, if a nurse practitioner says "I am busy", this cannot be seen as "brute data" since her utterance is connected to what has been described by Wittgenstein as a kind of stage setting - "a background of cultural beliefs and social practices" (Rubenstein, 1981, p. 135).

Thus if the researcher as knower is to follow the sense of the speaker as knower, she must enter into this mode of analysis. As researchers, we ask people to talk about the

everyday worlds to which they feel they belong. A researcher listening to the verbal accounts of health practitioners will hear the specific terms, vocabulary and syntactic forms which are derived from a health practitioner's world. Understanding is based not only on the actual vocabulary specific to, for example, a surgical unit or an operating room. It also depends upon knowledge of the social organization of the daily practices as they are structured and ordered in the local setting.

A number of studies have concentrated on conversational features of the use of medical terms. However, many of these do not insist on analysis concerned with the institutional organization of the medical setting. For example, Albert Meehan (1981), in a study of conversational features of the use of medical terms by doctors and patients, analyses the doctor-patient relationship as one which is characterised by the use of jargon and medical terms, which he notes the patient does not initially understand. However in his report, Meehan makes the claim that through a comparative analysis of patients' knowledge of 'jargon' with that of physicians, the patient is gradually brought *into* the use of jargon. He makes the point that since the patient gradually comes to use the jargon or terminology, the doctor-patient relationship is ultimately a collaborative one (Meehan, 1981, pp. 107-127). What might be added, and what this report omits in its assumption of a 'shared normative conception' of medical jargon, are the social relations within which the conversation is embedded.

A similar study reported by Phil Davies (1981), focuses on the 'structuring' work of an initial conversational meeting between a unit psychiatrist and a social case worker in the assessment of a young South-American patient. In this work, Davies is concerned

with the 'labelling' of the patient as a 'cultural problem'. He sees this as an instance of a pervasive procedure whereby a sense of order and intelligibility is established in routine clinical talk (Davies, 1981).

The analysis of talk by Davies is primarily concerned with the notion of labelling or categorisation and how this structures the psychiatric interview, and thus orders activities. This perspective closely follows the central tenets of ethno-methodology in illustrating what Schutz would determine as two separate sets of consciousness or two separate realities. Again the preceding analysis of talk with respect to an approach informed by institutional ethnography, would be that the frame of the talk would be taken further than its initial analysis. That is to say that the notion of categorisation in "talk" would be taken to be a feature of social organization, such as within the formal education policies for physicians for example. In both cases, here the researchers might then add that the 'accounts' under study are in fact, accounts about accounts.

A closer resemblance to institutional ethnographic inquiry can be seen in the work of Paul Atkinson. On the basis of fieldwork observation and interviews in hospital settings, Atkinson argues that medical knowledge is reproduced and given its own reality by the direction that medical talk takes in the process of bedside clinical instruction. Following his own field work analysis of dialogue between medical students and educators, Atkinson shows how 'talk' between physician educators and students is socially organized, achieved and managed. The point is emphasized that the 'reality' of the educator is reproduced through the process of bedside teaching talk, allowing the clinician to become committed to a unique 'faith' which Atkinson terms 'a kind of ontological

epistemological individualism'. Thus there is a definite distinction evidenced through 'talk' between 'visible' and 'invisible' pedagogy, in the manner by which the transmission and reproduction of knowledge are accomplished (Atkinson, 1981, pp. 116-121).

Thus in a study which explores the cultural experiences of practice by health practitioners in a health care setting, knowledge of the social relations which lie within the practitioner's account is an important aspect of the research approach. One of the difficulties, if the researcher does not possess or acquire a knowledge of these social relations, is an interpretation which directly follows the 'factual' account of the informant. An example of this can be seen in the following excerpt of talk between myself as the interviewer researcher and another practitioner:

> **Interviewer:** Yesterday we talked a lot about the idea of 'culturally sensitive learning' within the hospital and I wondered if you could give me some particular examples of the way this works out for you during your day?
>
> **Nurse:** Well, I'm not sure I can give you a particular example, but I know that the culture of the patient is important to assess. I mean I think you should always include it when you do the nursing data base.
>
> **Interviewer:** How often are you able to do the nursing data base?
>
> **Practitioner:** Well if you have a short-term patient, it's more difficult but actually we do the data base on most of the long-term patients.
>
> **Interviewer:** And cultural assessment - how does that work? (October 1992)[10]

Regardless of the various meanings which may be attributed to the preceding dialogue, the term focused on in this instant by the researcher was *cultural assessment.* In the course of data analysis a record was made of the ways in which cultural concerns were evaluated by the practitioner. Phrases emerged in the data such as 'open-ended

assessment', 'problem-solving strategies' and 'culturally defined evaluation' which were compared with accompanying documentary data. It was claimed that 'cultural assessment' was used in conjunction with a data base to determine the norms, values and beliefs of the family. It is evident from the way I, as a researcher, approach the data, that I am assuming (along with the nurse I am interviewing), the theoretical rationale of science-based language as a universal perspective which presumes one all encompassing way of understanding cultural care. I am embodying the interests of an *objective*, rational method by 'describing' reality *as if* it were the only 'normal' phenomenon in the everyday world. And so what becomes evident from the way I approach the data, is that I am assuming an ideological form as a method of doing research. In doing so, I omit knowledge of the social relations which are an inherent part of the informant's account. Instead a 'conceptual organization' is comprised by myself and the nurse I am interviewing as *the* analysis of the data and thus events come to be explained within that context.

Dorothy Smith explains how this process works in such a way that it is not always visible to those working within an "abstracted mode of scientific province". She tells us:

> The theories, concepts, and methods of our discipline claim to be capable of accounting for and analyzing the same world as that which we experience directly. But these theories, concepts and methods have been built up out of a way of knowing the world that takes for granted the boundaries of experience in the same medium in which it is constituted (Smith, 1987, p. 85).

Thus when we look at the previous data account of the nurse's and my experience of 'cultural assessment', we see that this joint assumption of the realities of theories, concepts and methods are deeply embedded within a particular 'extra local' science-based nursing or medical reality. Both the nurse I am interviewing and myself take-for-granted

that such a reality lies singularly within our 'boundaries of experience' and we do not question the history and practice experiences within which our utterances are rooted. It is a part of our joint sense of nursing professionalism which is rooted in an 'abstracted mode of scientific province of meaning' and which is not immediately visible to us.

2.6 Formal Documentary Data and Social Relations

The use of formal documentary evidence as a source of investigation forms a second essential component for an institutional ethnography. Here the analysis follows a different route to that which is associated with textual analysis.

In the approach taken by an institutional ethnography, the interest is not so much with the actual text. It is more concerned with what is termed textually mediated organization (Smith, 1987). The primary focus is not placed on evaluation of texts as 'administrative tools' and it is not intended to relate to questions of organizational competency or incompetency. What textual analysis informed by institutional ethnography can achieve here is to demonstrate how formal documentary data contributes to the organization of the everyday world of practice. Thus the emphasis is not so much on what the words in the text mean, but rather with how people's daily lives are mediated through the process of documentation. Dorothy Smith explains this further:

> The investigation of texts as constituents of social relations offers access to the ontological ground of institutional processes which organise, govern and regulate the kind of society in which we live, for these are to a significant degree forms of societal action mediated by texts. Bureaucracy, professional and scientific discourse are in various ways dependant upon textual communication (Smith, 1987, pp. 121-122).[11]

My concern here, for the purposes of analysis, is that in the everyday world the text or document is often not seen as an active part of organizational construction. People become routinely attached to the paper work, and become habituated towards filling in the form or in the case of practitioners, completing the data base and progress notes or making sure the history is complete. This process of 'routinization' pervades the act of using the text and does not immediately invite 'questions about 'routine use' as a topic in itself.

If we consider the everyday experiences of health care practitioners textual organization forms an integral part of their activities. In the day to day routine of clinic and ward life documents are an active part of getting things done: patients complete forms for admission and discharge and consent for treatment; practitioners complete chart documentation, memos, procedure and policy data. The documentary process is pervasive and totally engages its participants. Practitioners in fact do often see the text, the 'charting' and form filling, as jobs which are 'unnecessary' and things which are 'replacing patient care'. They do question the usefulness of so many documents. But they see this within an organization of 'local' happenings rather than within a broader organization of complex social relations. If you question a practitioner either a nurse or a physician, about 'charting', they will often tell you that it's an unnecessary chore or a hindrance to getting on with other dimensions of patient care such as understanding cultural concerns with care. Yet these same people would readily engage in the organization which determines and orders routine documentary practices.

Thus the methodological approach here is concerned with the "active ways in which texts organise relations within textual discourse both with respect to how local happenings are entered into its interpretive practices and how its social relations are organized" (Smith, 1987, p. 122). This approach to documentary study treats the text as social products rather than simply as a resource (Hammersley & Atkinson, 1983, pp. 127-143).

Using this approach, the researcher is able to join with, understand and analyze the 'interpretive' practices that went into the making of the text as a socially organised production. An example of this type of documentary analysis can be seen in the work of Marie Campbell and Nancy Jackson in their work on the learning process of student nurses with respect to nursing care plans as textual examples of accountable care. They show how the production of paper work in the form of nursing care plans is a major preoccupation and a primary resource for nurses to "achieve accountable care". They report:

> Students learn to recognize and reconstruct from the resources of their clinical experiences the *order* required by the plan or model that is meant to guide their practice (Campbell & Jackson, 1992, p. 492).

The communication and action which are achieved in this way are a form of socially organized practice. It is not that such actions are totally irrelevant, when nurses write their reports; they may write them with a well-intended reporting procedure. But it is argued that such 'texts or 'documents' must be seen not as literal accounts of activity on the unit, but as accounts which constitute a documentary reality for practitioners which renders their work accountable.

The point I am making is that as practitioners our 'knowledge is ideological'. We attach to a 'truth' of hard facts a fixed external reality which is viewed as universal and to which we assume we are responsible. Our practices are the result of this knowledge and are immediately visible in the production of documentary 'facts'. Yet these same practices also represent an entirely separate set of interests and values which are not immediately visible to us. Within the rigid framework established by science-based principles, rewardable practice constitutes an adherence to a fixed documentary reality, which immediately situates itself within the everyday common-sense of patients and practitioners.

2.7 Informal Documentary Data and Social Relations

The preceding discussion has argued for an interpretive approach to analysis informed by institutional ethnography with respect to 'formal' textually mediated organisation. The distinction between formal and informal documentation is perhaps an artificial one if we are considering analysis from the perspective of documents as part of a 'socially organised activity'. Still, there are some specific features of analysis that are useful with regard to what is often termed the "invisible" processes within texts (Andrew, 1985; Atkinson, 1988).

Health care practitioners draw on a wide range of documents which are often informal in nature. By this is meant the 'extra' paperwork which in fact may be perceived only as a fragment by practitioners of formal and more visible documentary practices. These fragments are often evidenced in the form of memos, drafts of minutes, informal

time schedules, casual notes, and in fact constitute another level of documentary data. An excellent example of this 'other' kind of data can be seen in the work of Bruno Latour and Steve Woolgar, where they describe the process of anthropological observation in a scientific laboratory. They argue that formal processes such as questions to scientists and analysis of finished research reports yield limited data and that one must go beyond these features to some of the taken-for-granted aspects of the scientific everyday world. Making sense of a writin research report in a scientific laboratory has to take into account draft reports of experimental work, the vast number of research documents that are left unused and scribbled notes all of which contribute to the finished research report. In the following account they describe the appearance of the 'lab' which reveals these secondary features.

> It is as if two types of literature are being juxtaposed: one type is printed and published outside the laboratory; the other type comprises documents produced within the laboratory, such as hastily drawn diagrams and files containing pages of figures. Beneath the documents at the centre of the desk lies a draft. Just like the drafts of a novel or a report, this draft is scribbled, its pages heavy with corrections, question marks and alterations (Latour & Woolgar, 1986, p. 47).

What this reveals for the purposes of discussion here is the notion that informal 'texts' are unimportant, a view which is often shared by health practitioners in their everyday world. Yet this myriad of subterraneous activity comprises a hospital subculture from which valuable information can be obtained. In an example taken from this writer's own research, a series of draft copies of a report on multicultural objectives for the hospital revealed differing features from those which appeared in the final report. Earlier drafts revealed attention to cultural objectives which were concerned only with the patient

population but through the process of modification of four or five draft copies of objectives, a final report considered the knowledge and concerns of the practitioner population also.

Often the informal reality of documentation is illuminated in the work of examining historical sources. Alison Andrew (1985), in her analysis of historical evidence on working class education in 19th century industrial Britain, illustrates the way in which ambiguous accounts, historical gaps and unanswered questions can yield hidden or beneath the surface information. She describes how starting with a broad notion of formal education helped to uncover 'fragmentary', yet vital information. These examples underscore not only the usefulness of examination of ambiguous accounts and historical gaps or silences in textual data, but they indicate a "selective" process which cannot be quantified. In other words data of this nature produces alternative definitions and it becomes possible to interpret ambiguities and silences in the light of textual processes which serve to articulate everyday practice. In a similar process, the research approach undertaken here aims to explain the experiences of nurses and physicians from their standpoint in the everyday world of hospital life. This research begins with the description of everyday experiences of health practitioners as "knowers" of their world and extends to the wider social relations that organize their knowledge and practice.

2.8 The Research Setting: University Hospital

This ethnographic study was conducted in a large university, multi-ethnic teaching hospital in Eastern Canada in five clinical speciality areas. Primarily these involved a

general surgical unit, a terminal illness unit, an oncology active treatment day unit, a psychiatric outpatient unit and a community outpatient clinic. It is important to know that many of the health practitioners and patients who work and receive care in these environments, describe themselves either as immigrants or first generation Canadians, and therefore as people who often have first hand knowledge of the immigrant experience through family or local community relationships. This population reflects the hospital community at large where there are about fifty different dialects spoken, aside from French and English.

The hospital setting has a reputation for high educational standards and medical research oriented clinical practice. For example, a particularly high priority is placed on cardiac transplant and kidney transplant surgery, as well as on experimental cancer and AIDS research. The present research focused on hospital units with surgical nurses and patients; cancer care patients, nurses and physicians; community clinic nurses, patients and physicians; and nurses and physicians giving psychiatric care.

In total, these units serviced several thousand patients each month and were staffed by approximately two hundred physicians and nurses - a number of whom were joint university faculty members of medicine or nursing. In addition to, and as part of university affiliation, all practitioners had access to on-site teaching and research seminars, unit rounds, hospital lectures and conferences regardless of their area of specialisation and level of expertise. The hospital had just begun a process of assessment with respect to the learning and practice needs of its multicultural client population as part of a broad level provincial mandate to assess multiculturalism in major health service

settings. The stated objective of the government mandate was to determine the extent to which health institutions were addressing the needs of an increasingly culturally diverse population. The method of program review was chosen by means of the creation of a multicultural task force which comprised multiethnic multi-specialty representation.

2.9 The Research Process

The field work for this study was completed within a period of ten months. As a result of my previous experience as a nurse and an educator, I had been provided with extensive knowledge which allowed me the privilege of becoming an understanding participant in this research. It also provided me with a preliminary ground for a working knowledge of the relations between the hospital and the Ministry of Health and the Secretary of State. This knowledge, and my ability to understand and relate to practitioners as an experienced nurse clinician in the setting established my credibility and trustworthiness as a researcher. This was an important and vital component of the research in what might be perceived as a sensitive multicultural climate of health care.

In this context, data gathering specific to the research was knowledgeably focused. I conducted interviews with many people who had direct knowledge of both the hospital and the learning needs under study. This included administrators, physicians, nurses and patients at University Hospital as well as representatives of multicultural community organizations both in the study setting and in the local community. I interviewed hospital ombudsmen, officials working for the Secretary of State Office of Multiculturalism, as well as a multicultural hospital coordinator outside the research setting, who held many

years of experience in the development and implementation of a multicultural hospital program. All interviews were open-ended and in-depth. All were tape recorded and transcribed. In total 50 interviews were conducted.

In addition to interviews, I observed and sometimes recorded a number of meetings including unit teaching rounds, in-service teaching sessions and a multicultural task force meeting. Throughout the period of field work, I studied documents related to health care learning and practice, in particular, documents related to course design and implementation, working documents of the multicultural assessment process and documents relating to multicultural policies of provincial and federal governments. In addition, formal documents relating to everyday information on clinical practices were studied such as patient records, nursing care plans and treatment plans.

I started from the position of researcher as 'knower' (Smith, 1987). This assumes that the researcher is in a subjective position, and is considered integral and essential to the overall research process (Anderson, 1991; Atkinson, 1982; Smith, 1987). Thus I began in a reflexive position, as 'knower' of the world of clinical life and practice, and I was also able to rely on a very specific *inside* position in the 'social world which I was investigating' (Smith, 1987).

My former practice as a nurse gave my research direction using my own knowledge of the environment - my experience of working with what seemed to be a tension between the knowledge and practices I was using and what was being organized around me. Thus I required a research method that went beyond a full or a fuller description in the phenomenological sense of people's experiences. I needed to extend my

inquiry to the broader social relations that organized those experiences. I wanted to locate those experiences in the context of multiculturalism and health care. Therefore it was necessary to create an analysis that would instruct our everyday knowledge of how multicultural health care works in experience in relation to what is formally known, and how what is formally 'known' is organized.

Having taken the view that what patients and health practitioners do is organized within a complex set of practices which are embedded in the intricacies of health care relations, there are many issues to be examined. How for example, did patients, practitioners and administrators experience the disjuncture in their everyday work between the reality of needing something different in terms of administering culturally sensitive health care, and work expectations within formally sanctioned health care paradigms. Thus I wanted to work with managing an in-depth understanding of, what Dorothy Smith terms, reflexive knowledge through practitioner and patient constructed accounts of how things come to work for them.

The task underlying the research process was thus to engage in "building inquiry" (Smith, 1987). The aim was to build on the perspectives of people in their daily practices to see not so much what was seen and experienced in a formal sense, but especially what was known and practised in a less visible, less formal sense. How did people express themselves and make sense of their accounts in the way that culture/health care works, for example, so that what is seen as "working" for them fits into the legitimate ground occupied by formal health care.

The actual data collection process underwent three phases: Early on, there were talks, informal interviews such as casual hallway conversations with people from a variety of work backgrounds in the study areas. I listened to nurses, physicians, people in housekeeping positions, orderlies and workers of plant services. I would ask them for an account of their experiences and how people had spent their day.

From these accounts I was propelled by clues that emerged which came to be questions, about learning regarding cultural understanding. I wanted to know how knowledge was gained and then, about strategies for making practice decisions around cultural care. How did these work and how were they made to work? The second phase of the process was brought about by the knowledge I gained from practitioners and what I understood in myself as the jointly agreed upon construction of accounts. This led in turn to the need to talk to patients as first hand knowers of the care they received. Patients' experiences of their 'clinical' day were then tape recorded, noting in particular, issues of 'cultural understanding'. I listened for issues of tension as I heard what was being said, for whom and how it was said. Patient accounts were followed with an examination of their charts, progress notes and records noting for whom chart documentation was instigated, how, when and for what particular purpose. I looked for omissions in documentation in an attempt to understand what I most needed to know. For example, one patient related her hospital experience of illness and treatment in the formal sense, but I observed that she had omitted to tell her caregivers that she was receiving concurrent alternative remedies from a Chinese doctor. This I observed as a point of tension.

Following these initial interviews with patients, a further phase of interviewing developed from clues, and thus questions gained by their accounts. Each new contact was arrived at by a specific piece of information derived from the previous contact. There was not an 'objective' selection of a sample. I worked and relied upon what Smith calls the stance of researcher as knower (Smith, 1987). For example, some practitioners talked about needing to personally modify the orthodox understanding of treatment planning which in turn, introduced me to a line of inquiry about approaches to treatment and care which I knew were administered in addition to standard care regimes. 'Clues' then eventually became a series of connected themes, which were then developed into illuminated, inextricably interwoven pieces of a whole - in the sense that a process of, what Smith (1987) describes as 'mapping out' (Smith, 1987) emerged.

I noticed that what constituted formal recognition as a health practice, or was prioritized as an important educational practice, was also usually firmly linked to clinical practice and research priorities in federal and provincial health mandates. These observations were informed by and informed my emerging use of this "mapping out" process I was able to link the central theoretical tenets of Dorothy Smith's Sociology of Knowledge, Michael Polanyi's Philosophy of Knowledge, and the work of Arthur Kleinman. And within this interchange of method, theory and data it became increasingly evident to me that the way that care was learned and practised was firmly embedded within a discourse that made science-based care highly visible and 'normalised', prioritized, and ultimately legitimized as a way of thinking about everyday hospital life. I began then to see the way in which people *worked in* the language, beliefs, and

traditions from their particular life experience and, from their standpoint the way in which they communicated, and in so doing, maintained practices which were subsumed under formal legitimized claims. And I began to see how knowledge and practice in relation to cultural understanding came to be organized. The language of the institution was clearly a language inextricably linked to scientifically accountable practice. For example, maintaining work load standards constituted a firmly embedded set of health administrative social relations organized in the setting. And within many such similar practices and accounts of practices, I came to see how what constituted legitimate clinical decisions and actions in the day-to-day routine of ward life, predominantly embodied science-based health care interests. Such an embodiment of interest moreover, while it represented and maintained the existing social order of the health care world, misrepresented the actual reality of the caring and practice needs of a multicultural clientele in the hospital. Furthermore, rather than maintaining a legitimate position within the order of health care and treatment, the concept of multiculturalism became relegated to an 'ad hoc' or informal reality in the hourly and daily work activity of patient and practitioner life. In this way, the research became an inquiry beginning with the standpoint of patients' and practitioners' experiences of their daily lives. This method of analysis will be illustrated in chapters four through eight below.

CHAPTER THREE

THE SOCIAL ORGANIZATION OF KNOWLEDGE

AN APPROACH TO THEORETICAL ANALYSIS

3.0 The Ideology of Orthodox Western Health Care Knowledge

While science-based care is considered to have predominantly legitimate claims to knowledge in the health care profession, less formal claims are made that physicians' and nurses' "clinical expertise is regarded as their personal power and private magic" (Gordon, 1988). It is often argued that the terms of this coexistence are changing (Gordon, 1988), and that in reality intuition increasingly effects a replacement of analytic reasoning to constitute 'practical expertise' (Dreyfuss & Dreyfuss, 1980).

I will argue here that this process of replacement remains largely restricted to the private realm of clinical expertise. Within this realm lies the practical wisdom that the personal knowledge of clinicians is often passed on by apprenticeship (Atkinson, 1988; Polanyi, 1958; Rawlings, 1981), however proponents of medicine's dominant paradigm argue persuasively that intuitive judgement remains beyond vision, that it is anecdotal and characterised by risk and uncertainty (Gordon, 1988).

Following on from these arguments, we will take up this discussion in the context of epistemological and ontological adherence to the dominant orthodoxy of medical science. Here we will consider the theoretical position that the organization of health care knowledge and practices generates illness and health care practice experiences specific to multicultural communities (Anderson, 1986). This argument holds the premise that the health care experiences of both practitioner and patient multicultural populations may be

understood within a set of tacit assumptions which underlie orthodox models of health care (Anderson, 1986). Such models of care, which inform current medical and nursing curricula, assume scientific-rational concepts of illness and health which are often antithetical to the everyday decision-making experiences of multicultural health communities.

In consequence, scientific-rational models of care constitute a form of 'expertise' which is exclusively recognised and practised as "normal", everyday practice. While perhaps unintentionally so, practitioners are positioned to support a strong scientific basis for practice and must learn to prioritize frameworks for practice which aspire to scientific rigour. The infiltration of science-based frameworks for care also effects a discourse which is legitimised in every day practice *as if* there can be no negotiated alternatives.

The effect rendered by scientific models of care constitutes a socially determined form of objectified reasoning, fully manifested in the communication processes of everyday talk and documentation. Textually mediated practices ensure that the displacing of multicultural learnings and professional symbolism becomes internalised and fully legitimised.

The purpose of this chapter is to demonstrate the theoretical argument that the social and cultural character of health practitioner knowledge is an ideological reality which is explained and ordered in everyday practices (Locke & Gordon, 1988; Kleinman, 1992; Anderson, 1987). It will explore the way in which orthodox beliefs and 'ideas' are believed to be contained in the process of formal 'contextualisation', and how the relationship between these 'ideas' and cultural understandings may be considered.

The chapter draws on theory conceived within the sociology of knowledge of Dorothy Smith and the philosophy of knowledge of Michael Polanyi. A theoretical argument is proposed regarding how current health care knowledge is organized and constructed, showing that other forms of knowledge which involve lifeworld experiences and commonsense understandings remain in practice within the private sector, and in effect are displaced in everyday professional practice.

3.1 Western Health Care Practice: The strengths of science-based care

In recent years much academic discourse within the medical and nursing disciplines has been concerned with challenging orthodox paradigmatic medical thinking relating to socially and culturally sensitive orientations of health care (Kleinman, 1980; 1986; Locke & Gordon, 1988; Anderson, 1987; Leininger, 1981; 1988).

Alternative orders of reality to what has also been termed 'biomedical reductionism' (Engel, 1977) have been proposed by a number of academics, and there have been periodic attempts aimed at reformulating this paradigm. Nevertheless the argument persists that a disjuncture persists between alternative and orthodox paradigmatic forms of thought. 'Biomedicine', or what is termed the medical model[12], is still considered to be at the cutting edge in a worldwide culture of science (Gordon, 1988).

Kleinman (1992) poses the following problem with this 'dominant intellectual commitment':

> Sick persons and their circles resist the objectivising rational technical procedures of the bureaucracy on behalf of the deeply subjective sentiment,

> tradition and ad hoc coping functions of the local moral order ... (these) existentially inefficient quiddities of human conditions place the chronically ill at the forefront of the unequal and conflicted power relationships between the informal and formal sectors of the social world (Kleinman, 1992, pp. 3-4).

Illness is a socially constructed phenomenon within a socially organized context (Kleinman, 1981; Anderson, 1987; Helman, 1990). Health care practices are the outcome of learning which is selectively applied to reflect dominant and persisting cultural ideologies within the larger society. Thus the health care profession affords an objectification of society, and its social relations become successfully incorporated into a set of tacit assumptions about the everyday world. The subjective experiences of health practitioners are arranged and ordered as part of the objective organization of the society at large.

This 'legitimated' objectivity formally renders an exclusion of 'tacit' connections between person and situation in the every day world. Student practitioners are trained to make biology visible as the ultimate reality; the fundamental substance behind complaints and illness narrations (Kleinman, 1992). Yet Polanyi argues:

> . . . the ideal of a strictly explicit knowledge is indeed self-contradictory; deprived of their tacit coefficients, all spoken words, all formulae, all maps and graphs, are strictly meaningless. An exact mathematical theory means nothing unless we recognise an inherent non-mathematical knowledge on which it bears and a person whose judgement upholds this meaning (Polanyi, 1969, p. 195).

The above statement implies that if knowledge is totally explicit or 'focal', then meaning can never be conceived independently of subjective human experience, perspective or unseen phenomena. Yet an underlying assumption of the biomedical framework of thought is a barely visible personal conceptualisation of experience. The

vital moments and mediations in every day life are not always included in everyday clinical work.

In the orthodox sense, medicine is characterised by scientific-rationality and there is a learned emphasis on objective numerical measurement; an emphasis on physiochemical data; mind-body dualism; a view of diseases as entities and emphasis on the individual patient rather than on family or community (Engel, 1977; Helman, 1990, p. 86)[13]. Implicit within these theoretical assumptions are the reification of 'scientific facts', a decomposed understanding of a local situation into 'variables' and an objectified reasoning process. There is also a process of quantification and a reduction of patients' situations, and of patient-physician decisions into parts, which contributes to and abstracts what has been determined to be an artificial experience (Gordon, 1988). Decisions are made on a single case of a disease, based on cumulative descriptions of previous clinical cases (Pfifferling, 1981).

Legitimate knowledge then, becomes knowledge which seeks explanations to phenomena. Through biomedical reductionism and exclusionist principles, personal experience may be regarded as myth, and thus eliminated from biomedical conceptualisation (Engel, 1977). Student clinicians learn to perpetuate the legitimation of this knowledge by placing conscious explicit knowledge as the dominant ideal (Polanyi, 1969; Gordon, 1988).

Polanyi explains how this process of elevating explicit knowledge disqualifies inherent or tacit knowledge:

> The ideal of the exact sciences, derived from mechanics ... aims at mathematical theory connecting tangible, focally observed objects. Here

> everything is above board, open to public scrutiny, wholly impersonal. The part of tacit knowing is reduced to the act of applying theory to experience and this act goes unnoticed. And the fact that tacit powers predominate in the very making of discoveries is set aside as forming no part of science (Polanyi, 1969, p. 151).

In health care practice, the ideology of 'getting well' is often related to actions based on the realisation of focal knowledge. Patients are required to comply with the completion of forms, the collection of demographic information and illness information. Instrumental tasks and environmental routines, designed to fit the 'treatment modules', require the everyday filtering of 'focal' knowledge often to the 'tacit' separation of private thoughts, cultural meanings and other realities. Two brief examples from my research data illustrate this process of the filtering down of focal knowledge.

As one patient, recently arrived from Greece put it:

> I come from a small village ... everybody knows each other ... hospital a scary place ... full of machines ... here, everything is big, very big and you don't feel what happens. You don't know the people.

And later the same patient explains:

> So many people, yes, of course, doctors, nurses, yes everybody ask the same thing, where is my pain, do I have bleeding, the pain it is here or here (points to stomach) How many ask? Many, many people ask it ... (14:4:2:1993)

Thus it may be argued that the way that ill-health is defined from a medical standpoint is based on what can be objectively seen as demonstrable physical changes. These physical changes are then seen to be quantifiable by reference to 'normal' physiological measurements (Helman, 1990).

Students and practitioners learn that all explanations of dysfunction lie within a biological, causal framework of structure and process. Human judgement is submerged in lieu of scientific 'truth'.

Theoretically all cultural, biographical, moral and emotional explanations become secondary to this 'idea' of knowledge. In this form of explicit or focal knowledge, formal orthodox medicine exemplifies materialism, and nature is objectively distinct from the observer. There is an extreme insistence on materialism on the grounds that single causal chains must be used to specify pathogenesis (Kleinman, 1992, p. 5).

The assumption that only tangible focal objects have authoritative meaning excludes and curtails tacit knowing (Polanyi, 1969, p. 147). Knowledge which is sustained by something uniquely personal, realities which can be sustained only by personal judgement and meanings which are implicitly inter-subjective within a biomedical idealised reality, remain as an unexamined resource. Taking this argument further, in reference to the *Birth of the Clinic*, Foucault has written:

> A whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naive knowledges, located low on the hierarchy, beneath the required level of cognition or scientificity (Foucault, 1980, p. 82).

In this view, cultural knowledge or alternative understandings would be maintained in the private sector or as phenomena which are given *ad hoc* or informal consideration in everyday practices.

3.2 Health Practitioner 'Expertise'

The way that medical knowledge is conceptualized, learned and practised owes much to the way it has been epitomised as a hallmark of science. In everyday practice, clinicians must be primarily concerned with the legitimation and development of conscious explicit scientific-rational knowledge, which effects a displacing of social, cultural and biographical explanation (Atkinson, 1988; Helman, 1990; Kleinman, 1992; Lock, 1988).

It is frequently argued that the medical model provides a theoretical formula for constructing curricula and delivering rigorous pedagogy which in turn calls for strict adherence and scientific 'expertise' towards a competent diagnosis treatment and prognosis. Inherent within this framework lies the premise that the asocial and the idiosyncratic are subsumed in order to attain the desired 'expertise', precise prediction and control of disease. In effect, students of the medical paradigm are taught to aspire to a scientific rigour of reliability, validity and predictability.

Within this process of desired learning, a subtle yet possible submersion of learned personal and biographical reality evolves. According to Dorothy Smith:

> The ethic of objectivity and the methods used in its practice are concerned primarily with the separation of the Knower from what he knows and in particular with the separation of what is known from any interests, "biases", etc. which are not the interests and concerns authorized by the discipline ... [This procedure] ... lifts the actor out of the immediate local and particular place in which he is in the body. He uses what becomes present to him in this place as a means to pass beyond it to the conceptual order (Smith, 1974, p. 9).

The 'expert' professional who has been singularly oriented to the medical model, as an outcome of formality comes to expect to replace taken-for-granted knowledge,

common-sense or local knowledge in favour of systematic protocol and technique, the epitome of deductive scientific evaluation.

In this vein, practitioners know that an ideal of detached 'truth', is demanded and encouraged within the learning milieu. The learning assumptions underlying this ideal medical expertise are outlined here by Deborah Gordon:

1) Clinical judgement is primarily intellectual, cognitive, analytic: it is "knowledge" as opposed to "skill".

2) Knowledge, such as clinical problem-solving, proceeds from part to part to whole; it can be analyzed into elements and then reunited.

3) Knowledge is organized into rules, formulas or some form of abstract representation ...

4) Objective knowledge is the ideal knowledge, best gained in a detached, neutral universal stance ...

5) Explicit knowledge is better than and equal to implicit knowledge.

(Gordon, 1988, pp. 269-272)

This mainstream orthodox approach to health practice encompasses within it the notion that personalised cultural knowledge is something to be coped with on an informal level. In this way, ordinary knowledge such as intuitiveness, personalised knowledge, is rendered extraneous and is not formally included in practices because it appears 'mystical'[14] and does not respond well to the scientific demand of rational, precise measurement routinely associated with 'professional expertise' (Gordon, 1988). This form of knowledge submersion can be seen as a form of

> decontextualising lay reasoning in order to make human behaviour nothing but a sequence of strange uninterrupted events whose sense is then reattributed to them insofar as they approximate the rationality mode. (O'Neill, 1989, p. 126)

In this formal paradigm, the notion of rational, explicit focal knowledge is linked to articulation (Taylor, 1985, p. 136), but it has been argued that higher claims to analytic knowledge in reality can be made by intuitive response (Gordon, 1988). Gordon defines this notion of intuition as:

> An automatic, implicit, non-rationalised response, that is neither mystical or guessing, but rather the type of know-how based on extensive experience that people use all the time (Gordon, 1988, p. 272).

Although it is not always apparent or actually acknowledged in the curriculum formally, clinical practitioners have nevertheless argued that practitioner expertise is, in fact, often a kind of 'know how' or an adherence to the voice of the life-world (Mishler, 1985, p. 14) - a particular common-sense understanding[14] on which we depend to know and understand the world. One reflects often on a personal response to a given situation, and this personal knowledge often precedes cognitive thought, becoming the guide and master of cognitive powers (Polanyi, 1959, p. 26).

In fact, much professional knowledge in the everyday common understanding is regarded as a "gut feeling" or an "inner sense" which is often fundamental in making a decision. Polanyi takes this further, arguing that all knowledge is inherently tacit:

> To claim that we can know the unexpected may appear self-contradictory. It would indeed be self-contradictory if knowing included a capacity to specify completely what we know. But if all knowledge is fundamentally *tacit* as it is if it rests on our subsidiary awareness of particulars in terms of comprehensive entity, then our knowledge may include far more than we can tell (Polanyi, 1969, p. 133).

It has been argued that clinical expertise, in an informal sense, is also experienced as instantly "grasping" a meaningful moment (Gordon, 1988) - a moment such a shared

pain or shared suffering. This accepts the dynamic and emergent events within an interpersonal experience. And at times, these moments are a function of being able "to sense, without a deliberation" (Gordon, 1988), what is needed at a particular time for a specific situation. Moreover, "understanding moves from being elemental to being holistic and intuitive" (Gordon, 1988) and thus the clinician intuitively senses what to do, drawing upon a large wealth of previous experiences.

With practice and actual clinical experiences in the everyday world, practitioners learn to recognize the "meaningful recurring situational elements" or as Polanyi describes in the structure of tacit knowing:

> In the structure of tacit knowing, we have found a mechanism which can produce discoveries step by step we cannot specify. This mechanism may account for scientific intuition, for which no other explanation is known so far. Such intuition is ... a work-a-day for scientific guessing with a chance of guessing right (Polanyi, 1976, p. 144).

One of the assumptions with clinical science that practitioners are aware of, is that with more clinical science, "physicians will practice more scientifically, and use technology more prudently" (Gordon, 1988, p. 279). Thus practitioners know that they must try to practice within traditional paradigms which establish all knowledge in terms of "explicit relations between sensory data" (Polanyi, 1969, p. 156). And yet this moment is often displaced within the formal learning process. Practitioners are also taught that desired learning prioritizes explicit replicable knowledge; an 'exercise of taxonomy' which progresses from symptoms to syndrome, and finally to diseases with specific pathogenesis and pathology (Engel, 1977; Feinstein, 1975).

These legitimated priorities pose special difficulties for practitioners, for they are bound to adherence to a rational sequence of thought which formally supports the exclusion of emotionality - or the sense of a moment in knowledge which is exclusively separate from the body as a biological mechanical apparatus. Lawrence Kirmeyer argues that this sequential rational order of diagnostic reasoning "eclipses the bodily felt reality of the patient" (1988, p. 61). In this vein, practitioners know that they must organize their work within the legitimate parameters of the traditional health care paradigm[15]. Physicians know medical science as the official, legimate knowledge underlying practice and they know that the tacit or subsidiary decision-making which they undertake must be subsumed within scientific medical authority and within that which is "integral to (their) reputation and capacity for continued productive work" (Young, 1981, p. 324). And following this view it must again be argued that social, biographical and idiosyncratic subjective experience is displaced in the process of formal reasoning.

In their everyday clinical encounters clinicians accept the authoritative and definitive position of formal practice informed by cognitive, mental or intellectual reasoning, that involves combining data through influence, deductive evaluation and probability statistics (Gordon, 1988). And they know that formal challenge and evaluation of decision-making must be based on the priorities of formal theories, rather than on knowledge which is imaginative, speculative, free-ranging and creative (Elstein, 1976).

3.3 Biomedical Separateness and Cultural Community

Prevailing assumptions underlying the orthodox biomedical model contribute to the persistence of 'ideas' or 'images' which separate and prioritise scientific-rational thought from culture. Deborah Gordon explains:

> Symbols/language/representations depict an independent empirical reality, rather than constitute it. Meaning is the correspondence between representations and external reality. Disease taxonomy mirrors nature's "real" diseases (Gordon, 1988, p. 27).elimin

In this preceding argument the decision-making practices of practitioners in multicultural patient settings are guided by an adherence to probabalist reckoning. In a formal sense, the measurement and quantification which comes to characterise decision-making practices separates from the idiosyncracies and uncertainties of the "cultural being". The empirical decision is separated from the linguistic and symbolic being, and the physical (the knowable, independent of perspective), is formally separated from the moral or the spiritual. In these observations it is frequently argued that the cultural, the social, the moral and the spiritual are superficial layers that "disguise" natural truth (Kleinman, 1992).

Thus symbols, language, the rhythms and rituals of everyday life are superficial layers which must be fitted informally into the workings of orthodox thought. And 'work' in everyday clinical practice comes in the form of a pervasive pressure which has the effect of prioritizing the "model". As such, health practitioners practising in multicultural settings know from their training that they must necessarily prioritise clinical events, procedures, medications, and yet work into their practice, intutitively sensed knowledge. They must work within a process which on a theoretical level, externalises cultural

layering and decontextualises events, biographies and cultural history. In addition, they must allow for their own common-sense responses within these phenomena. In this theory, in an objectified world of ultra-medical specialisation, all other conceptions of the world, religious views, philosophies of life in all possible social and cultural milieux, are phenomena that limit and restrict "reality". Within the process of clinical decision-making, practitioners are then led into encounters where a reasoning process is articulated with a rationale for action which openly acknowledges the necessity to leave aside informal clinical understanding. And yet at the same time it is argued: "Having a sense of a meaningful picture or of one that doesn't make sense is an important capacity that practitioners develop" (Hahn, 1985). Gordon (1988) notes that this understanding is usually intuitive, "sometimes described as a nagging feeling that something is not right, that something feels funny" (p. 277).

Thus, although the scientific (health practitioner) paradigm states its formal rights in knowledge, clinical experts do nevertheless, sense the meaning of a situation, and they often act on these responses.

In this way, biography and culture are seen to apply to an informal world which constitutes an external phenomenon and which is limited to its collective orientation, rather than as events which might empower the individual (Gordon, 1988). Clinicians do exercise differing forms of practical know-how, intuitively sensing what to do (Dreyfuss, 1986, p. 146). And since medical specialism encompasses the world within a disease and treatment cure determined process (Helman, 1990), the notion of having broad, intellectual or cultural sympathies is seen to lie beyond the scope of practitioners' scientific

specialism. On a strictly visible level, all expectations must be seen to prioritize care informed by clinical science. Practitioners are also expected to exercise this informal intuitive sense of knowing as a layering of less visible practice. Moreover, the displacing of alternative knowledge forms is not expected to detract from the professional work of the practitioner expert.

Thus, as professional medical specialism has evolved, an accompanying technical and scientific discourse is established which becomes a formally accepted phenomenum in medical practice. While it is a discourse which health practitioners know to be an artificially constructed one, it becomes a 'normal' practice for them in their everyday professional world.

At a formal level the practitioner describes the social phenomena as a structure of 'relatedness', but it is a structure which is artificially constructed. In the formal sense, personal life experiences and inter-subjectivity are articulated and voiced as sets of artificial concepts which are formally termed 'values' and 'attitudes' and 'compliances'. Social experiences become sets of 'roles', 'interdependent units', and 'sub-system sets'. There is a mechanistically conceptualised, yet separated view of people, rather than one which is characterised by local knowledge.

In this formal view, the self is autonomous and separate from social experience and understandings of community meaning, and it is not determined by history, tradition, biographical experience, linguistic or symbolic phenomena. Its person is fixed and "relatively invulnerable to experience". This movement of thought:

> . . . eliminates any quest for an understanding that carries with it the metaphysical implications of a groping for reality behind a screen of

> appearances. Natural science has been taught to regard itself as a mere description of experience (Polanyi, 1958, p. 20).

Relationships in this form of reality are seen as external to the self and potentially become a separation from circumstance in the objectification of all events. There are yet other arguments which postulate that flexibility, uncertainty and risk are central concepts in the theoretical frameworks of decision-making (Gordon, 1988, p. 261). It is argued moreover, that the 'real clinical expert' will supersede the ability of formal models to represent an expertise based on experience and in the end, know much more than formal theories can encompass (Elstein, 1976, p. 699).

3.4 Experience and "Normalcy" in Health Care Practices

Patients coming from life worlds outside the realm of orthodox medical care arrive with experiences and meanings which are derived from a complexity of interpersonal experience. Such experience can be understood by the definition attributed to it according to Arthur Kleinman who observes:

> Experience is transacted among members of a local world -- a village, a neighbourhood, a network, it is an inter-subjective medium of communicated worlds, sentiments, gestures, movements. Experience is constituted out of the lived flow of interactions among members of a group for whom something is vitally at stake in the everyday social rhythms and rituals that build cultural life ... Experience never has a natural course -- an objective, linear flow of impersonal time (Kleinman, 1992, p. 1).

For those outside the world of orthodox medicine there exist questions that are real and important in everyday life which may require solutions other than those characterised by concepts, categories, codes and schemata. Medical discourse becomes subsumed within the ideological currency of the institution and thus, becomes translated into a myriad of

standardized forms, treatment plans, records, progress notes, nursing care plans, computer files and audio visual equipment. Moreover, patients and families become encompassed within the standardization of the collective text and thus facticity, reasoning and rationality. In the words of Dorothy Smith, this phenomenon:

> Externalises social consciousness in social practices, objectifying reasoning, knowledge, memory, decision-making, judgement, evaluation, etc., as properties of formal organization or discourse rather than properties of individuals (Smith, 1990, p. 211).

Thus people who live in life worlds which are outside of the 'professional medical culture' may find their ways of knowing unrepresented in these formal scientific organizations of thought. Within the process of scientific 'facticity', others are excluded from an intellectual world which is represented by its followers as a model of universal truth. For practitioners who must engage in daily duties sanctioned by the professional scientific culture, there is an assumed fixed external reality which guides and directs each decision *as if* science-based practice were a singular reality. Practices which constitute decisions falling outside procedures informed by medical science become 'incidental' to the job of getting the work of procedure done. In this way, incidental occurrences such as language or cultural beliefs are seen as external to scientific reasoning which separates itself from other lifeworld values.

Adherence to a presenting reality characterised by the need for a purposeful and formal pursuit of culturally responsive actions and explanation by the practitioner are relegated to the 'other' realm of the incidental. Moreover, this 'other' domain becomes subsumed beneath the incontrovertible framework of goals determined by scientific

orthodoxy. The 'images' held by practitioners are therefore inextricably interwoven within a discourse of unquestioned objectified reasoning.

In a similar vein, when practitioners speak of 'charting the intake and output', doing the 'vitals' and doing the 'flow sheet', their forms of thought, focal knowledge and the images they use, are "rooted in (medical) discourse which is the work of specialists occupying influential positions" (Maxwell, 1980, p. 57) in an intellectually and culturally exclusive world. Thus the cultural language of the 'flow sheets', the 'data base record', the 'care plan', the 'consult form' and lab reports do not arrive spontaneously, they are manufactured. These textually mediated practices encompass a culture of "normalcy" of procedure which in turn carries with it the notion of a 'normalised' and idealised phenomenum of illness and procedure. As Dorothy Smith explains:

> Being a professional then, means knowing how to do it this way, how to produce work that conforms to 'normalised' standards, addressing these topics and following these methodologies (Smith, 1987, p. 60).

Embedded within the 'professional culture' these practices make the assumption that patient adherence to the clinical routine of daily life constitutes a finite province of meaning. Alternative meanings attributed to illness procedures, language or 'normalcy' are excluded. This 'normalised' focal phenomenum, or knowledge attached to the meaning of illness, leads patients and families to act *as if* alternative meanings were non-existent and *as if* the signs and symptoms and modes of treatment are the only *right* ones. The social organization of an ideology of "normalisation", informed by the formal curriculum, in turn sets the criteria for proper professional performance.

3.5 Professional Abstracted Discourse: The Language of Everyday Hospital Life

Professional and bureaucratic procedures are part of an objectified and abstracted system of relations. In everyday life, abstracted forms and procedures must be fitted into personalised and subjective worlds of sentiments, gestures and movements of experience. Dorothy Smith explains this:

> There is a process of practical interchange between an inexhaustibly messy and different and indefinite real world and the bureaucratic and professional system which controls and acts upon it (Smith, 1990, p. 153).

Hospital settings, which epitomise bureaucratic abstraction, tacitly exercise a filtering down process of terminology, meanings, abstract symbols and linguistic abbreviation in everyday life. Such practices that are part of the local experience are subtly encompassed within the abstract mechanism of the professional culture.

'Professional' language and meaning, and formal knowledge is filtered down to convey not only a linguistic function, but an implicit 'tacit' knowledge, to deal with the tension between the abstracted and the local reality.

Dorothy Smith explains how people such as health professionals tend to 'categorize' clients and the workings of institutional life into 'types' which helps to fit the bureaucracy to actual situations:

> People working professionally come to categorize people's problems as types in relation to the kinds of actions to be taken. Types are an integral part of a process that fits the abstracted terms of the profession or bureaucracy to the actual situations. They work as a matching process that assembles, selects and organizes within a specialised context. The individual (the patient) is already distant from her biography and her lived situation ... She is encountered in the form of a case history already written

> and through forms of interview that disclose only pieces of her life that fall into slots (Smith, 1990, p. 127).

Implicit within this analysis is the construction of formally learned abstract symbolism and language categorisation by practitioners which becomes unconsciously embedded and legitimised and which is defended within the realm of orthodox discourse. An example of this can be seen in the ethnographic work of Paul Atkinson, who demonstrates how in the process of "Socratic" cross-questioning, junior medical students are required to observe and "notice" *signs* and to elicit *symptoms*.

Here Atkinson shows how the 'effect' of an implicit logic of systematic contrasts between types and categories is invoked and exemplified in the bedside teaching process. He explains:

> The individual patient is thus located within a discursive framework - a sort of semantic space - in which persons, signs and symptoms and the differia specifia of disease categories are arranged in relationships of similarity and contrast. The medical students thus enter into a collaborative reproduction of this semantic system. The shared talk at the bedside ... organizes a joint display of clinical reasoning. It is indeed, a very powerful means for the reconstruction and transmission of normal medicine (Atkinson, 1988, p. 186).

Here the social construction of the medical model is not the outcome of 'arbitrary labelling' but rather the collaborative outcome of the teaching process. The students are asked to discover a series of disease categories which, implicitly or tacitly, is conveyed as finding the "right" collection of signs and symptoms. The teaching is based on finding (culturally) normal categories and (culturally) normal predictions (Atkinson, 1988, 193). Thus, Atkinson describes the subtlety of how the process of clinical instruction proceeds *as if* the process were inductive in nature, *as if* the "facts" of the case were waiting to be

discovered as a totally independent entity, completely on the outside of the discipline. The organization of knowledge by the clinical teacher - the sequence of questions as "facts", and the expectation of answers as "facts" - serves to reinforce the "invisible" (Atkinson, 1988, p. 201).

In this way, the discourse of bedside teaching, organized unit rounds, clinical seminars become then a routine means of the dissemination of knowledge belonging to the professional culture which are the "facts" in everyday practice. These "facts" or phenomena of "focal" knowledge, are what Dorothy Smith observed exercised by the describers of the definitional privilege. (The describers being those who exercise a pre-learned set of organization rules.)

> The social organization of the setting is always necessarily 'present' in the description . . . How the describer who is a member of her setting does her description is controlled by her knowledge of the socially organized processes in which the terms and what they mean are embedded. The sense that they do and can make in the descriptive context is 'controlled' by her knowledge of the social organization of the setting (Smith, 1990, p. 118).

In hospital settings, in the everyday process of unit rounds, descriptions of physical symptoms frequently arise from the describer's knowledge of an 'on the spot' patient situation. Yet the 'definitional privilege' allows a re-telling of the event within the social organisation of medicine. Thus the 'fact' is already categorized and framed in order to conform to the model.

Patients come to hospital with illness explanations which are derived from personal and biographical experiences that sometimes emphatically conflict with the definitional privilege categorisation by the professional culture. An example of an alternative illness explanation which relates positive energy to health can be seen in the

following case example from a family dealing with cancer. Explaining his notion of illness, a Chinese father spoke about what might help with his son's illness: "positive ... happiness can help him ... when you're happy, you don't think a lot of things ... if sad, more sick" (Sunli & Boston, 1989).

And in a similar example from a Greek family:

> Well we have had big trouble but we don't understand. Maybe something bad happened to my mother. Maybe if we say something she will die. (14:4:12:1992)

The preceding excerpts of patient and family talk reveal that many patients hold a life knowledge that provides a personal sense gained from inter-subjective experience which enables them to attend meaningfully to their home-world and which figures in each moment of the health experience.

This disjuncture between biographical experience and definitional privilege is also what Mishler has described as the concept of "voices" to distinguish between the actual pattern of meaning and the frameworks of meaning. It is explained as the voice of medicine and the voice of the life-world or the voice of scientific rationalism and the voice of everyday life (Mishler, 1985, p. 14).

Thus in the objectivisation of the patient there is often formal disqualification of other knowledge which Foucault has described as a "local regional knowledge, a differential knowledge incapable of unanimity" (Foucault, 1980, p. 82). This notion of the "objectivisation" of the patient is highly visible within many of the allied health care disciplines. In particular, the development of the family therapy movement has given rise to a new conceptual rational-technocratic process for making sense of family and

lifeworld events. In the following section, we will see how a new discourse has evolved within the family therapy field which has assumed the authority of technical abstraction.

3.6 Family as Technology: Theory and Practice

During the past decade, North American family theorists have developed arguments for including the cultural factors of families in family therapy. It has been proposed that family structures are manifestations of the family's cultural background and that personal interpretations in therapy must reflect the cultural values of both the therapist and the family (Di Nicola, 1985). While consideration of culture as an active dynamic has represented greater sensitization by practitioners toward the concept of 'negotiation' in family therapy (McGoldrick, Giordano, Pearce, 1982), this development remains within the sphere of scientific-rational discourse. This has necessarily affected learning and practice in North American multicultural settings.

It has been argued that:

> Technological changes must be transposed out of that generalising language and into a description of the actual work of people in actual work contexts . . . (Smith, 1990, p. 46).

In the field of family therapy, a new vocabulary of concepts and associated metaphors has emerged in order to structure and understand the phenomena of family and community. The difficulty which most trained clinicians will acknowledge is in being able to separate from, and analyze taken-for-granted clinical concepts, in terms of the everyday world. The issue is not that clinicians must disregard what such forms of thought achieve, but rather that they must acknowledge the way in which conceptual, abstract and technical

categories are also cultural categories within themselves, which also structure and order thought. Regardless of whether they are categorical tools which belong to day to day language in health care settings or whether they are part of an intentional purposeful design, the inherent difficulty ensues when such forms of classification affect and separate from the everyday world of common understandings (Smith, 1987). Such categories are part of a specialised technical medical discourse, which in modern western societies, it has been argued, is endowed with a distinctive and privileged position. (Helman, 1990; Turner, 1987; Waitzken, 1983).

In this section, we will consider the organization of knowledge within the discipline of family therapy. What is illuminated is that a conceptual world within the notion of family care has emerged, which has made possible ways of looking at family life experiences. This transformation of the conceptualisation of family care has significance in light of the present discussion, since it is an important instance of an evolution and extension of a scientific-rational mode of social regulation into everyday life. In this view, family life, which is a sphere of human experience characterised by culture and community, has been subject to a clinical and scientific transformation which Foucault has called the 'medical gaze' - whereby the patient (or family) becomes the object of analysis (Foucault, 1975).

Just as scientific medicine has separated itself from moral and spiritual connections (Taylor, 1985), and just as diseases were considered to have a separate entity and are located in the "atom" of society (Engel, 1977) - and in spite of well-intentioned attempts to the contrary (Brodkin, 1981; Friedman, 1986; Minuchin, 1980; Wright & Leahey,

1984). - 'clinicalised' family work and everyday family life have come to be seen as discrete and separate entities, not complementary parts of each other. The family therapy movement has evolved into a discipline which has objectified discourse and has formally created it as focal and explicit abstract phenomena. This kind of discourse has become more precise, authoritative and has become an objectivised ideal. As Polanyi puts it, it is a kind of discourse which saw 'flaws' in (previous) personal knowledge. In this vein Polanyi argues:

> And it seems almost inevitable then, further, to accept as an ideal the establishment of a completely precise and strictly logical representation of knowledge, and to look upon any personal participation in our scientific account of the universe as a residual flaw (Polanyi, 1958, p. 18).

Thus the family therapy movement has developed a framework built on reductionist principles, made all the more apparent by its emergent objectified social organization. While theoretically, it could be argued that this change would serve the notions of 'culture' and 'community', this change has also given rise to a field of professional practice and the acceptance of new conceptual rational-technocratic metaphors for describing and making sense of family and social events.

To illustrate the emergence of this new conception, we need only consider the discourse used in a brief excerpt from a standard modern textbook explicating developing models of family therapy and their perceived usefulness. Describing the rationale and usefulness of the 'systems' approach to cultural family therapy for students and practising family therapists, John Speigal explains how the whole family and thus the culture is taken into consideration:

> Family therapists pay as much attention to the family as a system of interactive processes as they do the individual who happens to be the identified patient or client. ... Any variation or deviation from the basic routines of family interaction will be countered by a reaction among the members to restore the previous balance, no matter how pathological its effects for one or more family members. Such resistance is expected during the course of therapy and is usually ascribed to a homeostatic mechanism within the family system . . . While the clinician may focus on diagnostic terminology ... the attention goes to the family process (Spiegal, 1984, pp. 31-2).

The systems approach to family therapy grew out of child psychiatry, exemplified in the work of Nathan Ackerman (1958) and Framo (1965) and Boszormenyi-Nagy (1962) and was concurrent with schools of thought such as 'learning theory' and 'behaviour modification', with the addition of cognitive theoretical components (Mash, Hamerlynck & Handy, 1975). The tenets of orthodox systems of family therapy most widely used in current clinical practice, followed the school of Minuchin (1974) and Bowen (1978).

What emerged has as an inherent part of the systems orientation is a form of technical abstraction, which has became apparent in the development of the discourse accompanying the discipline. If we consider an excerpt of the following account of the advantageous use of systems theory (which may in its intention be fully plausible) the potential for separation through technical abstraction is evident in the language being used:

> (Structural family therapy) conceptualises deeper structures, looks for hidden patterns: distorted or disguised interactions ... unappreciated ego masses, undiscovered coalitions, triads, rubber boundaries, pseudomutualities, schisms and skews ... the task of the therapist is to bring these to the surface (Spiegal, 1984, p. 32).

What is apparent within the teaching discourse outlined in the text, is again the assumed technical abstraction which is to be used to understand multicultural family life-worlds and day to day experience. Even when the notion of life-world sense is acknowledged, there is a precise authoritative accounting for it. Spiegal continues, noting that,

> Where the issue is "common-sense" the intervention is more complex since it frequently features a paradoxical form of communication that is alien to the logic of ordinary communications and to the interpretive procedures of the psycho-dynamic approach ... In order to facilitate the exposure of these hidden interactions (more technocratic-national solutions) therapists may borrow techniques such as family sculpting or guided fantasy, from other more psychodynamic approaches (Spiegal, 1984, p. 34).

And here it is apparent that while one can fully argue and acknowledge that "being" as opposed to "knowing" is implicitly and morally fully intended, 'family therapy' or family "truth" is best understood by relationships that take the whole as the sum of its parts or by removing parts from their context without altering their identity. Thus to arrive at real family knowledge, the therapist must stand back from 'local knowledge' (which may be biased and therefore invalid) and take a universal position which is separate and isolated from everyday life. Therefore it can be argued that these processes separate practitioners from everyday understandings which may encourage and contribute to the distance between health practitioners and the very personalised nature of the families and communities which they serve.

Taking this further to multicultural hospital communities, which serve immigrants with many life-world experiences, the problem of the separation of knowledge and language becomes ever more apparent. These separated knowledges theoretically permit

a separation of intrinsic from extrinsic knowledge. Polanyi discusses this in terms of personal knowledge, arguing that these distinctions of knowledge are falsely separated. As he puts it:

> I regard knowing as an active comprehension of the other things known, an action that requires skill ... Clues and tools are things used ... Into every act of knowing there enters a passionate contribution of the person knowing what is being known which is a vital component of his knowledge (Polanyi, 1958, p. VII).

Yet extrinsic or focal meaning is considered independent of the language of the everyday and of the common-sense or 'intuitive'. Abstracted, technical, scientific rationalism seeks to make words correspond to 'things' which serves to represent it as a separation between culture and reality. 'Cognitive perception' and understanding are separate.

Thus a cultural phenomenon originally seen as 'family quarrelling' now comes to be seen as a problem, to be cognitively rationalised, rather than seeing it as an inescapable fact of nature or even as a happily, helpful way of clearing the air. Expressions of concern about 'family quarreling' can certainly be found in the early literature (Aries, 1964; Boston, 1987), but it is only with the onset of the family therapy movement in the 1960s that 'family conflict' or the objectified and abstracted form of 'medical gaze', becomes a socially constructed phenomenon. A consensus has come into being that the problems of family life essentially belong to health care practices and thus a 'technicalisation' of the family has ensued which is clinically determined. A phenomenon such as 'the family working together' has ceased to be simply a part of a

moral discourse in which actions were judged against ways of doing things and having 'world voice' explanations.

The field of family therapy has become a means rendering an effect which serves to "lift(s) actors out of the immediate, local and particular place in which we are in the body ... a means of passing beyond the local into a conceptual order" (Smith, 1987, p. 17). Thus family 'truth' lies in the accurate explanation of objective reality, not in the "happy", the "good", the "romantic" or the spiritual or cultural. Ideological, conceptual abstractions of knowledge are separate from life-world views of family and community and thus knowledge is separate from and yet accessible to, the clinician in power (Foucault, 1977). Common-sense meanings, biography and personal history beyond and outside the conceptual frame are excluded.

Thus care of the family in hospital and multicultural health care institutions, informed by the western family therapy school, has been cast into an objectified mold. Its precepts are presented as rules informed by scientific rational thought which has become an integral part of everyday learning and practice.

Summary

A model-based, rational, scientific approach to learning and practice can have the effect of teaching practitioners to give their primary attention to practices and procedures which attend only to knowledge informed by technical medico-scientific paradigmatic thought. Regardless of the substantial and impressive contributions which have emanated from the influence of the orthodox medical paradigm, there remains the difficulty inherent

within all scientific explanation that other kinds of knowledge remain an unexamined resource.

The difficulty lies in the presumption that other kinds of knowledge - shared knowledge or common-sense knowledge - cannot be 'visibly' supported in formal learning and practices. The 'decontextualisation' of lay reasoning is a process which allows practitioners to approximate frameworks of thought informed by a "received view" or orthodox medical paradigmatic thought. Such a process of 'decontextualisation' becomes increasingly constant in the everyday world of hospital life where scientific focal knowledge is amplified through technical specialisation and scientific-rational accountability. While undoubtedly unintentional by those who learn and practice, these processes are binding and leave a persistent disjuncture between scientific neutrality and extraneous expertise.

CHAPTER FOUR

MULTICULTURALISM AND HEALTH CARE PRACTICE

4.0 Changes in the Patient Environment

This chapter will show pervasive changes in the patient care climate at University Hospital. In this section I will attempt to make more visible the evolving multicultural needs of patient and family clientele and the way this development in the hospital creates pressure for change in the daily lives of practitioners. I want to show how a particular change in the need for care and practices in the health care climate also creates pressure for practitioners to attain differing kinds of knowledge and expectations. I will attempt to show through the voices of practitioners, how the gradual appearance of the need for change has been growing, which has also demanded differing knowledge and decision-making practices in professional health care.

The evolving need for multicultural nursing and practice presents important claims for knowledge by practitioners at University Hospital. For in addition to standard treatment requirements and established models of care a separate form of knowledge surfaces which might been seen as an addition to standard practice knowledge in order to fully maintain satisfactory quality care. Many patients seeking Canadian hospital services, have knowledge for example, of neither French nor English and require special services such as language translation and medical interpretation in terms of understanding some of their questions, concerns and fears. Many are trying to cope with the experience of being a refugee or with the experience of the long processes and difficulties of

immigration, in addition to sickness and illness. Within these special experiences, being an immigrant and a refugee have special kinds of health implications. For example, the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees states:

> People usually choose to become immigrants, whereas they are forced to become refugees. This increases the risk for emotional disorder. Many refugees have experienced the loss of a house and possessions, the death of friends and family, internment in refugee camps and perhaps torture, which breaks minds as well as bodies. To add to the trauma of their past, when refugees arrive in a country of asylum, they are usually poor and are cut off from families and other sources of social support (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988, p. 5).

Many patients seeking health care at University Hospital are living with illness and coping with treatment within a special life knowledge which is often shaped by their own cultural and personal life world experience.

Bearing in mind these latter concerns, I want to consider them in the context of patients and practitioners at University Hospital. Here we are concerned with the growth of particularly specialised needs for culturally sensitive treatment and care which have been creeping in pervasively over time, and the way practitioners see and cope with these changes. Moreover we will consider the way in which these same changes come to be constituted within a technico-medico-scientific discourse, which in turn organizes and maintains health care practice in everyday hospital life. In this context, I will argue that the evolution of need for culturally sensitive care is embedded within a process of a restructuring which is not always immediately visible in the setting. In this regard, I will argue that these changes 're-conceptualise', redefine and make possible formal claims to multicultural knowledge and action. This is visible in the voices and practices of

practitioners and patients in their day to day relationships. I will also argue that these legitimate claims to multicultural health practices by both practitioners and patients are, in fact, subverted by the priorities, interpretations and choices underlying broad level government health care policies. Most importantly, the broader health care policy discourse makes the work process in the hospital setting accountable through a process of 'textually mediated organization' (Smith, 1990). And despite the evolution and development of pressure for change in clinical practice, the knowledge and training that currently equips practitioners does not always serve them in a multicultural service setting. Rather practitioner training becomes increasingly separate from the day-to-day means of decision-making. Moreover, formal claims for multicultural knowledge which might accommodate practice needs are displaced and embedded within a formal "documentary process" of medically determined care which comes to dominate and prescribe their work.

4.1 "Almost a United Nations": "Not Really a Problem"

Many practitioners at University Hospital express pride and pleasure with the opportunities they have to work with "people that come from all different cultures" (21:1:1:1993). They will tell you that they like the work they do and the many unique opportunities that they gain for new learning experiences, both within the reciprocity and collegiality of their immediate peer group, and within the exchanges that take place between themselves and the patients they care for. If you ask practitioners how they see working in a multicultural setting, they will express this opinion in a variety of ways:

> **Nurse Practitioner:** I think it's really neat - I don't - I don't look at University Hospital being a very different hospital from the -- (another hospital in town). I often wonder to myself why I really liked working at University Hospital and I think it's the people that come from all different cultures. (pause) Patients and families are always teaching new things and about where they're coming from. (pause) We have first generation Portuguese. (pause) There's always something new they're teaching us about themselves (21:1:1:1993)

> Well, I find within the hospital setting that there are so many people from so many various backgrounds that I get a very clear sense of how they think and how they react and how they behave, in their own way. (32:1-2:9:1992)

> Oh way back, when I was a student nurse here, there weren't people from anywhere other than - ... whereas working here now, there's a whole United Nations just within our staff. I mean if you go to X unit, it's like a mini-United Nations down there. (14:10:12:1992)

> And I do notice that the nursing staff comes from a vast array of countries and (pause) which is wonderful because they're able to address the needs of the patients from those countries. *Almost a United Nations.* (32:4:9:1992)

Some practitioners attribute the continuing growth of cultural understanding in both practitioners and patients at University Hospital to the "relative *lack of problem* in having to work together." They argue that the variation in nationality and cultural identity allows a built-in sense of understanding and sympathy in the process of working together, and the possibility of learning from one another, an opportunity which in other settings, might not be available.

> I think the beauty in a way, of being at (University Hospital) is that it's not only the patients who are multicultural (pause) it's also the staff. So if you're dealing with a population where it was just the patients who were multicultural and it was just anglophone physicians and nurses who were treating, I think there'd be a problem, because I think there would be a lot of frustration a lot of the time coming from the delivery people, from whoever delivers (the care) and whoever gets the care ... (pause, change

> in tape side) but as we were saying, the fact that the health care workers are as multicultural as the patients that we're treating, I don't think the problem is as significant here as it might be in other areas ... I think we actually learn from the co-workers we worked with that are also from other cultures, you learn from them and that helps ... (20:13:10:1992).

Other practitioners are able to look back over time and recall experiencing "different kinds of needs", and being "surprised" about the culture of their patients (16:3:9:1992). Still others do not recall the changes at all and say "I can't even begin to remember, it seems that this hospital has always been multicultural" (34:13:12:1992). Individual practitioners voice a wide range of observations about the direction of change in relation to the increasing variation in the cultural needs of patients:

> **Nurse:** When I think back to way back when, when I first came (pause) this wasn't a culturally diverse institution in the way that it is now. I think in the early 70s, not only was the type of illness that the patients were admitted with different, but I think the backgrounds were different. And I think it was when I came back (from being on leave) that I really *became aware and to notice* that the patient population that we were dealing with, the clientele that we were serving (pause) perhaps because our sectors at the time were in a different area, an area where a lot of immigrants come in to live (pause) *all of a sudden it seemed to me that we started having patients from different cultures in the hospital more. And very often, I mean I knew nothing about a lot of these people and their backgrounds and where they came from and I can remember being very surprised by some things.* (16:2:9:1992)

Some nurses identified the changes as a problem of needing to know and act according to unforeseen needs. For example, one nurse saw changes as an issue of "knowing where to start":

> **Nurse Manager:** I've been at (University Hospital) for thirty years, this length of time so *I've been an observer* of the cultural changes here and *the hardest thing is to know where to start.* If you talk about culture as being the country of origin, I've seen tremendous changes over time in hospital personnel, patients, nursing personnel. When I first came, the

> hospital was staffed by hospital grads from my own background ... Over the years that has changed enormously ... (36:1:9:1992)

Others saw the development of a changing cultural population as a matter of being able to get used to 'differences' in the setting:

> **Nursing Student:** Well *I've been here for five years, so I've been able to get used to the setting* ... I mean there's a lot changes, so many people speaking different languages, so many diverse cultures ... (29:1:3:1993)

Another nurse saw 'changes' in terms of exposure "over the years to different situations".

> **Nurse:** I've worked with pretty much every culture that is around at least in this city. Being here (at University Hospital) and having trained as a nurse here, I've been a bedside nurse for most of my life and over the years, *I've been exposed to a lot of changes and different situations.* (20:1:10:1992)

One nursing student saw "the need to change my approach" as connected to listening and reading about differing 'stories' of people in her care.

> **Nursing Student:** I think the nursing here is very multicultural - *I mean I'm getting used to it now and I listen to people's stories or read people's charts and from what kind of background and what kind of life they've led and it helps me to change my approach* ... like knowing if the person has had a hard time or a hard life. I mean when you realize that you have to accommodate, like the language barrier (pause) but I find there's always ways of getting by that ... (18:2:1:1993)

Another practitioner did not feel they had seen the need for changes in thinking and practice around cultural concerns in the health environment. This practitioner saw clinical practice as continuing in very much the same way as it had done previously. She saw patient's concerns not so much in terms of whether differing needs and expectations for learning and practice had been legitimated within the process of on-going

developments in the hospital, but whether indeed she should continue to expect *"more"* changes.

> **Nurse:** *Well the population has changed (pause) I've always been here, so for me, I haven't seen it as changing. It's always been "do we see more of it? Possibly* ... (20:11:10:1992)

Other comments revolved around changes in terms of the question of *knowing* how to get necessary cultural information from the patient in order to competently investigate relevant issues for daily practice.

> **Nurse:** If (in practice) you're asked to delve more seriously into certain issues, then you need to find out more about certain cultures. How do you get at *the information you're looking for? I don't know (pause) I've always been here, so to me, it's always been a United Nations here. I've never seen it less than that.* But that's just me. (20:11:10:1992)

The voices of these practitioners tell of several happenings with respect to the changes which have occurred in the population at University Hospital. On the face of it, we hear that the hospital cultural climate has seen a number of changes. We hear that people coming from outside Canada have sought health services and treatment at University Hospital and we also hear that practitioners themselves seek employment at the hospital. These changing cultural events might also lead us to believe that the practice and knowledge needs for care would also formally change.

At times it does become evident that practitioners visibly see these population changes in terms of "language changes", "diverse cultures", and "types of illness" (29:1:3:1993). And it does become clear that practitioners must try and "get by" and "accommodate" the cultural changes (18:2:1:1993). Practitioners also see that they must

try to manage cultural care and learn whatever they can on the job (20:13:10:1992; 18:2:1:1993).

What is not so readily articulated in the voices of these practitioners, but is evident within their accounts, is the presence of a legitimate claim to multicultural health care knowledge. For while practitioners do *see* changes and indeed, embrace the environment in which they must work, the formal work that is organized for them and by them, and is expected of them, is designed by the orthodoxy of western health care practice. And the work of "getting by" and "accommodating" cultural needs must be absorbed within this orthodoxy. It is this orthodox policy framework which occupies and maintains the legitimate space of health care and which subsequently determines the everyday "getting by" practices and activities of patients and practitioners.

4.2 Patient's Talk

One kind of talk which can be heard commonly amongst patients are reports of various kinds in relation to the experience of care they receive in hospital. Many will recount stories of their progress and the experiences of care and treatment they receive. Some of it they are happy with and some of it they are less happy with. They have a variety of views on what constitutes a patient experience, what happens and how. My concern here is neither to affirm nor disclaim patients' expressions of care, but rather to explore the formal practices within which their experiences are embedded. Patients' stories are the grounded experiences of sick people and their families. They are located both from the inside experience of their suffering and within the specific organization of

day to day health practices. Their voices exemplify how their sickness experience not only disrupts the fabric of their everyday personal lives, but also how these experiences are inextricably interwoven into the structuring of a health care system which embodies the specific interests of western health care practices. They speak of the crucial everyday workings of treatments, medication routines, reports and smaller conversations with varying officials and health practitioners, nurses, doctors, orderlies, social workers, secretaries and at a time when sickness and suffering is at the forefront of their experience. If we look closely we can discover through their words something about the social context within which these activities are embedded. This is because patients talk about illness as they experienced it in the past, what they experience in the present, as well as what is looked towards in the future.

One of the most striking things about the many views of patients in in-patient settings at the hospital is the appreciation and admiration of the care they receive. This is readily illuminated in the wide range of vocal expressions by patients and family members receiving care.

> I think the hospitals here are some of the best of the world - the treatment (pause) there's no doubt that the Canadian health system is, you know (pause) the best. (6:7:2:1993)

> They do everything for him. They give the treatment. My father can do no wrong ... they helped him ... we took a good hospital. (7:2:1:1993)

> They take care of you (pause) they tell you how to get better ... a lot of benevolent people ... they tell you it for your life. (10:1:9:1992)

> They are doing their best to help me ... They tried some more medication this morning because the other wasn't working. They are very, very good. (5:1:4:1993)

> My mother adapts well. She had three operations I told you and this morning they (the doctor), told her they still don't know what's wrong. But it's not like she's stressed. She's doing fine. He told her she's going to have more blood tests and maybe x-rays and something else. But they are very good. I think it's one of the best hospitals. The doctors are good. They are all good. (3:1:4:1993)

> We got in the next day. So that was good. From there we went straight to the top. (7:1:1:1993)

> **Patient:** And like Dr. -- he is treating me now, he is very nice. And when I tell him what shall I do? Don't worry - it is our problem. It makes me more relaxed that he is worrying about me. I can relax you see? (1:1:4:1993)

> And when I go to the emergency (pause) the nurses, they have all the information from before. It is good and they can tell what it is that I need for the sickness. They tell you this is it. Take this it is going to help. Some of the nurses, they are wonderful. (1:1:4:1993)

> **Patient:** My father he was satisfied when he found out that his doctor was top man in this place, so he had confidence. (7:2:1:1993)

> **Patient:** They (the doctors) are interested in the sense they're doing their job. They know what to do and they tell you. (8:2:1:1993)

> Is good, oh the medications. I have medications, every month, for the stomach, for the nerve, for that pain. The three (pause) next month, I get the other prescription. Is good. Doctors and nurses they helped me. (2:1:4:1993)

And yet many of these same patients and family members, notwithstanding appreciative affirmations of the care they receive, struggle to understand and make sense of the process of giving and receiving treatment.

> *I think they kind of have to be (detached)* because there are so many people going in and out of hospitals and you wish that maybe *they could be more emotional but maybe its better for them to be a little insensitive for their own - for them to do their job day in and day out - because if you start getting too emotional with patients, like us* for sure, every patient has a sob story and I'm sure a legitimate one. But I find that a lot of people that go into hospitals, they say "oh they don't care" (pause) they're just doing their job. Well, maybe the doctor spends two minutes or maybe five. Well I can understand that a little bit - *but there is maybe a little bit of separation from people.* (6:6:2:1993)

> *They don't always have time when they tell you something.* I got frightened when I come to have chemo. I'll have to take a pill to relax because I imagine I'll be sick, more sick. Then he started giving me antibiotics and I become better. But I didn't really talk to him. *They don't have time. Too many people. You have to understand them.* (1:3:4:1993)
>
> *I think doctors and nurses, they have to be insensitive. It protects them.* When people go to the hospitals they have more hope than fear. Who wants to tell a person that maybe soon he's going to die. It's hard. (16:4:9:1993)
>
> With them (clinicians) you have instant communication. *You might see them for 20 minutes in one day, but they're constantly with you, they talk to you, they ask you questions* ... (7:3:1:1993)
>
> They're busy, these doctors, they have so much to do ... (7:3:1:1993)

In another vein, when many of the same patients and family members talk about their experiences of formal treatment at University Hospital, their sense of felt absence from the professional culture becomes apparent in another way. For example, they feel that the health practices of which they are recipients creates a personally sensed distance, and a lack of belonging amongst the many interchanges which take place between themselves and their caregivers. They will tell you that their sense of distance and aloneness happens most visibly and is most acutely experienced through varying difficulties of comprehension around the language of the health care profession. They will tell you that medical talk, already complex in terminology, does not always come "in terms that I can understand" (17:5:3:1993).

Notwithstanding these concerns, patients and families at University Hospital who do not speak and understand the spoken everyday language of the institution must cope with several levels of understanding around the meaning of their care. In two such examples, they must not only try to make sense of the semantics of simple word

meanings when they are spoken to, but patients must also expect to understand and respond meaningfully to the technical language through which plans for their care are communicated. As one family member put it:

> **Family Member:** My father is in the hospital and he speaks only limited English, ok - but he speaks English, understands, as long as you speak to him at the level of whatever he's understanding and that may be grade 4 or 5 or 6. And then came the physician and said to him "Mr. X, you're situation is complex because you have a respiratory deficit on the left lobe and what you see in the x-ray is that you may have inflammatory process" - I mean that kind of terminology. And even me, I don't always know what's being said ... so give it to me in terms that I can understand. (17:5:3:1993)

In addition to this visible example of misunderstanding between the 'professional' culture and patients who are cared for there is a less visibly perceived reality. What we also see is an unquestioned regime of practice which is inextricably interwoven within the practitioner-patient exchange.

> **Patient:** Yeah, lots of people here especially after the operation. They put the tubes here and here and here. They tell me before I need operation, they explain me I need many medicines.
>
> **Interviewer:** And were you able to understand what they were telling you?
>
> **Patient:** No. Not understand me. But everyone very nice here ... speak English. The English language in my country (there) I had the school for the English.
>
> **Interviewer:** *Do you know what is wrong? Why did they do this operation?* (Interviewer gestures to operation site).
>
> **Patient:** *Emergency bring me here. I tell them I no sick. I stay home. Maybe yes, maybe no. I think so, I have the cancer. But maybe (they) bring me here for the infection* (2:5:4:1993).

Notwithstanding these struggles to understand and make sense of the care they are given, patients will also tell you of other struggles which are a part of their lives. For

when many of these same patients at University Hospital talk about their experiences, the life experience which is ingrained within their disclosures also becomes visible as they talk about themselves in the health care world that they begin to enter:

> **Patient:** I come, my country, I born in Yugoslavia. You know, now the war in my country, my brother to Germany. No see my brother, now the war there the people is the doctor. No medicine, nor no make the operation, must make the operation with the kitchen knife. Cut the legs, like that (gestures with hands). My daughter caught in machine gun (pause) Just close the operation, no problem (pause). No dead, is no dead. Just lose the legs, the operation was very good (pause) very, very, very good. (2:9:4: 1993)

> **Patient:** I'm no important for them (that country). Nobody try for me. Too much suffer, too much suffer. Too much. Now I get help (pause) government money. Canada is good. I get help the hospital. (This) my country, opening door, take me as citizen. (2:2:4:1993)

> **Patient:** Today, I am here almost 25 years ... I come from Prague, what is that (pause) revolution (pause) I am trying my best in this country. Nobody is here (pause) My sister, my brothers stay in Prague. I see my sister 1969. (5:2:4:1993)

And when we go on and hear more of the life stories of patients and families at University Hospital, we also become aware of what Arthur Kleinman has described as the "lived flow of interpersonal experience in a deeply particular local world" (Kleinman, 1992). Taking this description further, the concern here is not how these experiences become 'reducible' to 'culture' or culture specific care, but how the need for cultural understanding may be seen within the organized practices of the health care system. In this vein, Kleinman has argued:

> . . . these facets of social experience situate groups and their individual members along axes of power such that the *force* of macro-social pressures - economic depression, war, forced uprooting, ethnic conflict, the social

> structure of illness and disability is systematically attenuated for some and yet not accentuated for others (Kleinman, 1992, p. 10).

At University Hospital, when we hear patients own accounts of their lives and the backgrounds, we hear such stories of 'social experience, stories of uprooting, personal conflict, incarceration and persecution. It also becomes possible to consider these patients' stories in connection with the daily organization of health care work.

> **Patient:** Well my mother is Ukrainian origin, born in Canada and my father was born in the Ukraine. I don't know much about my father's family. He left when he was seventeen or eighteen. He never talks about it ... We think they (his family) died in the camp during the war. (15:1:9:1993)

> **Family Member:** For my family, you have to look at a person's not age - but from where they come, from where they come, from where they were brought up, how they were brought up. A person from a small village in Italy like my father's, maybe 300 inhabitants knows what it is if you don't eat ... so if you know the background. (7:5:1:1993)

> **Family Member:** My mother is Ukrainian and she moved here from France 35 years ago and my father is African American, who was born in Harlem New York. And well, I'm a combination of many races. I guess I know something about racism. (6:1:2:1993)

> **Patient:** My mother and sister in Sri Lanka. They, now must not leave. My mother very sick, very sick bad. I go back, maybe I go to jail. (14:1:10:1992)

> **Patient:** I am Portuguese. I arrived here at the age of 12 or 13. I forget how old, just that I was very small. It was very scary ... at the beginning - almost shocking because over there you're very protected. You don't just go out alone - it was different - even going out, at work for speaking out - you couldn't speak out there until your turn - you had to be very meek and stay in the background. (12:2:12:1992)

> **Patient:** I was born in Canada, you see. But my father who was born in Lithuania. Was in prison before he came here was suffering a lot (pause) when just he came here. (13:1:10:1992)

These preceding expressions of life stories are multivocal. Yet these extracts from interviews with people seeking health care at University Hospital reflect one common feature of the hospital experience - they exemplify not only how special life experiences accompany people who enter the health care world, but how these facets of social experience situate groups and their individual members along many levels of power.

As we have seen here, the talk of patients at University Hospital may be understood in a variety of ways. But I want to argue here that their voices reveal the workings of a set of priorities and interpretations within the regimes of formal health care practices which do not fully account for the breadth and depth of patient health experiences. For in addition to these patients' descriptions of their efforts to understand and make sense of the time managed constraints which hinder meaningful exchange between themselves and their practitioners, is their *assumed* position of separateness from the means of health care decision-making. If we listen to the words in patients' descriptions of these clinical accounts, the word "they" becomes a focal point of reference from the perspective of the patient around his or her health care experience. This observation leads us to consider the organized social practice within which this language usage is embedded. "They" as perceived by patients. we might argue, are the health care authorities, the keepers of knowledge, the process of which is being related in these accounts.

Although patients know they find the essence of lifeworld cultural knowledge most readily in relationships, family, friends and community, those who believe that all knowledge is received are more apt to think of themselves as recipients of a clinical authority which is the source of absolute truth. As recipients of the authority of formal health care knowledge, patients often expect and are expected to accept the mandates of the care and treatment they receive with unquestioned agreement on choices and decisions. The following examples from my field work help to illuminate this point:

> **Family Member:** The operation was successful, they removed the tumour and all that and we asked why should have these treatments. And *the nurse explained that you don't need it, but if you want to increase your chance of not getting it (cancer) it's better for him.* So at home I was explaining to him (my father) right then, read the pamphlets, read the protocol, that's what they said to do ... *he was worried about losing his hair but his doctor actually assured him "You will not lose your hair. It's going to maybe thin out a bit, which is sometimes good if you have a lot." So that's it .. other than that?* (7:1:1:1993)

> **Patient:** He took my blood. We kept there two days. I want to see him. My sister and my niece, they stayed with me until 3 in the morning. Sometimes they tell you need medication, treatment. At 6 o'clock I go for the x-ray. They maybe take one minute. They are busy, they don't have time to waste their time. But this one minute, it will help you to continue. The doctor will come check me. *He will answer one question (pause) try and hear what he is saying.* (5:4:9:1992)

> **Clinician:** It is important to take the medication three times a day and one before bedtime. Dr. - will follow you and keep us informed of your progress and treatment protocol.If there are any other symptoms we will change your medication.
>
> **Patient:** Thank you doctor (pause) When you are sick like this you get so scared. *Like you want to know what will happen. You want to, like you don't want to worry, you want to sleep.*
>
> **Clinician:** If there is no change in the medication protocols, we will get in touch. In the meantime you shouldn't worry ...
>
> **Patient:** One day they see me, they say Mrs X, they say I have a problem with ... maybe infection. Maybe I have operation on the lung. He (clinician) speak on many elements, he say many, many things. I must have the operation, infection, too much blood I cough. *I no like (cancer) (but) I must have the operation, I scared. That's it* ... for my life. (2:1:4:1993)

On first reading these preceding accounts of patients' experience of illness are an immediate instance of suffering and the fear which often accompanies sickness. But again, what is also heard in these accounts is the message of conveyed 'rightness' of the treatment regime in which both patient and practitioner participate. These ideological dimensions of formal health care knowledge become filters through which patients and families think about and interpret the health care world. Many do not readily talk about or insert into life at University Hospital, the variations of life experience and other kinds of knowledge they have acquired. The dichotomy they make between what I am calling here, formal knowledge and the common-sense knowledge of patients, reflects the world they know and experience directly and the dominant ideas and images that are designed externally.

What these accounts convey to us is not necessarily that formal medical knowledge in the form of these ideas is wrong or misleading in content. It is that, at times, these dominant ideas and images claim a distance from patient's and families' special sense of what might constitute health knowledge. Other kinds of judgements and capacities are called into question, leaving the sense of ambiguity and ambivalence which can be heard in the voices of patients.

4.3 "Certain Things That Clearly Help Healing"

Bearing in mind these latter concerns, I want next to address a differing kind of talk. It is the kind of talk which is sometimes heard in the form of patients' self-disclosures about their own particular methods of taking care of their health as a practice which happens *outside* the formal system of care.

At the broadest level, these practices of health care which fall *outside* the mainstream orthodoxy of care are often associated with what patients will tell you is "common-sense" or "something my mother taught me" or "something in my culture". These 'common-sense' practices which patients talk about are acquired by the *built in* assumption of having to manage several layers of health care knowledge. This in turn means that there is a separation between formal orthodox knowledge and the kind of knowledge which patients will tell you they associate with 'learning from life' or "growing up with" and which they have experienced through family, community and the many moments of life's smaller conversations. Here we are not then specifically bound to a knowing which belongs only to life ways and folkways and traditional ways of doing

things. Here we are concerned with a way of knowing which is quite distinct from the formal medical knowledge found in textbooks or in formal health curriculum[16]. The concern here is with a less visible form of knowledge which is intricately interwoven within community, family and relationships of cultural practices. In particular, I am interested in the interaction between these personal and unique ways of knowing and the formal health care knowledge which structures the patient's personal illness experience in the health care setting. The overall task here is to make visible the organizational processes that are occurring which often function to conceal the patient's alternative knowledge, regardless of the good intentions of the individual practitioner.

In hearing the following patient accounts it will be seen that from many patients perspectives, knowledge regarding treatment and illness in reality, often works at two differing levels of understanding.

> **Patient:** So then I just started reading, you know ... it's hard to explain (pause) there's your kind of information, the kind you learn, you learn it in school and then there's what I know. I mean ... you know, I find there's a lot of knowledge about nutrition - *well we know a lot, but unfortunately they don't emphasize it*, I think enough in hospitals. (7:2:2:1993)

For patients who have experienced differing lifeworlds in relation to North America, common-sense knowledge has a special place, in that it comes from living and working in activities that are embedded in experiences of extenuating circumstances. Sometimes this embedded knowledge becomes apparent in the immediacy and vital moments of the need for treatment and care. As one patient put it:

> Sometimes medicine for stomach good, here it no look good, the vomiting very strong. I go to emergency (pause) very strong. At my house, my place, I have this medication, you take it. The best thing in Yugoslavia, the best drug.

Interviewer: Can you buy it here in Canada?

I don't know. Because the Yugoslavia give it out, the people sell this, the people. (2:19():4:1993)

They use the herbs (in China) ... I don't know the name because usually we just know the Chinese name ... You eat it with rice and vegetable. It's a kind of medicine. It is not that fast because they want to balance the body. Need to balance the body, Chinese way. (28:6:9:1992)

Sometimes I would get the worst pain in my wrist. I said to myself) look, I'm not I'm going to do something else for this. So I saw a chiropractor three times a week and the pain just went away. (7:5:2:1993)

Sometimes common-sense meanings of health care vary in that, they relate to a way of assessing or judging a situation on the basis of what people have seen or know to be true. It is not only a phenomena associated with traditional beliefs and ways of doing things, rather it grows out of the wisdom of lived cultural and biographical experience. For example, some patients and families believe you can assess the 'truth' more reliably if the person is, in body and mind a demonstrable example of good health.

Like my grandmother. She came from India ... she knows a *lot because she has seen it. I believe what she says. She knows about all of these sicknesses. She didn't learn it in any school, she just knows what to do and well, if you're 92* ... (16:9:10:1992)

If you want (pause) *if you are concerned about health, you should go to a person that is healthy*. That has radiant health, that's content, that knows life, that's aware, you know. I'd rather take advice from a person like that (pause) *so one of the things that's lacking is the application of your own knowledge.* (6:5:2:1993)

It's been my common-sense that has gotten me through ... you see a person who doesn't drink and he doesn't smoke and you say well maybe that's it. My dad smoked all his life and there was this guy and he said look, you can have more pain. You know you can do something. But my dad couldn't stop ... I can relate to this now.

In many of the workings of hospital care and treatment regimes there exists the underlying assumption of a barely visible conceptualisation of personal health experience. The vital moments and mediations in everyday life are not always readily and fully visible. In health care practice, rather than a process of working with these affirmations of tacit wisdom, getting well is often exclusively related to actions based on the legitimization of explicit medical knowledge. Clinical tasks, treatment protocols are designed to fit the medical framework, and thus clinicians are trained to exercise the filtering down of medical knowledge. Patients and families know that they must expect and be expected to accommodate the formal medical framework. They also know that they must learn to make choices between which characterises much of medical care, and a less visible but every-present 'other' knowledge.

As one family member states:

> I asked the doctor, I said - and you know she was overweight, and she just had an operation and everything (pause) and I asked him, I said "doctor is there anything she should change in her lifestyle? In particular her diet, you know, because what you put in your body generally, you know, affects your health. It's the main thing that affects your health. You know. *So he says, well, the North American diet is just fine. And he didn't say nothing about vitamin A, betacarotene you know, and by taking extra vitamin C to help start new tissue* - nothing. And like, this stuff I've known, I mean I didn't study this stuff in university. I read this stuff. I maybe learnt it from my grandmother. You know. You can read it in the libraries. I don't learn it from the North American system. *So he says, the North American diet is fine, which is not true. Maybe he was taught that in his medical school textbook and maybe it's not his fault individually. But you know there are certain other things that clearly help*, (pause) *clearly help healing* and all this (pause) he didn't say nothing. That's all he said. (4:6:2:1993)

From this family member's account, it becomes clear that some illness and health meanings have a highly valued role that extends in patients' minds beyond the boundaries

of the health care system. It is not always legitimated by what the mainstream orthodoxy can teach, but by what you can teach yourself. Sometimes patients can tell you that they have a kind of wisdom which is learned and understood through extenuating circumstances or by what has been learned through the 'school of hard knocks'.

> Well it was probably (pause) it was very (pause) it made me realize a lot of things. There was a lot of things that happened because of my mother's illness (pause) it *triggered a lot on my own personal behalf in terms of acquiring knowledge* about human health, what's good for you, what's bad for you. (2:6:2:1993)

Sometimes the mainstream orthodoxy would appear to be challenged by the alternative beliefs and accounts of practices which we hear expressed through these voices. It becomes challenged by another form of training and experience, an alternative way to conceive the world as knowable and familiar and give it a personal truth.

> My mother comes down from Argentina ... so they were using this kind of herb. I don't know what it is, but something she was drinking ... *she didn't tell them here ... it's mild you know*? It just calms your nerves ... (pause) you mix it with water. It helps you sleep ... and the tisane there for them (my parents) that's so common. Then there's another herb - a medicine that she grew up with from her country. Well (pause) camomile tea, that's more or less regular. (4:4:4:1993)

Yet despite the presence of acquired wisdom and the claim of many patients who recognize and validate solutions from others who are 'health wise', patients are also clear that they must utilize this wisdom within a subterraneous world of 'other' knowledges. For example, when alternative ways of approaching illness and health are practised, patients will tell you that they do not speak about within the professional health care environment. Alternative knowledge is maintained by families and patients within the private realm. This creates a disjuncture between the voice of medicine and the voice of

the lifeworld which comes to be heard in the voices of many of the patients and family members at University Hospital. The following examples from patient and family talk illustrate these concerns:

> She (my mother) started developing some kind of bladder, kidney type infection and they had in hospital for 10 days. They gave this drug. I don't know what the heck it was ... (then) I went to Chinatown & I spoke to one of the doctors and said listen, she has urinary tract infection. Do you have something for this? So he gives me these - you know, a little box of $2 a piece for like 30 pills or whatever - and it's basically organic and herbal - just as a herb can kill you if you know, a herb can be poisonous (pause) well in the same way, it can be healing to the human body, you know. *So I told my mother, get off these pills that they're giving you, they're not working. So she went off, but she didn't tell her doctor.* She took (pause) there are like 5 little black pills, whatever, you take 5 of them 3 times a day. She went back to the hospital, they did the test and the infection was gone. *They couldn't figure out how.* (6:3:2:1993)

> Pierre, one man I know of, he has actually cured a lot of people of cancer ... maybe it's hard for some to believe. He had a medicine ... it's not expensive and the way it works is, it's an immune enhancer ... you go and get it from these guys. *You don't tell the doctor, maybe the doctors know, maybe not.* (6:8:2:1993)

> Maybe use Chinese medicine - balance the whole body. Y'know if you go to Chinatown and pass the Chinese herb shop. They have a doctor in there then they'll see what's wrong with you and they'll come in your house, see your pulse and your blood ... In the western medication *maybe not good, need to ask permission government.* (17:1:9:93)

> I did ask Dr - like, you know, I said, all these complications she's starting to get ... Anyways, he says oh, of course, chemotherapy is highly toxic because your liver - it's the detoxifier in your body. It's the thing which has to work really hard to detoxify anything that's not good for you ... And I didn't want to disturb him he was quite busy, but what he said was, the way he put it, was like a cue for me ... *saying to myself, this is not it - you'd better start looking somewhere else.* (6:17:2:93)

From a broader perspective, what we are also attempting to understand is the point of disjuncture in the way in which the medical model is embedded into the lifeworld of patients. It is not that clinicians and patients choose to disregard those they care for and

the alternative views and experiences they bring forth to the health care environment but it is argued that they too are conditioned within the arrangements of the formal knowledge which directs health care practice.

Thus in the discourse and in the formal practices there are depths and complexities of the way of health care knowledge is organized which interpose between local actualities experienced by patients and textually mediated clinical realities of medical and nursing regimes of practice. These ideological filters have the effect of subverting formal aspects of other world understanding. Patients' experiences in the form of personally lived experience and wisdom are not always made readily visible in the continuous shaping of the 'aura of factuality' (Atkinson, 1988) of clinicians routines.

CHAPTER FIVE

HEALTH CARE AND CULTURAL MODIFICATION IN NURSING PRACTICE

5.1 Reflexivity, Culture and Nursing Practice

Some nurses do reflect on their own assumptions of medical practice and will readily recall misunderstandings over what they say, are "conflicting orientations" of models of patient care. Some will tell you that their efforts to maintain and uphold the medical orientation by which they were trained, and which originally served as a direction for their nursing, doesn't always work. As one nurse put it:

> **Nurse:** One patient I had a number of years ago in the day center, a young Spanish girl, and she was quite psychotic and her family had come from the Basque area of Spain ... and they actually took her to their local healer in their area and went through some ritual with her to have her cured because they almost believed she was possessed and that was the first time I had ever run into anything like this *and I'm sort of saying 'but my medication's good' and the family would say* "oh no, oh no, someone has done this" (to her), and I remember going to the doctor and saying they're all delusional, the whole family has this delusion, "what are we going to do?" and I felt like the outsider because it was something that I didn't know and I couldn't really understand ..." (16:9:3:1992)

But with other practitioners it sometimes became evident that their practice was reflexively shaped by the dominant health care paradigm. Another nurse expressed to me a cautious view of the notion of incorporating the patient's beliefs and traditional ways of coping with illness into their everyday nursing care. This view was shared by several of this nurse's colleagues. As one put it:

> I think (treatment) cuts into the culture in the ritual that they observe. But as to their understanding of the disease, I don't think it's particular to any one culture. Their acceptance or denial of the disease may be a psychological problem ... in some ways, cancer affects different cultures somewhat differently, *but I still think the end bit is how much acceptance of the diagnosis and how much they are willing to work with cancer and staying well.* (38:4:4:1993)

These practitioners engage with their clinical world *as if* it were correct by definition of its reality to them. And within the process of this 'self-conscious' engagement, they act and practice on the basis of that perceived correctness. Other practitioners believed that alternative healing methods and the culturally related practices brought in by their patients and families might work out in the ward under certain permissible conditions.

> **Nurse:** There's (still?) we find in some of the Eastern cultures or the Oriental cultures, a lot of belief in, I don't know if you want to call it folklore or whatever ... *but in their different healing, their different medicinal traits(?) that they have, whereas they use these and as long as it's not prescription drugs that they've brought in from the outside it's allowed. They still end up taking the medications that are prescribed* for them here on the floor. (15:10:12:1992)

> Then you have other people, there are Chinese who practice holistic treatments here (pause) and they won't take any of the medications and *they just prescribe to their own holistic treatments that they have but they are still tended here on the floor.* (14:10:12:1992)

And in another interview between my self and a nurse, alternatives to standard treatment regimes were "allowed" from the perception of reality of the practitioner as long as the 'orthodox' regime was unaffected (14:11:12:1992). This nurse also raised the issue of "legality" with respect to alternative healing:

> **Nurse:** *We've had faith healers etc. come in here to tend to patients as long as it's nothing invasive that could jeopardize their health so to speak,* when they are in the hospital ... and *I think it has to do more with*

> *legalities than anything else ... we're pretty open* in allowing all sorts of different things ...
>
> **Interviewer:** How do you think that came to happen? Because it is interesting that there's a sort of openness to alternative treatments.
>
> **Nurse:** I don't know why it did. *I just have a feeling probably because terminal illness is, I mean there's no hope that it's going to go on after a point and so why would you even take that hope away from the person.* I mean if they hope this is going to help them and if their belief is strong enough, *who's to say it's not going to give them another week (pause) and I think that's probably why we've never withdrawn anything like that.* (16:9:12:1992)

This nurse also worried about the lack of existing knowledge around nursing patients from other cultures, noting "there are a lot of sub-cultures that are different as well" (16:10:12:1992), arguing further "that even if educational videos or booklets "could be broad-based" with "pointers that are important" (14:10:12:1992) it would certainly help.

Speaking about needing more education this same nurse related an experience of a case which she described as a learning experience, but which also posed a clinical dilemma:

> **Nurse:** (the patient) was a young man from China and he had been here for about a year and his wife had come over ... and he was diagnosed with cancer of the stomach (diagnosis changed) ... But the big thing was that as his condition started deteriorating that he should die with his clothes on and the problem was that he was diaphoretic ... they (the family) wanted an undershirt, a shirt, shoes, socks, pants and everything, plus he was incontinent[17]. And so he had to be in these clothes 24 hours a day, so we wrote up this nursing care plan - I mean this was the most important thing (pause) if nothing else happened, this patient is to die with his clothes on ... and his wife came in and she measured him - it was supposed to be a suit but because he deteriorated so fast, they didn't have time to get this suit. (pause) And he was lying there, totally aware of all this, and she's measuring his legs and his chest, and he seemed completely unperturbed about it. (pause) But that was the only thing that the family focused on. That was most important thing to them. So we would dress and undress him every time we washed him ...

Interviewer: And what was it like for you, going through that process?

Nurse: It was much more fulfilling, I think, than just giving him care ... this gentleman died and he died with all his clothes on ... so the impact on me was totally different ...

Interviewer: Because you had a newly learned ...

Nurse: These clothes became a part of him (pause) it became a part of this total person and the family (pause) we couldn't have done anything more for him than that. I mean if we had done absolutely nothing else, other than having him die and be wrapped with his clothes on ... and we did that, and the impact on me ... I mean, it was totally, totally different. (14:5:12:1992)

And yet this same nurse later told me that the beliefs held by this particular family about wanting to take care of their dying relative in their own special way, "posed a clinical dilemma". The family's way of caretaking was a situation which did not get full support from "the team". It was "something which needed to be discussed" and understood and which "we had to come to an agreement on" (16:5:12:1992).

Nurse: This was the thing that we had to come to an agreement on. Because the other problems didn't seem to be problems, *although some of the nurses, I think at the time, felt you know, this is more of a hassle what we're doing and granted the amount of work it took, it was* because he was incontinent. But at the same time, you knew this is what they wanted. This was the only thing that was important to them, maybe it wasn't the right way. - like maybe his hair had to be combed the right way for you, but for them, it was (having) his clothes on ... that's the memory the family is going to have ... (14:5:12:1992)

Practitioners at University Hospital readily acknowledge their experiences in terms of the misunderstanding and ambiguity which sometimes face them in their daily clinical encounters. Some practitioners worry about misunderstandings between themselves and their patients in relation to unfamiliar customs and traditions. They worry about the contradictions which sometimes appear within social and cultural exchanges which they

see as inextricably interwoven with patients' expectations and responses responses around the quality of care they receive:

> **Nurse Manager:** There is an example that has stuck in my mind. There is a cultural situation that not only was a necessary part of that particular culture, which was in this case, Jewish Orthodox. There are people for example, in other cultures that have a great value in showing gratitude by giving. And very often it is, by giving food. Food is a way where we express a lot of things and we can see it during Christmas ... What is bad associated with this? (pause) the gift-giving of and *especially* of food and the gift itself? (But?) the culture of the institution is that if you give me a gift you maybe try to bribe me (pause) so this is one thing. The second thing is if you give me food, I really don't trust, you know, cleanliness, taste of food and so on. And what happened in this particular instance, all of these components existed. For one, people felt, the nurses felt and physicians that they were being bribed by the gifts, and the food. It was even worse because they didn't eat it, it wasn't their kind of food.
>
> **Interviewer:** So there was a kind of cautiousness in that respect?
>
> **Nurse Manager:** Definitely, I think there is, at times like this where the family, in this case I think realized, and at times was very hurt, when these offerings were not accepted. The staff was insulted, offended by the kind of offering the piece, the slice of cake was insulting to some of the staff. While for the person who had bothered to bake it, and put a lot of affection into that cake and wanted to give everybody a slice, it was a big deal. So, that area needed a lot of exploration and explanation (on) both sides ... (17:7:3:1993)

Some practitioners will tell you that they have difficulty in understanding and accepting the differing beliefs, and customary ways of approaching illness and treatment, of some of their patients. These kinds of statements can often be seen as operating reflexively, as practitioners attempt conceptually to coordinate their own organized beliefs within the orthodox health care paradigm. For example, the daily routines of hospital and ward life encompass within them an assumption of 'normalcy' by practitioners in relation

to clinical protocol and procedure. For many practitioners this assumption constitutes a finite province of clinical procedural meaning.

> **Nurse:** There are patients who've refused treatments, if you think of Jehovah's Witnesses *who've refused blood transfusions, a lot of times we see that in our area. And surprisingly, they did pull through the surgery, where you think they'd get into serious trouble (pause) somehow they did pull through.* But religious beliefs, I think is a problem in that (treatment) context and you have a hard time to understand why people are so touchy on certain subjects. (20:4:10:1992)

> **Nurse:** We had an issue the other day - a family situation where the mother was being treated in our area and was developing problems based on her treatment. And we were trying to find out from the mother what she was actually feeling and experiencing so we could do whatever was needed to be done. And the relatives were there telling the mother that she wasn't feeling the way she said she was feeling and then blaming us for trying to have the mother talk to us, and we were saying, "you know, if you're having this kind of symptom, let us know" and (then) having the daughter saying "no, don't worry Mom, you're not having these kinds of symptoms" and (saying) "don't tell her these things, it's not good for her". So that was a difficult issue. (20:5:10:1992)

> **Nurse:** Another issue that is sometimes difficult to handle is the whole situation of the status of women in certain cultures. Where women are considered less than men and therefore are not allowed to make decisions, and are not allowed to participate in decision-making. And the husband makes all the decisions (about the treatment and care), asks all the questions, solves all the problems and won't allow his wife to come in and talk about what's bothering her ... (20:4:10:1992)

Some practitioners, who in the routine of their daily practices, encounter patients and families living with the experience of a life-threatening illness will tell you that they cannot always find ways of understanding or knowing how to approach the caring of a patient who may be dying. Questions about family management of the cancer experience, they find, are sometimes limited by their inability to make useful sense personally, out

of the patient's traditionally defined needs and expectations. Contemporary theoretical models of psycho-social care[18] for example, which advocate talking about feelings, they do not always find useful realistically as a "truly caring approach" (22:3:9:1992) to the patients and families they encounter.

In the following dialogue, a nurse who routinely takes care of patients and families who know a family member may not survive an illness of cancer, speaks about the added level of difficulty in "not knowing" (20:8:10:1992) the special needs, in order to help and support a family as they try to cope with the death of a loved one:

> **Nurse:** I think, if you're talking about the whole issue around death as something that we on this ward deal with on a daily basis, there is the issue of pain and the issue of how I am going to support my family, how is my family going to manage when I'm no longer here. And there is the issue of who is going to look after my children now, while I'm sick and later when I'm not around, my husband's not going to be able to do it or vice versa ... If you're thinking in terms of different cultures, it becomes even more difficult ... and if you're talking about Anglophone or Francophone (patients) it's probably a lot easier to get them to talk. But the minute you get into some of the Asian or Eastern countries, it's almost a taboo subject.
>
> **Interviewer:** So then what happens?
>
> **Nurse:** The dying process tends not to be mentioned, I think truthfully. It doesn't tend to be identified as much as it needs to be (pause) I think if there were something grossly wrong, it would probably come out, but it's not something that's addressed routinely by those cultures. (20:8:10:1992)

Some practitioners see solutions to these differences in understanding through, what they describe as "flexible options," (17:10:3:1993) within practitioner-patient clinical encounters. Speaking within the province of meanings surrounding health care, they focus

their concerns around what they see as being "a particular approach (which is) required to allow for flexible options". A nurse practitioner explains:

> Let's say a person in her forties has advanced cancer, with two children at home and a husband. And she comes to the physician and the physician says "well, I have three options to offer you. One is conventional treatment. The second one is conventional with some advanced radiotherapy(?) and which we don't really have enough statistics to tell you that the results will be so much better. So the life expectancy may be the same as the conventional, but there's a chance that it's a little bit better. And then there's the third type of therapy which we don't know anything about and it's very rough, but who knows. So at this point, the patient says, well, my chances are no good with the first one. Maybe a little better with the second one, both of them are really no good. With the third one I'm gambling. (But) I'm going to take it because I'm really, I'm 40, I have two children and I want to live ... Now the physician says to the patient, but with this therapy you're going to be very sick ... it's going to be very tough, ... the patient would still like to ... and the patient says I'll take it. But we also have to be understanding that to maintain this third choice, that by delivering what we have delivered in terms of options it is not finished. This is not the end ... Now we go back to the cultural factor, everything that is there. Because neither the physician nor nurse in that initial interaction, starts initially checking with the patient what in their culture is acceptable for managing these procedures. *How is this actual decision-making and acceptance between the physician and the patient going to be managed within for example, their family practices. How does support in the community come into it ... should the husband take off work, etc. etc.* (17:11:3:1993)

What becomes evident here is not the single dilemma of whether or not alternative approaches to care may be accepted into the regime of orthodox clinical practice. What is evident, is the embeddedness of western models of treatment and care which are firmly established as accountable health practice. When nurses speak of "fitting in" and "allowing" (14:11:12:1992) in alternative treatment methods, the reality of their accounts lies in an underlying strict adherence to the dominant medical model. Alternative approaches and rituals of healing are brought into the space of the orthodox model by

practitioners. The reality for the practitioner is that these other healing forms are permissible but must remain an incidental occurrence within specifically defined work conditions. The problem is not that practitioners deny the usage of other healing ways. Indeed as we have witnessed they are frequently participants and modifiers in this alternate process.

5.2 Formal Training

Sometimes nurses will tell you that in the kind of academic preparation they have received things "they have learned" have not "really been helpful" (16:4:1992). As one nurse manager told me:

> **Nurse Manager:** I don't know ... I don't think there's anything specific in terms of nursing training or things that I've learned that have really been helpful. And in terms of my own life no. I mean this is so alien to me, that, I mean, I've had a really good life you know. I haven't had a lot of trauma or troubles so (pause) sometimes talking and listening to someone I think "what would I do", maybe I'd just collapse and crawl into a corner and be a mess if I was in that sort of situation. (16:4:9:1992)

> **Interviewer:** A lot of people have talked about models (of treatment and care) you know, finding a way (for example) the primary nursing model[19] has been mentioned which often people see as a sort of holistic model for getting things done.

> **Nurse Manager:** To me, any model is worth it only if something is happening in the basic interaction. So you can apply any kind of model, as long as you try to identify from your patient what is needed for them. I mean somebody - An example of that is a patient that wants to do things on their own. Maybe there was an issue of culture in it there too. Somebody who has been used to doing things on their own and then they come in and they are totally limited (by us), they are limited by what *we* have been taught. We are telling them well, you can't do this because here we are doing it this way. It's about everything else (other than what they want). I think that is the dialogue that needs to happen.

Interviewer: So are you saying that there is a certain way of treating?

Nurse Manager: Yes, in the sense of whether its under primary nursing or is it under the family nursing, here we are doing the genogram. Do we learn that it's always relevant? Is that always how you go about it? Anything I think, if we are not the basics of a good interaction (pause) maybe this is what the question is. What is good interaction? And to me, it's really understanding the other person's needs, all of those needs. And maybe they are cultural needs. At the same time I would explain my position as well (pause) it's not (just) me as the care giver. I would explain (to) you what are my limitations. What is the availability (of what the patient wants). And so within *this* framework, if I can match your needs, then I think we can find a way. (17:7:3:1993)

Others expressed the need to make a distinction between 'received' formal cultural training, which some practitioners maintained had been either absent or unclear to them, and the subsequent, independently taken initiative of seeking out formal learning resources. These practitioners felt 'compelled' to go out and find multicultural learning resources, claiming these as a necessary adjunct to their clinical practice.

Interviewer: Did you have multicultural content in your training?

Nurse: No.

Interviewer: There wasn't a course or anything?

Nurse: I think we were probably told that we needed to respect our patient's values. It was said in that kind of very vague ... (way?) but nothing that was actually stipulated as, as multicultural.

Interviewer: And have you had any other courses or any? (pause)

Nurse: I haven't taken courses on multicultural issues per se, but I read books here and there, not necessarily medically related but (pause) that have talked about various cultures. (20:13:10:1992)

Some practitioners are adamant in the hierarchical distinctions they make between the choice of learning through formal schooling and the lifeworld experience they gain

in practice. These practitioners argue that "going to the books" (22:8:9:1992) is not something that received formal priority in their training and learning about people's needs "by word of mouth" (22:8:9:1992), is often the expected norm. They will readily tell you that they did not expect to, nor were they expected to study cultural care needs in any formal sense.

> **Nurse:** I would never have gone, while I was studying. I never would have gone to the books. And later when I was practising, I would have gone by word of mouth, speaking to maybe Mario (Pseudonym) and saying you know, what's going on here? I don't understand between this Italian husband and wife, what's the problem? I wouldn't have expected to have gone to the books (pause) not at all. (22:10:9:1992)

Others recalled situations whereby classroom discussion of cultural care had occurred informally as an incidental or accidental response during the regular class learning process.

> **Nurse:** The nurses who were in our course were quite a wide variety: Portuguese, Greek, Italian ... I mean I don't know what (pause) everything. *And very often it just came up.* You know, people would be talking about their clinical cases, and someone would be Italian and said "Well, you know this is very relevant", and maybe they would have a personal family experience which they could tell you about ... (22:10:10:1992)

> **Nursing Student:** I went to one (pause) lecture, not at school, while we were (training) in the other hospital. And I did go to one at school. They have different things, different kinds of seminars that you can go to. But we don't have specific classes on it, but it came up often. (29:1:3:1993)

Many nurse practitioners will tell you that the challenges of working with patients from varying cultural backgrounds also brings with it the awareness that they must find practical and innovative methods and ways of knowing to accommodate these challenges and expectations. These practitioners, on a day to day basis, recognise that they must seek

out learning resources. Many will tell you as they come to experience cultural care, that "there is a lot to learn" (29:2:3:1993). As one nursing student put it:

> It's hard relating a lot of times, especially (in understanding) (people's) religions, more than anything, I know that people's cultures have something to do with it ... but *there's a lot to learn about people. (29:2:3:1993)*

Although nurses recognise the need for specialised formal skills in terms of the cultural care they give, they will tell you that much of the learning that takes place has to take place through the varying cultural interactions and experiences of becoming acquainted with people from differing lifeways and traditions. They will tell you for example, that health care learning and practice expertise often takes place by having a friend from another culture.

> **Interviewer:** Is it difficult in terms of knowing what to do because you're not familiar (with some of the needs of) people from differing cultures?
>
> **Nursing Student:** Well at first, now I'm becoming more aware of culture and religions - what (for example) people's beliefs are - even with Jewish people you know - just being Kosher - I mean I had no idea what kosher was, now it's a little bit easier.
>
> **Interviewer:** How did you learn about that?
>
> **Nursing Student:** Mostly through school and by patients well, coming here (to University Hospital) and friends that were from different areas of the country or city. This has been a unique experience the past five years. (29:2:3:1993)

Others will describe the process of learning as an experience characterised by "touch and go", which comes to mean the working through of both negative and positive face to face personal experiences. Recognising the process of learning by one's mistakes,

they claim that this trial and error process helps to understand "acceptance" and understanding:

> **Interviewer:** So could you say that (managing care) was a way of informal learning?
>
> **Nursing Student:** More or less.
>
> **Interviewer:** Yeah?
>
> **Nursing Student:** *More of touch and go.*
>
> **Interviewer:** Can you talk about that a bit more, has that been a sort of process?
>
> **Nursing Student:** Well, meeting friends first of all, when I came (to this city) and went to high school here. ... So just talking, they (my friends) might have thought I was stupid sometimes, some of the questions I asked, but now I'm more familiar, more accepting, more understanding if (a patient) tells me something, I'll ask questions more (now) than I would say (then) that's stupid or why do you say that. (29:3:3:1993)

Other students will attest to having learned from the physical and practical clinical trial and error experience of cultural differences such as, for example, lifestyle and habit around bathing routines:

> **Nursing Student:** Well some patients will go "whatever is fine with you." Whereas some will say "I like to do it". Even with just bathing in the mornings, some patients have this - "this is my schedule". I don't know if that's a culturally ... er .. something cultural or something personal. (34:2:4:1993)

In another vein, nursing students sometimes argue that formal schooling produces learning 'generalisations' about cultural care which they believe is more readily superseded by a higher form of learning of actually "seeing something". They argue that book learning is less than adequate when one comes to experience the needs for care and the way other people like to do things in practice.

> **Interviewer:** You say you learned from your life experiences in a way? Is there stuff that comes out of school that helps or is it really something that's very personal in terms of learning?
>
> **Nursing Student:** Well not wanting to be negative, *it's not when it's stereotypical that we learn things*, how cultures are ... and then when you see something in the hospital that's not like that, and then you wonder ... They're supposed to be (in the books) very passive people and not very (pause) not touching or very quiet and then when you see that, even the nurses who are on the staff saying, well this is not how they act, there must be something ...

Yet others will tell you that 'book' learning impedes and prevents practical life experience learning since it prevents a face-to-face process of questioning. They will say that book learning brings one to "expect" "stereotypical", "generalised" cultural behaviours, whereas actually 'seeing' what happens allows you to know personally from people, whether cultural care concerns are "true or not":

> **Nursing Student:** I think people are (stereotypical) too, they accept too much what a culture's supposed to be like (from the book) and don't actually talk to the person and see if that's (so?) ... when we're told if we had a certain patient, or something like that, you might expect a lot of screaming in the case room and this ... I mean not feeling, (that) they're less likely to express their opinion. *But I didn't get to see either of those cultures giving birth, so I wouldn't know if that was true or not.* If I would see it, I would know it was true ... (36:4:4:1993)

Yet others, when put in a position to compare book learning and learning from practical experience, felt that having the opportunity to start with formal learning allowed a beginning knowledge, which in turn created a beginning understanding for individualised personal care:

> **Interviewer:** There are some arguments about whether we should learn this way or whether it's learning that is something else. But what's the alternative? You don't have a book and you don't know how to approach it. How would you like to approach it? (learning)

> **Nursing Student:** Well it's hard not to group people together - and I think sometimes you have to because there are similarities in cultures, even if it is religion, if fifty percent of the culture has the same religion ... I guess you start with it there and move onto the patient and treat them like an individual, any member of society ...
>
> **Interviewer:** So if you treat someone as an individual?
>
> **Nursing Student:** *That means finding out about them* ... their own beliefs ... whether it has to do with the country they came from, the area of the country they've come from because it's a new identity they've adopted. (34:4:4:1993)

On the face of it, these preceding accounts of how practitioners go about understanding the sickness and treatment needs of the many different people they care for, would seem understandable and plausible. It is clearly to the credit of the professionalism of individuals that so much thought and problem-solving takes place with respect to patients' needs at University Hospital. It would seem clear that there are a number of differing views on how to learn about multicultural health care. And it would appear plausible that there are many learning and practice realities for these practitioners, in what constitutes for them the 'truth' about ways of cultural learning. What does not surface in nurse's talk is the embedded assumption of their conclusions. The reality of multicultural practice for these practitioners is derived from neither the direct result of an available choice nor from a *visible* structure of formal multicultural education. Reality, or the ultimate arrival of a practitioner's independent conclusions on how to practice culturally responsive care, is the legitimate outcome of orthodox health education policy making. And thus the nurse's stated position of having arrived at the 'truth' or rightness of what best constitutes culturally responsive care, or what is the best choice of learning opportunities, becomes an ideological construction. Because in reality, these perceived

choices of schooling which are referred to do not actually exist. The plausibility associated with learning from life experience and wisdom that we hear in practitioners' accounts is not in question here. What is being questioned is that these practitioners' constructions of 'truth' serve to reinforce the invisible - the formal conditions by which multicultural health care education, and thus care, may be legitimately realized. These individual acts of goodwill and sincere effort towards the working out of meaningful solutions, obscure the formal opportunities for systematic, consistent policy making to take place.

5.3 Learning by Experience

Implicit within this latter analysis are also the routine methods by which many practitioners at University Hospital who have experienced life as an immigrant, expect and are expected to practice, health care. Many practitioners who have managed to successfully fulfil Canadian medical and nursing licensing requirements are not qualified to help others only by their medical training. Many have had the experience of trying to cope with a new country first hand. Their accounts reveal that 'ad hoc' learning often comes as the direct result of a similar real life experience to those they care for. Some will tell you that this is the "best form of life's wisdom" (22:7:9:1992). Others will sometimes tell of experiences which have caused personal hardship, such as the loss of a house and family and their experience of war and internment. There are still others who must daily endure the knowledge and pain of the possible torture and suffering in countries they have left, but which are still devastated by war. These practitioners will

argue that personal experiences have enabled them to develop a special 'sensitivity' to the kind of reception patients sometimes experience

> **Nurse:** It's my experience (coming to a Canadian hospital) there were some doctors and nurses who allow me to express my own feeling. My own. But for some nobody give you opportunity ... So you give up. So with that point of view, you must say to patient, no matter who you are, "I am here waiting". This way, you will learn more from the patient. (28:7:9:1992)

This same nurse saw her ability to work with differing cultural understandings as the direct culmination of her own feelings of being judged. Learning came as a result of this particular experience and was combined with that of her patients:

> **Nurse:** Me our religion which everybody Buddhist you know, sometimes for me people judgemental ... For (other) religion, for the patient, I'm totally naive. You know, I have to learn from patients. For immigrant this is best. I no judgemental because religion is a very touchy subject. It's (necessary) to listen to patients, ask them about their background. You very *carefully*, *tentatively* (take a) learning attitude to explore their religion, background, so you learn more, then you can use your knowledge, patient knowledge and my knowledge. (28:6:9:1992)

Sometimes learning and practice meant 'feeling' the attitude of practitioners from the experience of one's own background.

> Because I have such a background you know, I *feel*. For example, I go to hospital myself, I'm a patient go to a nurse or a doctor ... I feel the attitude (towards) for patient I have learned from my own experience how it is for patient. (22:7:9:1992)

Other comments suggested that learning through the process of culturally experienced moments produced common-sense knowledge that take place without an inherent "philosophy of caring" (22:8:9:1992). As this same nurse put it: "I can learn, develop ... but the philosophy of caring inside doesn't change to me" (22:8:9:1992). "My

philosophy is, always, give 100% *yourself* when you take care of patient ... and then you will learn." (22:9:9:1992).

> No matter how the nursing pattern changes, practical nursing, the technical - I thought it out, it doesn't change me. Maybe you (here) learn different philosophy (of) nursing. You know, the people from different culture, my culture. If I see patient, very sad, she individual, I care, I feel the attitude for patient .... Look no matter how you change, but your caring that part you have, that's still there. (22:9:9:1992).

Thus in this nurse's view, culturally sensitive care ultimately happens as a result of a basic inner personal philosophy, based on personal experience, and not an external layering brought about by received and directed change:

> I mean if you, you know what I mean, what I am, you put (different) clothing *I still me, you know what I mean, so you cannot change a person* by primary nursing. To me it depends on philosophy (of) individual person, nurse, professional .... (22:10:9:1992)

And the wisdom required to learn and administer cultural care, this nurse tells us comes from the broader world view recognition of the notion of having an openness to others in society (22:11:9:1992).

> I think the culture, different culture, the people from different culture make the society more interesting to me you know and er I wish we didn't have the culture clash, we try to help each other ... if we can only accept. The world has changed so much it's impossible to close door as nation to nation, we talk about the common market ... you know of free trade I mean, in a small sense, a smaller sense which is our society, here in the hospital, *we cannot shut oneself from neighbour ... you know what I mean.* (22:11:9::1992)

5.4 Patients' Stories: "Initially Hard to Listen To"

And again, these preceding accounts of the efforts of professionals towards cooperation and partnership within their many clinical exchanges make imminently visible

the individual goodwill and personal compassion of many practitioners. On another level, these practitioners' attempts to *work in* life experience as a function of practice also obscures opportunities for these skills and experiences to become formally incorporated within a broad level policy framework. These individual moments of goodwill and cultural partnership are potentially the very same moments which could make visible the solution for formally acknowledged, legitimate and properly resourced, culturally sensitive care.

The call for better preparation of health practitioners in multicultural hospital settings is an even more pressing consideration in the accounts that follow. Many practitioners say they take care of people on a daily basis who have life experiences which reach well beyond the immediate moment of the clinical encounter on the ward. These same practitioners will tell you that frequently they feel unprepared and unable to cope with the care needs of some of their patients. For example, some spoke to me of the personal difficulty they sometimes experience emotionally when they are faced with many of the realities of patients lives. One nurse found some of these experiences hard to listen to. As she put it:

> **Nurse:** Most people who have been in concentration camps would not talk about the experience ... But there was one man who spontaneously started talking about his experiences in the concentration camps ... *You aren't really prepared for this initially it was very hard to listen to - you know, I'd seen documentaries and stuff but hearing someone and talking to them about it is much different.* But the thing that stuck out in my mind about what this man said was that the people who survived were the ones, that when they were given a cup of water they would drink part of it and they would keep part of it to wash themselves ... (22:1:9:1992)

In another account, a nurse explained that she finally managed to nurse according to the patient's needs, by shifting gears:

> **Interviewer:** Do you come across a lot of differing cultures in your daily experience?
>
> **Nurse:** Yes.
>
> **Interviewer:** What do you think about that?
>
> **Nurse:** Well I find that you shift gears very quickly and you don't realize you're doing it. But then very often you don't shift when you should and can't figure it out. And sometimes then you hear they've had a bad experience from before they left their country and you are yourself affected by it and it may be months before you finally realize how come something isn't working here. How come this isn't why aren't we on the same wave length - how come this person *still* isn't taking their pills or what am I missing. And then you start thinking about it. (22:6:9:1992)

Notwithstanding, practitioners spoke of what came to be called "routine management" and "dealing with" the clinical concerns of patients with differing life meanings and cultural histories. And they attest to this sense of 'routineness' in their accounts of their experiences of care:

> **Nurse Practitioner:** *Well you know, there are a lot of really sad cases that you come across* and it's really hard to understand - I mean there's a guy from Shanghai, an academic, who just got out, just before Tianamen Square. He was studying and was afraid to go back and he's separated from his family (pause) I mean you're always aware that these (patients) are very special human beings with these kinds of stories. (15:11:9:1992)

And other practitioners talk about "dealing with" patient experiences. They also tell of the pain they 'expect' in themselves that is evoked by their patient life stories.

> **Physician:** *I have a Cambodian patient who in life experienced what 'Killing Fields' in the movie showed - with the murder of his family and*

> *extended family* and flying from Cambodia, being pursued by the Khmer Rouge ... *we deal with it* ... (31:3:9:1992)

> **Nurse:** I think now I'm aware but the first few times that I heard someone who would tell me about the experience they had was for me personally devastating. For example, *I had a young man who was applying for refugee status - he's been tortured, he's a political activist (pause) and I very nearly left the room and threw up ... But you have to expect that ...* (16:4:9:1992)

Others speak of the "tragic" circumstances they encounter and try to grasp an understanding as to how patients manage emotionally. They wonder why more patients are "not so tremendously depressed".

> **Nurse:** Yeah, it's tragic that you leave your homeland in tragic circumstances. It's one thing to decide that you want to go live some place else but you know, they'll never be able to go home. It's got to be really tragic for them and it just tears everything apart. And it's devastating ... I mean, I often wonder why more of these patients are not so tremendously depressed because the losses are so great (pause) to me, in my value system, are so great (pause) but I think we have a big, you know, population of a) very diverse group of people which we have to follow. (16:12:9:1992)

> **Nurse:** I guess, we follow what we'd call "boat people", many of them have come from many war-torn environments. They still have families that are left behind and they are very, very distressed and you try to do the best you can I have one patient from Sri Lanka and he's torn because his mother and sister are in Sri Lanka (pause) they can't leave ... (22:7:9:1992)

When these practitioners describe their patients and aspirations it is clear that they "try to do the best" they can (22:7:9:1992). But these efforts to intervene in health situations which are not readily comprehensible, obscure the moments when provisions for multicultural training could happen. They obscure the opportunity which might be given for systematic cultural care.

5.5 "A Very Real Learning Experience"

In the same vein other learning assumptions centred around what practitioners identified "making things work by a system of learning easily from co-workers" (20:2:10:1992). They described an intricate system of reciprocal exchange of cultural knowledge brought about by the daily presence of interdependently shared patient-nurse cultural care and the inherent taken-for-granted willingness to share. Some others were focused on the process of learning in the form of an easily available practice of learning about special care needs from one another. These practitioners saw the resources that were available to them in their reciprocal daily and hourly interactions with colleagues as a readily available resource which they could readily draw upon at any given moment.

> **Nurse:** I think we actually learn from co-workers we work with and that are also from other cultures, you learn from them and that helps ... you learn from the staff as well (as in other ways) because coming from various cultures themselves, they will teach you things, that your patients won't necessarily tell you and they'll tell you how to possibly approach a situation or what is acceptable in their culture vis a vis whatever problem you're wanting to address. Or what is not acceptable ... *I think a few times I've just gone to people who've come from that culture and I've said, you know, how should I go about such and such a situation or can I say this to this kind of person and what are they going to tell me back ... (20:13:10:1992)*

Some nurses describe the practice of working with a variety of different cultural backgrounds as *"a very real learning experience"* (14:6:12:1992). They embrace these practices as experiences which are instrumental in creating new kinds of learning situations. And they describe learning in these situations as the result of encounters with very concrete and varied experiences of illness. This has been described in the literature as a form of practical knowledge.

> (But) theoretical knowledge derived from traditional medical paradigms contrasts with another kind of knowledge - "knowing how" or "practical knowledge". A practical knowledge paradigm emphasizes knowledge as embodied "know-how" that derives predominantly from extensive encounters with real concrete situations and their outcomes. (Gordon, 1988, p. 268)

Practitioners couple this embracing of learning experiences with "very real" concerns around being able to "care for these people in a beneficial way" (14:6:12:1992). Being "crucially" involved in a person's life had more of a guarantee of "rightness" that caregivers would learn and understand from their patients differing needs, concerns and understandings.

> **Nurse:** I guess it's (having patients from differing cultures) a *real learning experience* ... and as we have more and more patients that are from differing ethnic backgrounds, just the learning experience of all their different ways and traditions. It's interesting because there are so many and just how illness impacts, it's very different. *My concept of what I feel is right may be very different of what they feel is right.* We've really *got* to try and *learn* from people ... if we are going to care in a beneficial way. (14:6:12:1992)

5.6 "A Learn As You Go Process"

Some practitioners described their efforts as a process of 'building' in terms of "learning as you go" (20:9:10:1992) on from one case experience to the next and in so doing, building in personal life-world experiences of tacit knowledge into the clinical encounter. They described this experience of accumulating knowledge as a gradual process of accumulating cultural 'know-how', a life world sense of what is required both for themselves as individuals and for themselves as a caregiver.

> **Nurse:** I think it is a learn-as-you-go-process. I *think you take off with every cultural experience that you have to build, so what ever has worked before, you take it on to the next thing and say, well, this is how I*

> *managed the last time. And so you use some of these techniques to move on to (the next?) and so over the years you build up* (pause) *It's hard to identify it point by point because you deal with it when you're dealing with it, but I think you build on all your experiences.* (20:9:10:1992)

Other comments were confirmations that culturally sensitive practice is a building of knowledge enhanced by personal life experience:

> **Nurse:** *And (you build) not only your experiences as a nurse, but your experiences as a person throughout* (pause) *so whatever you pick up, your experiences with people you use obviously.* (20:10:10:1992)

These practices came as the result of opportunities for multiple encounters with differing groups and social levels:

> If you're able to be (pause) if you've had a chance to meet all kinds of people in all walks of life, in all stratas, whatever. If you've done this then you can be more sure that you're doing something right. (19:4:10:1992)

But this 'building on knowledge' to gain cultural expertise was not viewed by practitioners as something which they were under pressure to think about on a daily basis. This form of learning was not something they "consciously" decided upon. They did not describe the process of "building from one case to the next" (20:11:10:1992) as a form of known and "conscious" "learning" (20:11:10:1992). As this same oncology nurse put it:

> *I don't think you're necessarily conscious of that (building process),* (pause) *I don't really think* you even think about it ... You maybe find out one day that a patient from say, the Philippines is lactose intolerant. But you don't think any more about it. (20:11:10:1992)

Other comments expressed the belief that cultural learning by "building" was something which happened when it was made "easier" by "positive" experiences.

> **Nurse:** And I guess if you had positive encounters, it's probably a lot easier for you than if a lot of your encounters for whatever reasons, have

> turned out to be very negative encounters (pause) if you're always met a brick wall with every kind of situation you've dealt with, for whatever reason (pause) that's probably ... But you do gain that expertise. *I think through experience over the years, all of that stays with you and you (find it) becomes a little more easier (pause) it becomes a little easier.* (20:11:10:1992)

Practitioners saw their experience of face-to-face contacts with differing lifeworlds as the predisposers which had provided them with the ability to assess and intervene with respect to differing patients concerns, needs and ways of communicating. Deborah Gordon has argued that:

> Not infrequently experts are inarticulate as to why they do what they do. Things often "look right" or "wrong", "make sense" or "feel" complete, or do not. This inability to articulate suggests that they are likely not perceiving "elements" or calculating reasons. (1988, p. 276)

And some caregivers at University Hospital do attest to having "a sense of what's happening" (20:10:10:1992) or having a "good gut feeling" as to "what is wrong" (20:10:10:1992).

> **Nurse:** You learn to identify the kinds of issues that people are concerned with (pause) how to deal with issues (pause) what they're willing to talk about - when they want to talk, when they're wanting to close in (pause) you get a lot from non-verbal behaviour. You pick-up a lot in the non-verbal (pause). If I meet somebody for the first time and you know, I'm just introduced to them (pause) even that little brief encounter (pause) *I mean I might not know even what's wrong with the patient. I usually have a good ... gut feeling.*
>
> I think it's (learning) a combination of being with people to listen to people, learning to communicate, learning not necessarily just to hear it yourself but figuring out what they're telling you and reading about various culture even if it's in a non-medical area. I think all your experiences help you. When you're dealing with people, I think all your experiences help you. I don't think it's one thing. (20:10:10:1992)

The voices of nurses in these preceding accounts make clear the methods by which many at University Hospital *work* into their practice, their sense of culturally responsive care. Some nurses believe that lifeworld cultural experience, as opposed to book learning, results in the required culturally sensitive expertise. Others say they see learning as the result of built-up personally experienced moments. Yet others will tell you that cultural learning and practice come from an inner philosophy of deeply felt personal caring which transcends all formal frameworks of knowledge. These variations of nursing perception of what constitutes learning with respect to the care of people from differing and varied racial, cultural and linguistic backgrounds are formulated on knowledge which is sustained by something uniquely personal. But nurses' expressions of cultural learning constitute a construction of knowledge that is not the outcome of a legitimate body of formal knowledge which has been realized through the multicultural policy framework. Rather cultural learning is accompanied by the assumption that learning associated with multicultural health care was accidental or incidental in nature. There is a progression of assumed thinking which is incorporated within this assumption. First there is the organization of formal knowledge by an overarching health care regime, then there is the progression of accidentally built up cultural knowledge, as if it were perceived fact and finally there is belief in the anticipation that the process of building up cultural "fact" constitutes the true clinical reality. And it is this 'true' clinical reality that presents itself at a the given moment of individual practice.

In this way, vital moments in these caregivers' practice, where the substance of culturally sensitive awareness takes place, again I will argue are nevertheless ideological

moments. For these moments of learning do not happen as the product of a developed systematic formula for practice. They occur as a learning practice which is both separate to and separated from accountable regimes of the formal health care system.

Chapter Six: Multiculturalism and the Evolution of Nursing Practice

6.0 The Nursing Profession: Challenging the Paradigms

In order to fully appreciate the degree to which alternatives to science-based paradigms of thought have been explored by medical anthropologists and cross-cultural practitioners, we may consider the current scholarship within the evolutionary field of nursing. Not only does the profession posit its own sub-speciality of transcultural nursing (Kavanagh, 1993; Leininger, 1980) but the profession as a whole has undergone many revolutions to develop alternative theoretical formulations to those informed by scientific paradigms (Meleis, 1991).

One of the profession's sub-specialities is transcultural nursing, to which Madeleine Leininger, an early pioneer of this school of thought and the Transcultural Nursing Society, has contributed the fundamental tenets. These principles underscore the need for a greater knowledge of "people's world-view of care, health and illness" (Leininger, 1985). In a view similar to that of medical anthropology and transcultural psychiatry, advocates of transcultural nursing argue that technological medicine can be enriched by an understanding of alternative healing systems, contending that many 'establishment' drugs have their roots in just such traditions (Branch, 1985). The problems which the field of transcultural nursing has attempted to address have been explicated in detail by Madeleine Leininger. She argues that nurses currently base their judgements, decision and actions on knowledge informed by personal and ethnocentric values and beliefs which are taught in nursing schools (Leininger, 1985). Leininger further argues

that the nursing profession cannot claim 'professionalism', and fail to, at the same time, care for all cultures and subcultures without knowledge of them. This position holds that all health knowledge and skills should be equal to that which is attributed to care associated with the dominant North American culture. Proponents of this subfield of nursing claim that current leadership priorities and financial barriers do not prepare faculty and students to develop more broadly defined life views or cultural understanding, but reinforce prejudice, bias and ethnocentric tendencies. These concerns are shared by a number of nurse theorists (Branch, 1985). Yet in spite of theoretical and empirical contributions of the nursing profession, and over three decades of consistent attempts to establish the transcultural nursing field in hospital-based practice, the formal adoption of transcultural nursing has not taken place. Moreover, as a sub-specialty in curriculum and practice, it is vigourously argued that "financial and human resources have not been forthcoming" (Leininger, 1988).

At a broader level, theoretical frameworks which inform the formal nursing curriculum have been the subject of considerable scrutiny and debate in recent years. This critical debate has not focused specifically on the integration of cultural nursing into curricula practices, yet there has nevertheless been considerable attention paid to the importance of patients' experiences (Meleis, 1991), a multicycle view of the nurse-patient encounter, 'uncertainty' and thus, a greater collaboration with patients and families (Anderson, 1987). In this regard, academic interests in the development and promotion of the profession have been seen to be more recently concerned with the development of

holistic models of care informed by humanistic paradigmatic thought (Gottlieb & Rowat, 1987; Meleis, 1991; Parse, 1992).

Competing scientific and humanist paradigms (the latter gaining more recent recognition in the field of clinically applied nursing), have translated into a conceptualisation of the nurse-client relationship as conceived within a paradigm which focuses upon inductive reasoning, holism, discovery, and inter-subjective experience (Meleis, 1991). Considerable work has also been done to afford a closer examination of the interactive process within nurse-patient/family relations and to support the argument that an open-ended exploratory and reciprocal approach to the concept of nurse patient/family relations is the most beneficial for care (Gottlieb & Rowat, 1987; Kravitz & Frey, 1989; Pepler, 1982). However, nursing academic discourse has struggled, and continues to struggle, with the movement from a "received view" of nursing towards attempts to make theoretical conceptualisations which are not exclusively based on mathematical theory and tangible focal data. There has been a struggle to sustain the argument that theoretical analysis does not begin when theories are accomplished "facts". Rather a direction is being taken with a view of nursing which could accommodate culturally responsive care into practice. It is a view that accepts and values subjectivity, history, intuition and multiple realities (Munhall, 1982; Parse, 1992) and which in turn could encompass an open perspective towards multicultural health care.

Underlying these theoretical conceptualisations are ideas which are associated with the outcome of care. Incorporating the 'needs theorists' conceptualisation of the human being, these nursing theorists are concerned with the "individual's harmony with the

environment, stability, conservation of energy and homeostasis as potential outcomes with consequences at a high level of abstraction" (Meleis, 1991, p. 262).

Nurses who have been oriented to "needs' theoretical conceptualisations, and "outcome" theoretical conceptualisations, would project the combined clinical practitioner image of a counsellor, an information giver, an existential nurturer of human potential, a deliberate helper who focuses on extra-sensory perception, conservator, an environmental nurse who gives personalised care based on both extrinsic and intrinsic knowledge (Meleis, 1991), all of which potentially acknowledge negotiated care in multicultural settings.

Yet some nursing philosophers argue that the 'scientific method' or 'received view[7]' underlying nursing theory persists and are concerned that many scholars continue to support a view which singularly reinforces reductionism, objectivity and operationalisation. These nurses are concerned that the 'received view' orientation breaks away from and disqualifies traditional metaphysics and ethical considerations (Suppe & Jacox, 1985; White, 1985).

Meleis (1991) explains some of the inherent difficulties of many scholars who wholly embrace in practice humanist paradigms of thought, arguing at the other end of the spectrum there are many nurse scholars who have encouraged and promoted a nursing orientation which exclusively embraces concepts, laws and theories underlying scientific paradigmatic thought (Meleis, 1991, p. 85). This latter theoretical position is also evident in the work of a number of contemporary nurse writers who express worry over the

relative lack of growth and development of an "investigative, analytic scientific approach" to nursing scholarship (Moore, 1993, p. 28).

And in addition to prevailing concerns regarding the scientific rationalism underlying many nursing theories, hospitals promote persistent and rapidly technological practices which support and justify science-based care. Reporting on their ethnographic inquiry into the learning process of final year nursing diploma students, Campbell and Jackson have argued:

> (Skepticism) has not interfered with the wide diffusion of management technologies that draw on nursing theories for their legitimacy. Computerised information systems that are now a major part of nursing and hospital management make nursing objective and transportable so that it can be integrated into objective decisions . . . (1992, p. 479).

Moreover, contemporary nurse scholars argue that hospital institutions will require increasingly sophisticated and complex computer skills to deal with a rapid proliferation of technology. Personal bedside computers, for example, will allow access to libraries of objectified information which will inform clinical decision-making (Chunn, 1991).

Other problematic issues exist within the discourse of the profession which may perpetuate the disjuncture between "received view" orientation and the "perceived view"[8] humanist thought. There is much variation and ambiguity associated with the definitional meaning of nursing concepts which may influence consensus around the content of nursing frameworks for teaching. For example, the concept of "health" is defined by differing scholars in a number of ways. It is defined as a personal commitment whereby the individual knows a personal way as the incarnation of his own values; something genetic; something perceptual; something cultural and relative and something which is a

multidimensional approach of human beings actualizing their own potentials (Huch, 1992).

Other disjunctures exist between 'received view' orientations and those which inform humanistic paradigms. There are competing and contrasting theories within the same theoretical orientation. As will be seen in a later discussion, many nursing practices are based on systemised methods of scientific accountability as a function of everyday institutional practice which does not always account for or give credit for intuitive judgement, or exploratory common-sense meanings (Campbell, 1987). For example, these systemised methods of learning and practice fully contradict the role of the nurse as an "existential nurturer of human potential (Meleis, 1991). In addition, competing ideas of the way nursing practice should happen are evident even within the same institutions:

> Competing ideas exist simultaneously and have existed for decades (different research methodologies, conceptual approaches to care, comfort and pain). Competing theories are being used even within the same institution (Meleis, 1991, p. 79).

And while there is some initial agreement on major concepts central to nursing practice, the continuous evolution of alternative competing and contrasting theories may have served to strengthen the pervasiveness and predominance of scientific-rational paradigms both in their underlying tenets and in the dissemination of their content into everyday health care practices.

6.1 Nursing: Tacit or Focal Knowing in Practice

There has been lively debate over which theoretical approach best describes the knowledge which informs the discipline of nursing. Several broad definitions are currently being put forward. These are that the nursing profession is characterised by a distinct body of knowledge, which comes to be characterised by multiple "patterns of knowing" (Carper, 1978), or multiple overlapping realities that inform the science of nursing and nursing as an art (Smith, 1992). Other theories advocating similar views, emphasize the 'participative experience' of nursing (Parse, 1992), and also put forward the argument that nursing:

> . . . takes into consideration that human beings live with their health incarnating values which are each individual's unique connectedness with the universe (Parse, 1992, p. 37).

Yet in another approach, the meaning of working in practice with these abstract phenomena is often seen to be problematic. As Marlaine Smith puts it:

> The (theoretical) framework, then, becomes a convenient grouping of categories for organizing discrete components. For example, all science belongs in empirics; nursing art fits with esthetics; and ethics is decision-making about the right or wrong nature of nursing actions (Smith, 1992, p. 2).

Thus a tendency to categorize and make nursing knowledge a science according to Smith, may happen even within the postulating of the most abstract theory. And regardless of whether nursing theory is seen as informed by natural science paradigmatic thought, or whether the practice of nursing is seen within a humanistic tradition, or both, all concepts, Marlaine Smith argues, eventually become molded into a taxonomy of principles within a concise framework of classification. Thus what is being suggested here

is that in the necessary process of relying on explicit knowledge, tacit knowledge effectively becomes displaced in the attempt to effect a formal system of categorization:

> Tacit knowing is reduced to the act of applying theory to experience and this act goes unnoticed. And the fact that tacit powers predominate in the very making of discoveries is set aside as forming no part of science (Polanyi, 1969, p. 151).

In this vein, nurse writers argue that in fact, nursing decision-making is personal, and knowing how to sensitively act in a practice situation is the direct result of personalised knowledge (M. Smith, 1992).

Notwithstanding these concerns that nursing knowledge could erroneously subject itself to classification or taxonomic evaluation, other nursing writers argue that nursing indeed *should* have a singular world view characterised by precise, quantified knowledge. Here the argument is that the discipline of nursing must realistically position itself within the knowledge realities of current world trends of scientific progress and discovery, information systems and technology (Moore, 1993). These nurse academics argue for an efficient, conscious attempt to accommodate continuous innovations of science and technology in the form of objective approaches to evaluation of the discipline. They advocate that systems of thought and practice which allow the design and implementation of systematic and objective evaluation methods such as quality assurance must be applauded as effective and realistic ways of evaluating nurse-patient care (King, 1992). In a similar vein, emphasis has also been placed upon scientific conceptual systems which advocate 'theories of goal attainment' (King, 1992). Speaking of the effectiveness of such systems, Imogene King outlines the documentation system which she herself designed. She advocates it as a system which:

> . . . provides a way of designing a record for documenting nurse's actions and patient progress and which provides a permanent record which nurses can use to record and evaluate their observations, actions and client's response to care (King, 1992, p. 25).

The advantages of it she notes are that:

> When nurses design and use reliable and valid assessment instruments to gather data to plan care, they will have their data available to retrieve at a later time to conduct studies (King, 1992, p. 25).

In these latter views, knowledge which allows for the 'planning, implementing and evaluation of efficient nurse care' has been brought forward as a sound basis for bringing about 'quality improvement in clinical nursing practice' (King, 1992).

A paradox arises from all of these conflicting, and sometimes contradictory, aspirations to situate nursing within a current world view. On the one hand, nurses want and expect to prepare themselves for an increasingly complex and sophisticated technological economy in the health service environment. Yet on the other hand, they must expect to think critically and creatively in order to make informed and autonomous decisions in their everyday on-going interactive encounters with patients and families.

While nurse theorists and academics in these latter two arguments struggle with differing theoretical formulations in their effort to properly represent the knowledge characteristics of their discipline, a third argument reveals the search for ways to guide nursing in a direction which avoids polarities within its theoretical paradigms. Here there is an attempt to merge the empirical and the esthetic, with the argument that while nursing theory is embedded in "meanings, patterned relationships, hopes and dreams", it must also recognise the embeddedness of "psychological, sociological and physiological" attributes (Parse, 1992, p. 36). In this latter theoretical argument, nurses argue that by the

twenty-first century, nursing will be viewed as a distinct human science and will share its education with medicine, law, theology and business (Parse, 1992). This argument is currently supported by a number of nurse academics (Pepler, 1982; M. Smith, 1992).

This integrative theoretical approach appears to be a plausible, viable, well-substantiated alternative. It would appear that the conscious integration of personal knowledge and focal knowledge would then give legitimate space to culturally responsive practice. In this way, the 'participative experience' within nurse-patient encounters would allow the full visibility of culturally sensitive care, as well as nursing conceptualisations consistent with a rapidly proliferating technology. Nevertheless, these aspirations must at once be considered within the clinical realities of current hospital nursing practice. Any attempts to synthesize and effect collaboration and partnership within the wide dichotomy of 'art and science' must realistically take into account current evaluative procedures for measuring cost-effective nursing care. Thus formal training programs which attempt to offer a realistic representation of what nursing is and wants to be, still face the challenge of needing to adequately take into account day to day hospital realities such as the need to standardize nursing care. It is to this latter concern that the remainder of this discussion is devoted.

Nurses currently working in Canadian hospital settings are becoming increasingly familiar with the need to work with methodological practices designed to satisfactorily accommodate federal and provincial global budgets (Campbell, 1987). And so, in spite of nursing education and aspirations for practice which are theoretically designed to take into account the notion of nursing knowledge as a 'dynamic emergent process' at the

bedside (Parse, 1992), nurses in hospital centres are currently in a position where they must learn to accommodate the realities of organizational evaluation structures which determine how and when their practice is cost-effective. This means that they must undergo particular training procedures which expedite nursing practices which best serve the efficiency of health-cost related goals. Thus many nurses and administrators currently working with budget restrictions in Canadian hospitals must expect, at some level in practice, to embrace the kind of learning formulae which is offered and which is aimed at helping them to most efficiently represent their work actions in terms of cost-effective care. One training approach routinely in use in many Canadian hospitals and which has received considerable attention in the nursing literature, is the use of taxonomic approaches to aid nurse learning and thinking. These learning approaches are significant in that they have been found to be useful in "the production of administrative evaluation, service reports and projection of hospital costs" (Campbell, 1987).

On particular method which is currently in place at University Hospital, is the systemization of nursing care, through what has come to be known as workload measurement classification. Derived from the need to monitor staffing patterns in order that maximum nursing care is provided in the most cost-effective manner (Auger & Dee, 1983), this method of evaluating nursing action for cost-related assessment assumes the beneficial use of a taxonomic approach. This approach is designed to ensure learning outcomes which can reveal accurate measurement and quantification of nursing actions.

6.2 Patient Classification

In our search for an understanding of how cultural care works at University Hospital, it is perhaps necessary to understand workload measurement in greater depth. In order to make use of the workload measurement tool efficiently, the kind of pedagogy used to direct workload measurement practice within University Hospital must encompass the necessary principles of efficiency, hierarchy and control. It is of a pedagogy whereby:

> Knowledge (is) divided into components or relatively discrete components (and) success in acquisition in part, if not most, of the knowledge is recordable in quantifiable form . . . (Aronowitz & Giroux, 1985).

This form of training at University Hospital is illuminated by the example of what is commonly referred to in daily interactions of physicians and nurse practitioners, as the workload measurement and staffing system. They will tell you that this system offers "a scientific tool to measure the required nursing care needs of patients hospitalized over a 24 hour period." (23:1:1:1993).

This conception of the workload measurement in hospital care is by no means a new concept, and its usefulness to nursing care has been analysed by a number of researchers (Tilquin, 1976). It has been vigorously argued that patient classification systems may be operationalised for nursing care use in all varieties of clinical settings, including psychiatric settings (Giovanetti, 1979). There have evolved a number of competing views as a result of these workload classification developments. A particular research concern which has dominated the literature argues that such systems do not always take into account the variations and complexities of differing patient and family demands (Joel, 1984; O'Brien-Pallas, 1988). For our purposes here, the description provided by Marie

Campbell provides us with a thoughtful way of considering the nature of workload measurement and staffing systems:

> Patient classification is the name of a management device which controls the definition of "need" for nursing care, the concept central to organizing the objective and efficient management of nursing labour. A patient classification system offers a hospital increased control over the productive capacity of its nursing labour force. Efficiency in applying professional labour to a body of nursing work depends upon management's capacity to control the nurse-hours expended per patient (Campbell, 1987, p. 7).

At University Hospital some of my discussions with managers were heard to be focused around the usefulness of the workload measurement tool in terms of "using staffing members efficiently and effectively" (23:2:1:1993). Others talked about its "importance to budgeting and planning" and some expressed concern about "the problem of quantification of nursing practice" (29:6:3:1993). It is not the specific purpose here to disclaim or affirm the general usefulness of patient classification as an objective form of workload measurement although these issues have been discussed at length in the literature (Campbell, 1987).

What is at issue here with respect to the concept of workload measurement practices, is a particular perspective of nursing learning and the way this is organized in hospital practice so that competent workload measurement practices are achieved. Learning workload measurement systems necessarily entails learning activities which demand absolute precision, scientific rigor and accurately defined mathematical formulae. These expectations and aspirations of the practitioner learning experience at University Hospital are clearly evident in the accounts of nurses involved in the education and learning requirements of workload measurement systems. In the following dialogue with

myself, a nurse teacher is reviewing the rules and formulae within the content of the workload measurement system for my clarification.

> **Interviewer:** Can you tell me a little bit about what (workload measurement) means?
>
> **Nurse Teacher:** It's a workload measurement tool that was developed in -- by nurses ... a scientific tool to measure the required nursing care needs of patients hospitalized over a 24 hour period. So that, in the development of this tool, specific nursing actions that were practised, and are practised currently, were identified. Currently there are 99 nursing actions identified within 8 major categories of care. *From activities of daily living, to psychosocial needs of the patients and family members, treatments and diagnostic procedures.* Within each of these major categories, specific actions are identified and themes on each of these actions were also identified in order that the nurse be able to select the corresponding value, which represents time for nursing action. (23:1:1:1993)

What is being described here are the detailed specifics of knowledge which are categorized into phenomena, which proceeds from part to part, and which can be analyzed in quantifiable elements. The implied assumption is that all nursing actions and decisions are "selectable" and can be "value" classified (23:1:1:1993). This same nurse teacher continues to speak about the usefulness and efficiency of the workload measurement tool, since staffing "needs", which covers both physical and emotional needs, are able to be quantified.

> **Nurse Teacher:** The purpose is to use staffing members efficiently and effectively. And this tool has been very helpful in identifying the required care needs that are performed by the nurse for the patient and family ... So we're measuring what should be done. In some circumstances, some of the needs are not met over a 24 hour period. It could be the psychosocial needs, it could be the difference between a bed bath and a tub bath. But the basic technical requirements are met because one really has no choice - if a patient requires medication, it must be administered. The patient must have a dressing changed - it must be done. (23:2:1:1993)

Nurses who must use the tool, are thereby trained to recognise competently and efficiently, the care needed for whole situations and predict, through conscious, deliberate planning over a 24 hour period. As some nurses put it:

> **Nurse:** So we're measuring every single patient and we're quantifying this data to give a sense of workload overall for the nursing unit. Basically, we are supposed to be able to predict the patient and family needs over a 24 hour period. (25:2:2:1993)

> **Nurse:** We have to think of our own individual patients and families *because it does really involve thinking about how many units* of nursing care are required for measuring everything that's done. (36:11:4:1993)

The rationale associated with the benefits claimed by this system of measuring nursing practice has been discussed at length in the work of Campbell. As she puts it:

> In the larger Canadian hospitals ... nurses are now being introduced to systems designed to capture costs. Staff nurses are beginning to report that, at least in the initial stages of implementation, these systems may not only add to nurses' workload but also disorganize their methods of going about their work. In the beginning nurses must learn to operate computerized Admission, Discharge and Transfer procedures, around which cost-accounting is organized and which relates only peripherally to their delivery of care (Campbell, 1990, p. 8).

In this way, both nurses and nurse administrators have been propelled towards aiding the development and implementation of efficient workload measurement systems, as a response to the demand to find tools to classify nursing action. These tools, nurse teachers will tell you, are "used to group or categorize patients into a number of care categories according to the perceived requirements for nursing care time" (23:10:1:1993).

Thus learning realities for nurses, nurse teachers, managers and administrators are translated into realities which singularly value the promotion and implementation of precise, predictive measurement. Nurses are trained to make quantified care a visible

reality. There is a learned emphasis on objective numerical measurement and a learned view of nursing activities and situations as reducible entities. This particular approach for measuring and evaluating productivity is considered fundamental to the "effective use of workload measurement tools" (Giovanetti, 1978). Moreover, contemporary advocates of patient classification are concerned that certain kinds of knowledge must be addressed in order to maintain and ensure accuracy of workload measurement procedures. These concerns are focused on the need for knowledge around greater reliability, greater determination of the predictive validity of patient classification instruments and a need for enhanced predictive ability (Haas, 1988).

These approaches to learning and practice are by no means new to currently practising nurses. As nursing has been traditionally grounded in the natural sciences and social and behavioral sciences, what is also referred to as a taxonomic approach to learning and practice is inherently familiar. Douglas and Murphy (1985) note that taxonomic learning approaches towards the progress and development of nursing knowledge, have received attention in the nursing literature since the early 1970s (p. 64). They observe that many nurse authors concerned with developing a unique body of knowledge in nursing embraced the use of classification systems. Moreover, it has been argued that the use of taxonomies for teaching and learning nursing function to assist in the ongoing development of research hypotheses necessary for the many questions and challenges that nursing as a discipline needs to address (Sokal, 1974).

6.3 Factor Values, Culture and Responsive Care

The theoretical formulae of deductive reasoning and objectivity, which is essential to and forms the basis of learning requirements for workload classification students, presents a particular challenge for the 'tacit' connections which happen between nurses and patients at the bedside. In particular, this theoretical learning and practice formula presents a challenge for nurses caring for patients from varying and diverse cultural backgrounds. Nurses looking after patients in multicultural communities must undertake a broad range of care within the biographical, the personal and the cultural. In this manner, and following the approach to the argument that nursing knowledge is essentially social, rather than rationally scientific (Campbell, 1990), nurses must work with these orientations and strive to *allow in* all that is unpredictable and incidental at the same time. There is however, some difficulty with these everyday work outcomes of taxonomic learning. The problem with the result of such learning of has been described by Campbell:

> Nursing knowledge itself is social and not antiseptically scientific. It is interpretive, intuitive, often shared and collaborative. To be useful in an objective decision-making process, whether it be automated or not, this knowledge must be constructed into forms that give the *appearance* of being separate from this interpretive process in which it nevertheless is produced (Campbell, 1987, p. 11).

Therefore, in practice nurses must expect to systematically *work in* the common-sense incidentals of the cultural reality of their patients, as well as allowing for continuously routinized specifics of learning by taxonomy. They must learn to speak and practice in terms of 'patient needs' as units of work time, and they must *learn* to systemize their reasoning into deductive categorization schemes. And within these requirements, they must try to work into their care other forms of learning and practice which

relate to the idiosyncrasies and dynamic processes within the numerous unpredicabilities of daily multicultural patient and family care. Thus in the process of making nursing actions accessible to evaluation in the realm of hospital organizational and government administration, two differing kinds of learning formulae take place. Rather than singularly working with the theoretical notion of nursing as a dynamic emergent process (Meleis, 1991), nurses must prepare and expect to receive from their instructors, learning ideals which favour accountability to systematic[20] protocols and scientific technique. And in this respect, they must expect to adopt formal modes of practice and learning which act as the very antithesis of the contemporary theoretical focus in nursing - that of "human becoming" (Parse, 1992). It then follows that workload measurement instruction must encompass learning which directs students (nurse practitioners in hospital) on how to best process taxonomic formulae, not on how to include in culturally defined care. They must ensure "competency of learning which reflects rigorous methods of standardization of care" (23:10:1:1993). Thus the personal, intuitive, dynamic process which accompanies the intense complexities of culturally specific care, must either be designed to 'fit in' or be left to 'ad hoc' practice.

While students of classification systems learn either to systematically think out of and separate from the idiosyncracies related to the care of people from differing cultural backgrounds, they also know that any form of clinical judgement which they do make on the basis of personal or 'common-sense' cultural knowledge must be subsumed within the strict criteria of the workload measurement process. This designed process of thinking arguably then is in conflict with contemporary theoretical visions of nursing knowledge

as the practice of "weaving of threads of conceptions, perceptions, remembrances and reflections into a fabric of meaning" (Smith, 1992, p. 2).

At University Hospital, nurses readily argue that these problems of *fitting in* intuitive, personalised thinking that must be a part of, and yet get separated from, the cultural and biographical, are really solvable by "thinking in a different way". At the same time, they also point to some of the difficulties that accompany their learned responses in the nature of the dilemmas and confusions that surround the fitting of cultural concerns into the reasoning process of workload classification. Let us now consider some of these issues within the following dialogues of nurses and nurse teachers:

> **Interviewer:** Are these issues that come up in the teaching (of workload classification) - the issue of communication for example?
>
> **Nurse Teacher:** Yes, because it does call into consideration (the) activity of the nurse in terms of selecting the factor value[21]. (pause) What one may address as a concern, the other may not. So it's very important (for nurses) to be on the same wave length ... Nurses sometimes, they don't realize that they can use factors for the language barrier (pause) so this is specifically repeated (in the teaching process). In terms of specific cultural practices, *they've asked for factor values. But in so much that they need to be factor valued, it's that the nurse has to think in a different way*. That she really has to be considerate of the culture which the patient belongs to.
>
> **Interviewer:** So when you say she has to think in a different way? Can you expand on it?
>
> **Nurse Teacher:** That she has to consider the patient as an individual. That she can't necessarily go by her usual approach to a patient, that she has to address a patient in a different way. Perhaps she needs to consider the privacy or the feelings of a patient more. (pause) Perhaps in certain cultures things are done in a certain way. (pause) There's a certain protocol which, within our own Canadian culture, the nurse may not be familiar with. And in that sense she feels that those considerations need to be quantified, whereas in fact, it's not (just) that it needs to be quantified, but it's her way of thinking that she needs to consider. The whole thinking process. (For example) Oh, I have to approach this patient in a specific

> way because if I approach them without knocking on the door, or the patient won't come out of the room unless they're dressed in a particular way. No it's not that it needs to be quantified ... These are just some examples ... (23:1-11:1:1993)

And other comments by this teacher refer to the teaching process of 'demystification', the need within the teaching process to *work back in to the process of taxonomic learning*, from the common-sense reasoning which nurses, in fact, begin with at the start of the learning process.

> **Nurse Teacher:** I realize that it's (patient classification) *quite a massive chart, but every attempt is made to demystify it because even though a number of nursing actions are identified, in reality only 40% are used on any specific nursing unit.* And because on much of the nursing units there are set (pause) or specific types of clientele, the nurse *becomes quite familiar with this form and in time, doesn't have to refer to it unless she needs to make an adjustment* on the selection of the factor value. (23:10:1:1993)

Nurses practising at University Hospital are clear about the nature of precision, predictability and accuracy of measurement which is required for determining patient care requirements. This becomes evident in their descriptions of how they are expected and expect to think, act and use their reasoning within their day to day activities with patients.

> **Nurse:** Well basically you're giving a number for each of these nursing actions. We're expected to decide based on this (points to classification chart) how many points to give to each one of these nursing activities. (29:7:4:1993)

One nurse teacher does worry about these emphases on focal knowledge in nurses' practice and learning experiences. This nurse expresses concerns that getting to the real event in nursing care is superseded by the instructional requirements which, more often than not, place emphasis on focal knowledge or the 'concrete physical needs' of the patient (23:8:1:1993). This has the effect of creating priorities related to cultural

understanding such as language translation only at times when these are actually considered "crucial":

> **Nurse Teacher:** *The priority of care is to the physical needs of the patient* - it really depends on why the patient is hospitalised. *So definitely, you will see that (the patient's) culture or language falls back ... but it's not to say that the staff are not sensitized to that. But it will fall back* - at times they will call a translator *to deal with very crucial interactions* (pause) ... for example, *discharge planning*, getting the family together, discussing what the plan is, assessing whether the family is able to cope with the patient returning home. All of these things ... (23:8:1:1993)

Other expressions of concern point to the issue of the time-managed conditions with which nurses must expect and learn to work in order to fit the categories of workload classification *into their* working day. Nurses must learn to organize themselves in such a way that personal and tacit knowledge which necessarily involves prioritizing biographical and cultural concerns is left to "fall between the cracks". (23:8:1:1993).

> **Nurse:** And you know, we look after the family and the patient. And you're putting that time all under the communication factors (pause). And you think how does all this fit in here. So maybe you have your seven or eight patients and maybe you see one of the families. I mean there's a lot here that doesn't really fit in. (29:8:4:1993)

And another nurse explains further how these learning requirements lead directly to accountable justification of budget requirements, even in the face of nurses' resistance towards this way of organizing or constraining their actions and attention:

> **Nurse:** I mean what comes across is that this hard cut, cost-related scientific way of measuring what we're doing with the patient which doesn't really allow for how much time you're spending. I mean, teaching people can be very different if you're from a different culture and some people can readily understand but others, I mean I'm sure maybe we hear or understand half of what is needed by them. And then you're saying, oh well, I'm putting x points down. (47:8:4:1993)

These concerns also stress accountability and justification of care, thus ensuring that the learning process is suitably tailored towards precise measurement and accuracy. This is reiterated by a nurse teacher with respect to cultural and biographical and family assessment in terms of which particular nursing thinking processes are considered important:

> **Nurse Teacher:** And (I tell them) it's very important to *measure the care needs* of the patients and the family and how this data is used. It's very important to justify staffing levels in terms of costing, in terms of budgeting, in terms of planning. And it's very important to *measure the care needs* or quantify the care needs of the patient population and ensure that it's accurate on a day to day basis *because if the data is not credible, it's not usable*. (23:10:1:1993)

Another nurse describes the use of learning aids in practice by which the assignment of classification categories can be carried out:

> **Nurse:** You learn that when you assess the patient, that you're needing to plan what the care will be. And if certain changes in the nursing care are necessary, then we need to understand how many points to give on the sheet. *So you need to know what (factor) value to attach to the care* ... So the idea I think is to keep the chart here which can be referred to at any time (points to large workload measurement chart on nursing station wall) and then you have it ... (29:7:2:1993)

Sometimes the intuitive judgement of nurses in relation to the cultural background of the patient poses a particular challenge, since they must try to fit it into the classification formulae provided for the work that they do. Cultural care which involves a broader than usual approach to patient care, such as consideration for the family's traditional way of coping with illness and perhaps death, also means that nurses must adjust their thinking to accommodate the need to both categorize, and include in their

work the cultural ways of coping and health care. This becomes visible in the following example:

> **Nurse:** Sometimes we need to adjust our plan of care for (the) patient because now they're incorporating the care of the wife too.
>
> **Interviewer:** You're saying that it's problematic?
>
> **Nurse:** That's right. And for that particular couple, I mean even their children who were adults got involved. Because they wanted the mother not to go in (to the hospital). They wanted to keep her at home. And we were not just working with this family as a unit, we were trying to fit the culture in too. It was traumatic. So we couldn't put in the classification criteria because we were working with the wife too.
>
> **Interviewer:** *So is it a case of trying to fit nursing actions into the plan of care*?
>
> **Nurse:** Oh yes. *Because sometimes we aren't sure how to go about that. How to go about fitting it in. I mean we are doing it, "but how are we going to measure this?" Quantify that. Because there is now only a factor value for one patient instead of two.* (26:15:1:1993)

Other nurses, instructors and managers of the workload measurement system at University Hospital, as well as the nurses themselves will readily agree that the quantification of care removes the element of the idiosyncratic "leaving it to chance", and it removes the element of visibly including the 'incidentals' into the clinical process. Moreover, it does not, they will tell you, accommodate all of the thinking and action which go on between patients and nurses. For example, some nurses are concerned about getting "enough time" to know the patient and family in terms of giving cultural care.

> **Nurse Teacher:** Often the nurse will say, I really don't have the time to sit with the patient and hold their hand and really get to know them. A lot of what they do know about different cultures comes from in-services or perhaps from cases, case studies or situations where you discuss a specific patient & family in relation to culture. But it's true ... and nurse have been very open in making that statement. We barely have enough time to do

> what we have to do, and part of our job is getting to know the patient and family to make sure that all care needs are addressed. Often the nurses will say that they don't feel comfortable - at the end of the day if you're tired, you barely had time to do your charting and my feeling is that it's all the other events which are taking bits and pieces of time, or disrupting the work course of the day for the nurse - it could be spills of specimens on the floor or it could be patients or families from another floor are asking for directions - all of these things are eating away at the time the nurse can use to spend with patients and families and getting to know them better. But I understand that we are now (officially looking at some of these issues) some of these events are being addressed (in workload measurement)... (23:9:1:1993)

These concerns demonstrate an important feature of nursing practice as cultural care practice. That is that the operationalised procedures for ensuring that nursing care maintains fiscal accountability according to provincial health care stipulations, creates a problem for ensuring culturally sensitive practice. For administrative purposes, the working tools of the health care system are those which support an objective scientific-rational course of action. Rather than ensuring a set of priorities, interpretations and choices that illuminate and make visible 'the stuff' around cultural care, cultural care is displaced by the need for ensuring the fiscal accountability through quantifiable procedures. For administrative purposes, this then places ultimate emphasis on *methods* of ensuring that procedures are accountable. In this way there is a superimposed focus on quantification methods in order to 'operationally define' the myriad of idiosyncrasies which come to characterise everyday human encounters. In this case, daily 'ad hoc' cultural practices with their many variations and complexities which physicians and nurses have described here and which they know they administer, are continually subverted. The many idiosyncrasies of cultural biography which happen in practice, and which we have previously witnessed, at once characterise the lives of practitioners at University Hospital.

Many of the 'chance', 'touch and go' learning and practice encounters which we have heard about, surrounding cultural and linguistic practice endeavours do not become formally legitimized. Practitioners understand and know these 'chance' endeavours take place in the health practices around multicultural concerns at University Hospital, but they also know that these do not become 'operationalised'. The learning by experience events, such as the many accounts of 'common-sense' practices of learning through modification which we have heard about here, in effect become displaced within the procedures of maintaining orderly workload measurement reporting. Nurses do sometimes attempt to adapt to these ambiguities. Knowing that 'chance' cultural idiosyncrasies do occur they sometimes engage in thinking processes which will *allow in* these *extra* features of practice. In the following two brief dialogues, I am trying to understand from an instructor how the stuff of 'unexpected' or 'chance' or 'touch and go' learning process and ultimate practice is actually managed by the nurse within the structure of the workload measurement tool.

> **Nurse Instructor:** Some of them (nurse practitioners) will see (a difficulty) because they have to approach a family in a different way that they're (the family) difficult - it's not necessarily that they're difficult, it's just that this is how the culture works - like (caring for) some Jewish families for instance. Or Indian cultures, where there's a death - things are handled a different way than what the nursing unit or staff are accustomed to. *And it's not that it has to be quantified*, it's that they have to be more sensitized to (pause) more sensitive to that and more appreciative of that.
>
> **Interviewer:** But isn't it quantified in the sense (pause) of (the) communication factors?
>
> **Nurse Instructor:** In the sense of language barrier?
>
> **Interviewer:** They do have to account for that. Is that not so?

> **Nurse Instructor:** *Not so much the cultural aspect.* But the language, if there's a barrier. Definitely. But in terms of psychosocial support, *only if there is really a problem*, you know in terms of mourning, in terms of interrelationships between family members - if there are problems there that the nurse sees, (she) will deal with it. *But you don't quantify it* (culture). (23:11:1:1993)

In another exchange around the issue of cultural care and workload measurement, a nurse talks about problems with quantifying the time that it sometimes takes to obtain a satisfactory translation.

> **Interviewer:** Then if I understand, language translation does receive a factor value doesn't it?
>
> **Nurse:** Sure, if you need to get a translator for the patient then you give that 4 points.
>
> **Interviewer:** So then how would it work if the patient had difficulty understanding the treatment plan. What if that process were to take a very long time?
>
> **Nurse:** Well, it might take an hour or you might have to wait. But you're still giving that action 4 points.
>
> **Interviewer:** So that all of the intricacies of finding a translator and finding someone who will be suitable wouldn't be classified.
>
> **Nurse:** Well you're still giving that 4 points. (24:2:2:1993)

These preceding dialogues are perplexing and present some difficulty in our search for how cultural practices work at University Hospital. How is the learning process of nurses in this case, made visible, and thus, how do the decision-making practices within a trial and error process of cultural learning work? How do these processes which nurses readily acknowledge to be an integral part of their care become accommodated within the workload measurement tool? At a later date, when I returned to talk to this same nursing instructor in order to better understand these issues, it was revealed that 'that kind of

thinking process does not yet have a factor value' and that "it (the tool) has not yet been refined enough to accommodate that thinking process."

> **Interviewer:** I want to clarify some things that have been puzzling me since we had our last talk. I wanted to see if you could explain how the tool works in the clinical process where for example, a nurse needs to undergo *a process of working through* a sort of trial and error process when she is trying to nurse a patient and family whose cultural ways are unfamiliar. Many nurses for instance, have described a particular process of learning which I am understanding as 'ad hoc' learning. This seems to mean that they often have to 'work through' a processing of culturally sensitive learning via the exchange of knowledge between themselves and the patient. How does that in fact work here?
>
> **Nurse Instructor:** At the moment, we do not have a factor value to deal with that thinking process. The tool hasn't been refined enough yet. But it has become a recent concern in some of the literature.
>
> **Interviewer:** How so?
>
> **Nurse Instructor:** In relation to the emotional factor, there is someone by the name of Giovenetti who writes about it. It's definitely a concern.
>
> **Interviewer:** How would nurses describe what they do in terms of these sorts of cultural explorations?
>
> **Nurse Instructor:** That would have to come under "other". Or for example, there is always a place where these kinds of concerns can be raised and we note it for future consideration. (25:1-2)

Learning in the context of workload classification then fully establishes,not only an all-encompassing adoption of a categorized, deductive approach to assessing and evaluating nursing work, it also establishes the terms and ideals for the getting and receiving of instruction. Nurses must learn to think of their care in strictly mathematical terms, using objective formulae for nursing actions, in order to achieve the maximum potential of skill in the achievement of precise, consistent, accurate measurement of their daily nursing workload. Therefore, in spite of contemporary nursing positions, which

argue for theoretical frameworks encompassing concepts of 'multiple realities', 'holism' and 'existentialism' (Parse, 1992), the way that nurses process their learning and thinking in terms of a taxonomic approach related to workload measurement must deny these theoretical aspirations and broader level considerations of care related to cultural, biography, life ways and history. Instead, pedagogy becomes directed by the implementation of totally explicit methods of knowing. Creative thinking becomes directed by "methodological forms of reification" (Aronowitz & Giroux, 1985), while teaching and learning strategies strive to achieve excellence as they become increasingly technicalised in the interests of achieving quality care.

In sum, the central issue is that although nurses and their teachers look to a vision of nursing which brings them closer to those they tend and care a for, major frameworks for learning in everyday practice confine them to a highly organized regime of practice within the frame of technical rationality. This has the effect of both obscuring and denying the culturally defined moments that both patients and practitioners, with differing lifeworld histories, bring to hospital settings. At a broader policy level this approach to learning and practice fails to deal seriously with differing patient experiences, linguistic practices, individual cultures and the many idiosyncrasies of everyday experience

At University Hospital, nurse managers often speak about the "flexibility" and need for "open-ended" approaches in the daily care of patients and families. Some will tell you that a certain degree of "autonomy and individual management" is required within the nurse-patient relationship (17:3:3:1993).

> **Nurse Manager:** I guess I'm saying it more and more loudly (pause) that if we want to give quality care and that includes treating this or that

> person as an individual who is shaped by many things including culture, we must practice primary nursing ... Because that patient needs someone who truly understands them and it takes time to really understand your patient. (1:12:9:1992)

Moreover, their aspirations and visions of future directions for the profession are placed within goals which support "nurse case management" and "primary nursing" (17:4:3:1993). These aspirations also fully acknowledge the kind of flexibility which is required within the multicultural nurse-patient encounters at University Hospital.

> **Nurse Manager:** I think by now we are sensitive to the interaction with the individual. I think by now, we probably are attuned, or we are exposed enough to be able to extract in an interview or in an interaction with the patient some things that are very important to them. Whether it's important for them to rinse their mouth *before* they have their breakfast because I think in some religions that might be the thing - or is lighting candles an important thing? So what I think we need to do now is when the nurse interacts with the patient is to have some open-ended questions. (For example) "Is there anything that you'd like us to know about you which would help us to understand you better or your needs ... I think that kind of thing. (17:7:3:1993)

6.4 Cost-Effectivenss, Accountability and Science-Based Care

While these nurses describe visions of the nurse role as one which is characterised by autonomy, creativity and increased individual decision-making, many of these same nurses will argue that "the budget" often functions to maintain a strict control over the daily actions and broad scale decision-making. These nurses argue that federal and provincial budget mandates "restrict" and "control" a good deal of nursing time (1:14::9:1992) and that many nurses expect to work within boundaries of maintaining "cost-effective care". Yet at the same time, these and other nurses will tell you that they hold steadfast their hopes and aspirations of what nursing care should be:

> **Nurse Manager:** I think that no matter what happens we still have our same beliefs about what nursing is and what we want to be doing ... the only jolts that are enormous that I've seen are the budget cuts and they really haven't shifted our values. They've shifted our practice a little bit, but our values have not been built up as a result of budget cuts ... (1:9:9:1992)

The primary interest in maintaining a workload measurement system for these managers and administrators was that it functioned as an efficient way "to ease health care deficits". These concerns for and with on-going provincial budget restrictions were also evident in the talk of nurses and students. Budget restrictions were, as these nurses explained, often visible in the management of time on the ward.

> **Nursing Student:** I think with all these budget cuts you're hearing about now, it's hard. And it's hard because they (the nurses) don't have the time. I think as students, we have the opportunity to go a bit further than the nurses themselves (pause). I mean we usually have only one or two patients, while the nurses have eight or nine patients. So we're encouraged by our instructor to do as much as we can for that patient and go that extra because we have the time (18:10:3:1993).

This strict management of nurses' time was also described as creating a 'stressful' environment. Both nurses and managers talked about an increasing emphasis on technical and physical procedures. These same nurses, students and managers worried that many of their visions and aspirations, such as spending time with the patient and family around cultural concerns, were not always recognized. Documentary priorities were seen to entail procedures specifically defined by provincial legalities. Concrete physical procedures they argued, "always seem to be more important ... than the emotional needs of the patient (18:11:3:1993). In the following accounts from a group of nurses it became visible to me, the interviewer, that much of the work done by nurses at University Hospital is work that must be seen to be accountable. From the voices of nurses it became apparent that much

of the work in their day to day activity entailed the fulfilment of explicit obligations to bodies of authorities which did not determine multicultural care:

> **Nurse:** What I notice most is the medications, that takes up most of the nurses' time. I think that what's lost in that time (when) putting so much of that kind of physical work (concrete procedures?) is being able to sit down for a few minutes and talk with the patient. That has to wait for later on. *If there is extra time at the end of the shift, okay.* Because the focus is on doing the physical things like meds.
>
> **Interviewer:** So the focus is on giving meds?
>
> **Nurse I:** The whole issue is one of time ... What are you going to prioritize? I think, you know that psycho-social interventions get lost because of the time factor. And some interventions such as medication are much faster and effective than saying (to the patient) for instance, "what's the underlying reason you can't sleep?"
>
> **Nurse II:** Um ... the tasks have to be done ... I mean you know that basically we are taught that we must give accountable care. And specific tasks have to be done. Like the medications we're talking about (here). You don't want to run antibiotic therapy too late ... And you're also responsible to the 4:00 people who come in (at the change of shift).
>
> **Interviewer:** And so the psycho-social interventions? Wouldn't those also be things that would be seen as accountable?
>
> **Nurse Manager:** Sure ... But for all kinds of reasons, the patient needs his meds, they have to account for that in terms of legalities. You've got to have continuity of care carried over to the next shift. And if they are doing what we are supposed to do in - (workload classification) then they have to see that those values are assigned to their actions. (38:4-5:4:1993)

In listening to these preceding accounts, we begin to see that the methods by which nurses understand and carry out their actions do not fully make visible "the stuff" which actually gets done. Part of what practitioners do in their everyday routine practice is organized for them. It is organized by the regimes of legally administered medical and

nursing procedures and tasks which sustain the *exclusion* of 'stuff' around *culturally accountable care*, which practitioners will tell you they desire and are anxious to see.

6.5 Multicultural Policy, Strategies for Change and Provincial Health Care

These omissions of cultural care within an objectively ordered system of nursing actions, do not begin or end with hospital administrative control. It does not depend, as some nurses fear, when they talk about stress-related conditions of their work, singularly upon the time-managed conditions directed by 'administration' or by 'management'. Instead the sensibility of administrators' actions, like those of nurses themselves, arises from the particular set of organized social practices in which all practitioners and health care advocates' actions are embedded. Nurses and physicians' priorities, their concerns for the care they give and their sense of accountability are ultimately ordered and determined within an extended bureaucratic, legislative and political set of provincial and federal relations. And it is within these organized social practices that policies of learning and practice within the health care system are embedded.

To understand more clearly the notion of organized social practices, it may be necessary to consider more closely the 1988-91 strategies for change by the *Bureau de coordination des services aux communautés culturelles*. In Chapter One it will be recalled that most broad level policy objectives of the *Bureau* were focused primarily upon the establishment of cultural communities within the health and social services network.

The *Bureau*'s concern was also with the dissemination of adequate health care information to cultural communities. I want to argue here that while these central aims

and ideals were well-intentioned and, if realised, will allow greater cross-cultural networking of community services, they do not address many of the learning aspirations and practice concerns of practitioners and patients at University Hospital. These policies do not address practitioners' learning needs and concerns since they too are embedded within the framework of the orthodox health practices.

For example, the *Bureau*'s concerns for a greater acknowledgement of the multicultural reality of health populations does not include questions about current broad level systems of health care evaluation. They do not include an examination of the current priorities, interpretations and choices that continually subvert aspects of other kinds of health care knowledge that are needed to actually practice culturally responsive care. Rather, government bodies who aspire "to take multicultural reality into account" (Quebec, 1989, p. 12) are also part of the same organized social practices which reward and determine objectively ordered forms of accountable practice, such as the practice of workload measurement and scientific models of medical treatment. Moreover, government legislative bodies, both federal and provincial must depend upon objectively ordered forms of documentation which determine accountability of practitioners through science-based reporting procedures. It is through the form of objectively ordered rational procedures that the framework is provided for the broad level health policy process. The final point at issue is that this scientific-rational organization of practice accomplishes itself in and through a process of formal decision-making that must be viewed as fundamentally separate to the needs and interests of individuals and groups. In this case the health policy framework is external to the interests of nurses, patients, physicians and

administrators alike. Moreover, objective documentary communication processes which were manifested in formal health care practices such as workload measurement systems, serve to exclude patients and practitioners from the formal culturally sensitive care. Therefore, practices of culturally sensitive practice will continue to remain ideological as long as they endure as a product of the organized social practices of the health care system. Moreover, as long as 'ad hoc', 'accidental' and 'incidental' cultural practices are pervasive and used to maintain the status quo, ultimately serving the broader level organization of the health system, policy frameworks for promoting and implementing multiculturalism will remain ideological.

Chapter Seven: Culture and Modification in Medical Practice

7.0 Health Care and Cultural Modification in Medical Practice

In an earlier theoretical chapter it was seen that a number of prevailing theoretical concerns underlying the views of critics of the content of knowledge informing the biomedical model, focus around the notion of theoretical assumptions of separateness within this orientation, of all that is cultural, social and spiritual (Gordon, 1988; Kleinman, 1992). Within this critical position there lies the argument that symbols, language, culture and the patterns of daily life are less definable and are displaced by universalist models of medicine characterised by scientific rational thought[22]. (Kleinman, 1981, 1992). Moreover, the sequential rational order of diagnostic reasoning "eclipses" the individual and personally sensed reality of the patient (Kirmeyer, 1988, p. 61). This classic critical stance of medical anthropology following the orthodox critique of medical paradigmatic thought, maintains the position that biomedicine, which subsumes much of western medicine, assumes an inherent separateness from the everyday realities of the personal and bodily felt sense of the human being (Gordon, 1988).

This theoretical position is an important one for hospital practice considerations in that it makes the assumption that the theoretical foundations on which biomedicine is based, that of Cartesian dualism (Engel, 1977), means a commitment in clinical life to scientific-rational authority and legitimacy. It makes the assumption that people in the everyday world of feeling and emotion must expect to act and are expected to act from the theoretical positions of scientific rationality. If we review again the definition of

Cartesian dualism by Laurence Kirmeyer, it becomes possible to understand and to conceptualise the symbolic classification of the way that formal frameworks of learning are organized. Kirmeyer explains:

> Biomedicine was founded on a Cartesian division of man into a soulless mortal machine, capable of mechanistic explanation and manipulation and a bodyless soul, immortal and immaterial (Kirmeyer, 1988, p. 59).

Thus while the task of the practising physician is to try and understand the patient's experience of illness, the physician also knows that he or she must accurately and accountably fit the patient's concerns into a well-ordered and well-defined classification system of illness and disease.

7.1 Maintaining a Model of Certainty

Paul Atkinson has argued in his research on medical learning, that 'the status' of the learning process lies in procedure and rules which are used to 'establish and validate' knowledge. He observes that:

> An event is transformed into the truth only by the application of a canon of procedure, a canon that truth seekers use and analysts must formulate as providing the possibility of agreement (Atkinson, 1981, p. 118).

These 'canons of procedure', which become translated into the authority and decision-making practices of the "they" referenced in the patient voices we heard in a previous chapter, have the effect of creating certain kinds of expectations from patients for their care, and sometimes effect a disengagement between what is needed by the patient and the tenets of orthodox health care knowledge. It is these same canons of procedure which manifest themselves within the authoritative process of knowledge, that

practitioners will tell you structures and dominates their practice. This is embedded within their experiences of teaching, learning and practising the medical model. As one physician put it:

> I think the (model) approach puts us in that very classic position of authority, of certainty ... We try hard to read books, we learn next to the older doctor, the apprenticeship (way). And we left *medical school* thinking that all the older physicians were illiterate and *we knew everything*. (26:5:10:1992)

This sense of "certainty" with which all practitioners know they must be equipped, and which they readily acknowledge must follow the orthodox learning process, reproduces not only for patients but for themselves also, the authoritative nature of medical work and medical instruction in such a way that it becomes for practitioners, a 'natural reality'.

This fundamental position of 'certainty' can often be made readily visible in the talk of people who represent patient and family concerns, they are formally known as hospital ombudsmen. Hospital ombudsmen are frequently put in the position of representing patients' concerns and can confirm what practitioners themselves know and have expressed. This is, that the knowledge and training with which health practitioners are equipped is not always able to readily accommodate the practice expectations that are put on them by patients.

> **Hospital Ombudsman:** *People come in with certain expectations.* Doctors argue that medicine is an art, not a science. And so you've got the combination of patients' expectations going "fix it" because I think there's an implicit sense of "you can fix it", this is what we pay for. And doctors are saying, "hey, don't put this on me" ... And then when it doesn't there's a complaint. And a lot of complaints that you deal with, when you get down to it, you think that, well, but what you asked for wasn't possible. (34:10:1:1993)

But some physicians do argue that the 'biomedical' thinking process which conducts and organizes their practice and which must accompany formal medical training, acts to steer and propel them towards what they term as a 'lack of awareness' of the cultural and personalised life of the patient. They will tell you how they can immediately recognise, by the incidental happenings or occasional extensions of their hospital work (such as "making a home visit", 25:1:1:1993), within the treatment and care process, the extra or added pieces of learning which are sometimes left out of their clinical understandings. As one physician put it:

> **Physician:** I'm impressed by our (trained way of thinking) ... essentially total unawareness, lack of awareness of the other dimensions of who they (patients) are ... this is strikingly brought into focus by every time we make a home care visit. You suddenly realize you know in an instant far more about that person driving on their street than you'd know if they were in a hospital for a year. For example, walking into the (patient's) house and seeing their pictures and seeing how it's furnished ... you know whatever it is, you immediately know more about the person than you'd know in your clinical work. Well that's all, if you add that to cultural differences (pause) it makes a mockery of any pretext of care that doesn't extend beyond the mere rudiments of directing ourselves to the disease. And I think if we ever think we do more than that, we're making a wild assumption ... And you know we all hear anecdotes sometimes from people who've suffered because we hadn't understood where they're coming from. (25:1:1:1993)

Other physicians will argue that not all patients can be accommodated through the central tenets of the 'medical model' and some are actually done a disservice by the attempt to make this fit. They contend that a certain amount of 'clinical flexibility' (25:2:1:1993) is important in order for satisfactory patient-practitioner treatment outcomes. And they will tell you that in their practice, they must insert into their model individualised 'cultural' exchanges. They must *work in* different kinds of questions within

the clinical exchange which allows knowing "what is needed to fix" (19:2:9:1993). Some practitioners argue that biomedically focussed training, which tightly specifies illness complaints informed by reductionist classification effectively displaces alternative knowledge within the clinical experience for both patients and practitioners. One physician worried that Italian patients, for example, are frequently misunderstood because "they don't fit" into the medical model of symptom complaints (19:2:9:1992).

> **Physician:** I had really done a lot of thinking about what some difficulties were that there were very strong reactions towards getting what we want from the complaints of these patients ... Because they come in and they don't fit the usual symptom complaints ... it's more of an emotional complaint and *we're trained to look for symptom complaints and to treat symptoms and it was very difficult I found, at first for me to develop ways of getting the symptom - getting the emotional complaint translated into a symptom complaint and to know what I was needing to fix* ... You couldn't get a straight answer because the emotional aspect was taking over and a question about something as concrete as weight was seen to be meaningless to them. So they would talk about the emotional aspect and *I was left at the end of the session feeling like I didn't know what to treat.* (19:2:9:1992)

Physicians do not necessarily argue for singularly alternative treatment approaches to the practice models and learning which inform their care. But many do argue for the need to knowledgeably understand, and thus be able to decide differences, between what they term "behavioral emotional difficulties versus concrete difficulties" (19:6:11:1993), or what Polanyi has termed 'focal' knowledge (1969). They contend that to aim for these "basic" fundamentals of training informed by focal knowledge is "folly":

> **Physician:** And I think that the difficult thing is for the therapist - or (we need) for a model (pause) to be developed whereby you can decide what are the most superficial behaviourial emotional or attitudinal difficulties *versus what are the most implicit, ingrained, concrete* difficulties. (pause) I think that aiming for the most basic ones is folly. I think it's ridiculous ... I've seen Italian families who've gone through family interviews and

left because what was being addressed did not make any sense to them. (19:4:9:1992)

The preceding concerns of this same physician do become more apparent when particular patient and family cases are recounted. For example, this same physician argues that certain western-derived diagnostic categories are not always conceptualised in the same way by patients as they are by physicians. This is not just a discordant perception in terms of academic knowledge versus non-academic knowledge, it is also that for some cultures, the meaning underlying some concepts does not exist in their lives. Moreover some concepts, such as the diagnostic concept of "emancipation", as it is sometimes termed by psychiatrists, does not exist as a concept - doesn't "make sense", and "making it a concept" is "too uncomfortable" (19:7:9:1992).

> **Physician:** Like one family, I remember, where they had gone to a family therapist (pause) it was a problem with a child who had severe enuresis - he had a bunch of generalized concerns. And the therapist felt that the problem was that the mother needed to emancipate and said that the problem was that the mother was at home too much and she was over-involved with the children (pause) *it not only didn't mean anything to them, they felt like this was an assault on something that didn't make any sense. I mean it (autonomy) wasn't a concept for them and making it (autonomy) a concept was too uncomfortable for them to work with. So they left the therapist.* And then they came here and I don't think I did it much better, because they didn't like the idea of doing some psychological manipulation ... But I think that the idea that we have a preconceived notion of the basic level of patient understanding is not a good idea ... So I think it's a much more fluid concept ... It's more variable than having a concept of "what's pathological and what's healthy" that you must apply to all families, a model where you assess what is most ingrained versus what is less ingrained and then what kind of changes you can affect. It's a little more difficult than that in the long run because it's (so) variable. (19:6-11:9:1992)

Again, a major difficulty or complaint about this type of exchange is that the nature of medical training is such that it doesn't allow much flexibility in the learning process to fit the circumstances of all clinical cases. The same practitioner describes "limited flexibility" in power as a "feeling" that formal knowledge and trained skills were "inadequate" to meet the particular "complaint" needs of his client (19:3:9:1992).

> **Physician:** And what come to mind from that experience was that I was feeling some frustration, feeling like my training was inadequate to deal with these sorts of complaints and that my interview techniques weren't adequate to transform their (patients) complaints into something that would fit into my brain. (19:2:9:1992)

Another physician described a similar sense of frustration in the process of trying to link standard symptomatology criteria to the presenting complaints of his patients. He explained that "your training provides you with the model to help but it doesn't really give the help in all cases."

> **Physician:** We learn to look at patients and we think well, if you let them (the patients), they will talk and they will tell you everything. And then you will get an idea from what is being said. (But) with the Chinese people, and the American Indian people for example, you begin to see that they don't talk. Most of the words you hear from them are "I feel well" and "sometimes". I will ask perhaps "do you get angry?" and the reply is "sometimes" and "do you ever cry" and you hear "sometimes" and "do you feel depressed" and again (the reply) "sometimes". So it's a very frustrating experience because you don't get any idea. You say, "do you get headaches" and the reply is "sometimes". so it (the encounter) is not verbal. And yet they may be quite aroused and then suddenly explode and you are left unsure. Sometimes it can be a problem of language, but this is not really the case with American Indian people. so this is what I mean ... (26:8:9:1992)

These preceding statements affirm and parallel the theoretical concerns upon which much current debate regarding cultural understanding and science-based medicine rests. For example, they affirm in part "the extreme insistence on materialism on the grounds

that single causal chains must be used to specify pathogenesis" (Kleinman, 1992, p. 5). They affirm also what has been called for as a need for "interface and partnership" (Prince, 1981) in relation to western medicine and alternative forms of healing. What these accounts of practice at University Hospital reveal is that practising physicians, on a daily basis, do work into their thinking practice some of these theoretical concerns. They know that extremes of 'focal' learning do not always accommodate their practices in the everyday workings of treatment regimes. And equipped with such knowledge, they try to *work in* 'ad hoc' inventive strategies of patient understanding in order to allow for these differences. And while they know they can *work into* the practice process their 'tacit' concerns, they also point out that much of the emphasis on 'focal' knowledge which characterises their formal training, and to which they are accountable, "cannot be deleted" and "separated out" (19:9:9:1992). For example, physicians will readily argue that in medicine "you *succeed* if you learn about symptoms" (19:3:9:1992), that the mandate for "western health care (is) to investigate, diagnose and cure", and that this is what singularly directs its "success orientation" (25:5:1:1993).

7.2 Clinical Training and Intuitive Judgement

Health practitioners, many of whom are physicians, know and will tell you that they hold legacy to a life world of extraneous knowledge in clinical life. Yet practitioners will also tell you that they must attempt to *work in* this knowledge as an accidental happening within formal clinical life. Practitioners also know that they must try to work

out of their daily practice clinical explanation, which is sustained only by personal or intuitive judgement. As Elstein puts it:

> While the "clinical" approach dominates in practice, and while in fact the statistical one has not been well received by practising physicians, a medical opinion is growing that the traditional informal approach should be made more formal and "rational". Despite their heterogeneity, most working in this field share this and other assumptions: that medical practice and clinical judgement can and should be improved by replacing or supplementing intuition with more rational, formal and for many quantitative analyses (Elstein, 1976, p. 288).

Some physicians at University Hospital expressed concern about their training in terms of its emphasis on learning scientific facts with its lesser formal emphasis on subjective and intuitive experience. These physicians affirmed again, that knowledge which would aid and assist them to care better for their patients came "from experience" (31:7:9:1992).

> **Interviewer:** Did you in your training receive any specific formal preparation for working with the cultural variations of illness?
>
> **Physician:** Zero. Oh, I may have had one or two lectures with Dr. - but there's a very poor introduction or preparation for it. No formal training, you get it from experience. (31:7:9:1992)

Physicians put forward a number of reasons why formal multicultural health care training and health care is not "practical" at the level of clinical training. Some physicians' responses to the lack of formal multicultural training related to known and commonly believed learning priorities around the medical learning and evaluation process. Sometimes the absence of multicultural courses, they observed, was as an inevitable rational outcome of a highly intensive formal education.

> **Physician:** There are no courses because a course like this would be impractical. It would be competing with other courses and young physicians want to read and study about pharmacology because it is important for treating disease. But culture is vague and far away ... (26:7:9:1992)

> **Physician:** What happens as they (medical students) go along in training is just the barrage of information that is imposed on them which is not related at all to psycho-social or cultural issues. You know (pause) you (have to?) know the latest New England Journal cold. If there's time for anything else, that's fine. (37:3:4:1993)

> **Physician:** This is North American Society. We are so spoiled by advertising, that is if someone doesn't come to advertise whatever it is, a course in this case, ... we don't think of it. Because everything advertised is sold to us. (26:9:9:1992)

> **Physician:** When I went through school, there really was nothing much. We had maybe a lecture on transcultural psychiatry ... (24:2:1:1993)

> **Physician/Professor:** I don't see that giving them a lecture on it ... early on to the medical students would do very much. I mean they would listen to it, take notes on it and like a lot of things, they would prioritize it and figure how many questions on the exam would be on that and if they think only one or two, then out the window it goes. (31:7:9:1992)

Many practitioners expressed various concerns about the health care environment that they saw developing as a result of the increasing emphasis on specific kinds of thinking in training. Some described their practice as the result of a learning emphasis on success-orientation in science-based curriculum, with its accompanying emphasis on *focal* knowledge:

> **Physician:** *Well the training from our perception is that, you know, you succeed if you learn about symptoms* ... it's the model of pain. The pain model. What is your pain? How large is it? How long does it last? And then you look for stressor and then you get an idea if its something that's easily removable or something that goes way beyond what you would

> expect from a stressor. And then usually you look for a medication (to see?) if it fits with the stressor. (19:3:9:1992)

> **Physician:** I think what I understand to be the bio-medical model, I mean seeing illness as the pathophysiology of the disease. And *simply* in terms of pathophysiology. And I think it's success orientation brings in a different dimension for me. What I understand there is that it's how we perceive our mandate and we perceive our mandate usually in Western health care to investigate and diagnose and cure. *And to make an impact on the disease trajectory (pause) and success is measured in terms of prolonging life, in terms of cure.* And (pause) so (pause) I think those are very limited perceptions of illness. We should broaden all of those. (25:5:1:1993)

Other comments observed that the knowledge and training resulted in a "propensity" for reduction of people to categories of disease:

> **Physician:** You know, I think generally, I'm impressed by our propensity to reduce all clients, patients or family members, in particular, patients, to disease and to see them in terms of an interesting case or a not interesting case of (pause) whatever the issue is diabetes, chronic heart disease, or whatever. (25:1:1:1993)

> **Physician:** Oh, I think the success of the biomedical model, you know the whole Cartesian dualism came along for a very good reason, to escape the total control of the church ... and I think the very success of the biomedical model has fed on itself ... (29:4:1:1993)

Another physician, in caring for chronically ill people, while recognising the need to gain 'mastery' of focal knowledge and the increased requirment for greater concentration by physicians on focal medical knowledge, also expressed the hope that other kinds of patient knowledge would still be addressed. This physician worried and expressed the hope that patient concerns which demanded knowledge and skill beyond the "province" of the model would be taken care of by other members of the clinical team (24:5:1:1993)

> **Physician:** *I think science, which became the God of medicine* has worked on a reductionist model where you look for smaller and smaller components that you can completely understand and so as physicians *we tend to be focused in on the pathology of disease* and going from gross pathology down to sub-molecular pathology at this point in time and *to gain a mastery of understanding of* why things happen the way they do but the more sharply focused your perspective comes, *the more issues are left on the side as not being your province, and you hope someone else picks those up* ... I think collectively as a team, it's our responsibility to make sure all these are addressed. (24:5:1:1993)

Thus the physician's paradigm is reductionistic as she or he tries to blend varying experiences of illness and discomfort into a well-ordered pattern of disease and symptomology illness classification. The practical dilemma in the daily workings of clinical life becomes an issue of providing for the more obscure areas of the clinical exchange.

7.3 Modifying the Model in Everyday Practice

Some physicians in addition to recognising and affirming the benefits of a team approach to the added dimensions of cultural health needs, also say that in fact they do engage in alternate ways of thinking informally during their practice and care. They explain that the emphasis on certain kinds of science-based knowledge and perceived difficulties such as those which have been described in previous accounts here result in their "having to do a process of modification" (19:7:9:1993) to allow for "flexibility" within the parameters of the model. They argue that a beginning point for such practices of modification is to try to 'work around' "one's personal attitudes" (19:7:9:1992) which are formed by the model. This often means for the practitioner that a very individualised and reflective process of change in personal thinking must take place in practice to

accommodate cultural differences. Sometimes it is described as a change in terms of "modifying your attitude". (19:7:9:1992)

> **Physician:** Yeah, *I think what you modify is your attitude* ... I would say that the people I'm working with ... they're Italian speaking ... I guess that the most difference compared with our model here, is the level of education and understanding ... *I shouldn't say understanding* but looking at the complaints from the conceptual point of view, which is that symptoms are something that happen to you like something from outside coming into you that you then talk about as being separate from you. *For them, they come in and the symptom isn't separate from them and they can't, they don't tend to look at it as something which is an entity in itself* ... they're experiencing the symptom ... they are the symptom. In a way, they don't have the symptom *and so it's really different* and you're saying ok, well what about that little thing you know, and they don't understand what you're talking about ... So you modify your attitude. (19:7:9:1992)

The problem that practices must be modified is an important one and must be emphasized for our investigation. It immediately draws our attention to the question of the location of the knower. What must be modified and for whom,in contrast to what alternative which does not need modification? Through the talk of this physician, the notion of 'modification' becomes clearer.

> **Physician:** We don't know how to fit it (cultural manifestations) into our model. You know - *when you have someone come in who complains about things that you don't feel fit your models, you may say "well, why are they seeing me? They should see somebody who's into that model"* you know - if the problem is that there's something about the son and the son is having problems with the daughter, well then, why don't they go and see someone(else) you know. *That's not our model - our model* is "where's the complaint?" and "what happened?" ... *You want them to come in and say "the problem is coming from there but it's causing this in me"* ... you know. (19:5:9:1992)

So there is a problem in that practitioners feel personally restricted by the practice and training principles which direct their activity. This dilemma often results in questions by physicians as to how patients may be evaluated and treated. Practitioners also argue

that rigid adherence to current model is "not always satisfactory" (19:8:9:1992), either for patients or for practitioners. In order to cope with this sense of dissatisfaction, modification of the practitioner's attitude comes to be followed, sometimes, by the individualised, "ad hoc" practical action of actually 'modifying'or molding the clinical process. And when the process can be more practically and realistically shaped the practitioner then begins to feel "more comfortable" with the modified clinical fit:

> **Interviewer:** If you had the chance to work around the curriculum a little bit, would there be things that you ...
>
> **Physician:** That's a good question, it's hard to answer, because I feel more comfortable now than a year ago ...
>
> **Interviewer:** You're adapting in a way?
>
> **Physician:** *Yeah, I'm adapting. And I don't think I know how I've fully adapted yet. But I feel more comfortable now* ... But I'm not sure that what I can tell you is what I'm going to agree to in a few months but what I think is, is that I've taken an attitude that whatever I can do, like I said before. *If I feel I may be helpful, I'll do it. If I feel like I can be detrimental, I just won't. And I just have to be satisfied with my limits in a way*. (19:8:9:1992)
>
> **Physician:** I think to whatever degree I'm effective (with patients from other cultures) or not now, has been very much more a case of learning on the job. (24:11:1:1993)

Another form of modification with respect to the formally learned model is the practical solution often described by physicians as "referring away"[23] or "referring out". Practitioners who feel restricted in not being able to skilfully modify the model when giving direct patient care describe the solution of "referring away" as a method of working *around* their sense of limitation in knowledge.

> **Physician:** I think you have to make a decision from the interview about whether you're clear enough that you've got the information straight and

> that your treatment will do no harm ... but otherwise I think it's really important to refer them (the patients) away ... So I don't blame people who refer them away, but I do feel bad about the fact that they're not always (pause) people are referred away because of misunderstanding, because of language, and sometimes they're referred away because of not understanding the type of complaint (pause) (the patient's problem, for example) and also the emotional intensity may be such that they (the referring psychiatrist) feels, "I don't want to deal with this". (19:9:9:1992)

Some physicians attributed successful cultural collaboration in practice to "experience" rather than formal acquisition of skills. Many described how the workings of day to day experience became a sort of trial and error process in terms of trying out what seemed to work and then trying out an alternative if, in fact, it didn't work. As one practitioner put it:

> **Physician:** *You get it (cultural knowledge) from experience. From seeing patients from different cultures and then the family members and then doing your best to put it together*, and usually unfortunately, initially in an oppositional way. The family might make a request and you would react by saying "no, this is the way it should be done from my perspective" - my culturally determined perspective as well as other formal training perspectives. And then the family would say "well, no, this is the way we would like it." And then it would get into a difficulty until a supervisor might step in and say "Well, let's see if we can arrive at something that these people can live with ... (31:6:9:1992)

> **Interviewer:** You seem to have quite an indepth understanding of some of the (cultural) issues. How did you learn that?

> **Physician:** Well, that's another part of learning your degree. *It's like a practical fellow who plays the violin - a fiddler without going to a teacher - it's just burning your fingers ... so you learn it in a practical way ...* There is no book or experienced teacher ... I never learned ... I had to learn the practical things myself. (26:3:9:1992)

> **Physician:** Knowledge is absolutely necessary. But if in the beginning of your training, when you haven't seen a patient yet and I am then going to talk to you about culture, you react, because you are busy with so many other things you are supposed to do ... the reaction is, "what's the big deal,

> why should we spend time." *It's only later, when, to use that expression, your fingers get burned* (and) you realize it (knowledge) is needed. (26:9:9:1992)

> **Physician:** One experience that stands out very much for me, early on in the ward experience here at -- was with one particular man who had come to Canada as an immigrant - an Urdu-speaking man from Pakistan, an older gentleman. His children had moved to Canada and they had brought their parents ... so this man did not speak English or French, he spoke Urdu ... And we were very concerned about this unfortunate, isolated elderly gentleman and we were trying to remain in the room a lot and since we could not speak the language, we were trying to convey the concern by touching and so on, only to subsequently find that he was a very devout Muslim and that we were invading his prayer time a great deal of the time and for females to be touching him was quite the antithesis of his cultural background to what would truly be supportive to him. So, *with all the right intentions, we did all the wrong things. And I think that was a real learning experience* ... (24:3:1:1993)

These preceding accounts of physicians attestations with respect to some of the contradictions and ambiguities they face within their cultural and clinical encounters at University Hospital, lead to some further theoretical considerations. While the argument is clear that the medical model has formally continued to establish itself as the dominant health paradigm in the West (Kleinman, 1992; Lock & Gordon, 1988), the argument is also clearly made in the theoretical literature that alternate and contrasting health care paradigms have not been forthcoming as a working model of clinical practice (Leininger, 1990). It is apparent that medical anthropologists, transcultural psychiatrists, medical sociologists, transcultural nurse practitioners and the nursing profession as a discipline, have offered alternative and contrasting paradigms to the orthodox medical scientific model of health and disease. However, as argued in an earlier chapter, efforts to posit alternatives which may be realised in formal hospital practice have been relatively unsuccessful.

Alternative & challenging paradigms of thought have also been proposed by medical sociologists who have shown that medicine in capitalist societies reflects the values of unequal power distribution and they have also shown how medicine can act as a form of social control (Navarro, 1978; Waitzken, 1983). These assumptions continue to prevail, concluding that the scientific rationalism of 'biomedicine', with its insistence on reductionism has maintained its orthodoxy in spite of decades of many pervasive and persistent alternate schools of thought (Kleinman, 1992). While these preceding assumptions must be largely acknowledged, the point of departure here is in the additional assumption which lies within this opposition to biomedicine. The additional assumption by these critics of biomedicine is that all practising physicians are unanimously incorporated into the 'canons of procedure' (Atkinson, 1988) informed by biomedical orthodoxy.

An alternative challenge to the view that the dominant healing model remains the exclusive model of practising western physicians and is thus secured within "tenacious biomedical assumptions" (Dossey, 1984, p. 15; Eisenberg & Kleinman, 1981), may be seen in the work of Raymond Prince. For example, the notion of formal "cooperation" and "partnership" between western medical practice and folk healing practices has been given attention specifically in the area of transcultural psychiatry (See for example, Prince, 1981, 1984). Prince points out that due to detailed field work across psychiatric and anthropological disciplines, the work of folk healers has gained increased "intelligibility" and "credence" by western medically trained physicians. Reporting on the First Pan-African Psychiatric Conference in Nigeria in 1961, Prince has argued that there is

evidence to suggest some affirmation and recognition of folk healing practices, which in turn has made possible some 'cooperative ventures' (Prince, 1981).

In line with the concept of 'cooperative ventures' and partnership some of the physicians' accounts of clinical practice at University Hospital, may be considered not only from the perspective of whether alternative healing views are accepted and acted upon by practitioners, but also in the context of the concept of 'cooperative ventures' (Prince, 1981) and 'partnership'. Earlier in the chapter we listened to the accounts of physicians and nurses with respect to modification in practice of the science-based models which inform their practice. I will elaborate further on these practice actions of modification here and show the way in which the effort to 'cooperate' happens in practice. If we think of this notion of 'cooperation' in the context of an informally acknowledged practice or in a way that is not readily visible within the orthodox space of health care, it becomes possible to see that the *informal* processes of thinking that physicians and nurses at University Hospital engage in, do in fact, acknowledge this 'interface' and 'cooperation' in terms of cultural care. For example, in some of their views, physicians at University Hospital argue that, in practice, a "combination of biomedicine and cultural knowledge is necessary" (19:10:19:1992). They argue that strict, orthodox adherence to pharmacological rules, informed by standard principles, sometimes "needs to be loosened to accommodate" (37:1:6:1993) culturally defined illness concerns which often fall outside orthodox biomedical clinical evaluation. One psychiatrist argued that the need to cooperate with two differing orientations comes from differing complexities of known biological phenomena.

Physician: Biologically there are a lot of (cultural) coping things too, that have to be accommodated. The use of medication for example is often (culturally?) different. For example, a lot of people will respond to a dose of medications that are a third of what you give normally ... with like an anti-depressant, the minimal dose from the CPS will sometimes give people side effects that they can't tolerate ... a dose that would be considered non-therapeutic *is* therapeutic. We know that fact if we happen to read about it. We tend to doubt it and to really resist going down (decreasing the dose) you know ... that's something I didn't do except by just going through it clinically. (19:10:19:1992)

Physician: A patient I have, a woman in her 30s with Schizophrenia. She's on neuroleptics *and* herbal medicine. And she came to ask me how I felt about these two different medications and I know quite a bit about herbal meds and I find them fine. They don't generally speaking, interact negatively with the other bio-drugs. (40:5:3:1993)

Physician: Yes, integration of what I do is a conscious, deliberate, thoughtful modification of medication based on a particular interest in this field, based on my experience and based on some of my own knowledge of differing cultures and from my own reading and research. It is integral to my practice. (40:5:3:1993)

Physician: With that particular patient, it was a cultural and physiological dilemma, and I figured medications are not the answer. I'd tried every medication in the book, Orap, Haldol and Prozak and I thought that's enough, we have to look at how it's done in their way ... in their tradition (42:5:8:1993)

Other comments pointed to the need for "stuff to be done in terms of understanding biomedical and cultural differences" (19:10:19:1992).

Physician: So from a biomedical point of view, *I think there is stuff to be done in terms of understanding that the (formal) therapeutic windows of medications aren't necessarily true.* (19:10:19:1992)

Physician: And in your practice ... if you (try to) see every patient, every family as being on a continuum as being a microculture to being part of a larger culture that's different from yours ... then every culture ... everyone of those little microculture, let's say different levels has things ... has (pause) I wouldn't say myths exactly ... (?) But have preconceived ways of doing things (coping) that are not going to change (pause) and

> that the therapist might think would be important for them to change ... (29:10:9:1992)

In reading these preceding views, it becomes clear that these physicians are arguing that issues of 'coping' with illness do not necessarily follow the orthodox, pre-determined specifics of pharmacological intervention. In addition to the argument that "there is stuff to be done in terms of understanding the therapeutic windows of medication aren't necessarily true" (19:10:19:1992), physicians are also adamant in their view that first encounters with patients need to encompass an introduction of the knowledge and expertise of *both* practitioner and patient. Speaking about the notion of open-ended exploratory assessment in the clinical interview, this same physician expresses the need to "explain" "the context" of the western therapists orientation as being something that is indeed possibly different.

> **Physician:** I think that's a big idea that we have in our way of dealing with people (that they will openly talk). Some people come in and you've got to do a lot of explaining of the context (pause) what you're expecting, what you're role is ... they want to hear an explanation of how that fits in with their experience ... (19:12:9:1992)

And this therapist goes on to say how sometimes the notion of using 'silence' a western practice orientation in terms of the psychoanalytic interview must be understood and negotiated as phenomena characteristic of western practice:

> **Physician:** You know, the psychoanalytic model where silence is something which supposedly fine, I think in the first interview (with families with a differing cultural expectation) if you haven't defined the context, I think silence in any social interaction is pretty damn uncomfortable if it lasts a long time. So, unless they know ahead of time that silence (in western psychoanalytic orientation) is a chance for them to introvert and to think over things and to come up with their thoughts ... In other words (for some cultures) silence isn't silence, it's absence ... silence

> doesn't have the meaning (that western orientation) that's been ascribed to it (pause) it's just damn uncomfortable. (19:12:9:1992)

One major perceived paradox at University Hospital, in practitioner's attempts to effect collaboration of western medical knowledge, with treatment realities of differing cultural populations, is in the expected practice of following a continuous refinement of science-based medical paradigms.

Practising physicians do know that their efforts at reciprocity in care are superceded by the central tenets of medical curricula. For example, many are vocal around concerns which have been raised in the literature, which emphasize the need for medical training to allow for a greater sensitivity towards culturally determined issues of illness and disease. Other physicians at University Hospital agree with the known worry that 'biomedical data' not only dominate curricula, it proliferates, becoming central to the evaluation criteria for successful graduation from medical school (Moffic, 1987). As one physician put it.

> **Physician:** Well, I think we don't have time, (for cultural considerations) that is the result of having a biomedical model be it the operative model in an acute hospital. So clearly, it's biomedical data that takes precedence in terms of attention and discussion and so on. And indeed one comes to hospital because one needs to have pathophysiology understood and disease treated from that perspective, but what then gets unfortunately too often overlooked, I think, is the impact that these cultural issues have on how one is feeling physically. (24:5:1:1993)

The consequent problems raised by some physicians practising at University Hospital can be witnessed in a common personal complaint about the everyday workings of the medical model. These physicians argue that "it often conflicts with some very basic humanistic principles", "does not always accommodate the unexpected" (24:5:1:1993) in

the process of decision-making and places limitations on their practices in the "lack of formal emphasis on cultural assessment" (24:6:1:1993). Moreover, these physicians worry that the content of knowledge with which they are provided "does not always provide the optimum conditions for culturally sensitive health" (24:6:1:1993).

7.4 Paradox and Reciprocity in Western Health Care Thought

As we have heard in their accounts, physicians working in multicultural settings such as University Hospital, often find themselves in 'ad hoc' or 'accidental' decision-making practice dilemmas. These practice dilemmas not only occur in the process of finding a discordant clinical fit. They also sometimes occur as the result of a personally felt experience of history and culture of which they too, as immigrants themselves, are an integral part.

Some of the reasons that have been seen to account for the preceding questions around practice, it may be argued, point to the other somewhat difficult paradox which currently characterises the discourse of health care in the United States and Canada. One problem for example, is in the concern that students both of medicine and nursing, need adequate and sufficient preparation to keep abreast of ever-changing demands of a sophisticated and increasingly complex technological economy (Barley, 1988; Parse, 1992; Maxwell, 1979). These writers assert the inevitability of a progressing technological and scientific world which must be seen to encompass concomitant knowledge and expertise. And yet, these same proponents of health professional education are concerned that there is a need to prepare students to think creatively in terms of the every day choices they

make about their work (Parse, 1992). These advocates of curriculum change include in their argument the need for decision-making knowledge and skill with respect to life world practice and cultural sensitivity.

Again, this backdrop of concerns is the notion that state health policy decision-making has not taken seriously these apparent polarities of learning technical excellence, versus informally and creatively organized practice. Therefore, there is an absence of the academic possibilities that could be given to practitioners and thus patients may not always receive maximum benefit from their practices.

Much health practitioner training policy has in fact offered solutions that either takes away curriculum design that might prepare practitioners to be knowledgeable and critical thinkers in personal and family relationships (Anderson, 1986; Leininger, 1976), in this case multicultural relationships, or leaves out substantially the role of anthropologists, transcultural practitioners and educators of health care and multiculturalism. Solutions that are offered do not always benefit from the judgement and experience that for example, a cross-disciplinary approach to health care practice might bring to bear on these issues (Anderson, 1987; Boston, 1992).

The result is that current health education policy formulations appear to leave practising physicians and nurses without the formal knowledge and clinical skill for understanding racial and cultural concerns (Moffic, 1987; Masi, 1988; Stephenson, 1990). In addition to the concerns we have heard here, in the voices of physicians, about needing to personally *work* cultural health content into the existing structure of the medical model, another question arises on issues of language understanding and communication. The

question then arises that if physicians and nurses must depend on 'ad hoc' creativity to ensure that a goodness of fit exists between themselves and the individual patient they serve, how in the absence of language understanding does this actually take place?

In a previous chapter it became apparent from the voices of practitioners and patients that there was a gradual yet steady increase in the number of people who identified themselves as foreign-born who were seeking health care and employment at University Hospital. We heard through the talk of patients and practitioners about a global diversity of people at University Hospital whose cultural, socio-economic, linguistic and political backgrounds are substantially different from one another.

Chapter Eight: Multilingualism
The Practice Setting In Action

8.0 Competency, Culture and Language Understanding

The issue of language and translation presents a significant challenge for practitioners and patients at University Hospital and is an important one for our understanding. Since an estimated 35 per cent of patients in the hospital speak neither French nor English, the question then arises as to how, within the daily workings of treatments, procedures, information giving, diagnoses and bedside care, patients and practitioners come to understand each other. The issue of translation is complicated moreover, not only around simple translation of a given language, but also around its various meanings and interpretations. As Ralph Masi puts it:

> Clinical, professional interactions depend not only on the spoken word but also on body language. The issue is not simply one of translation: different cultures express themselves differently. Characteristics and mannerisms, if misinterpreted, may lead to difficulties in interaction. For example, some populations may, as a sign of respect, be more reserved. Others may be more expressive ... Even simple gestures, such as a handshake may be interpreted differently by a variety of groups (Masi, 1993, p. 15).

With this sense of the complexities of language and interpretation in a multicultural health environment, we may then look at the ways in which language and understanding are managed by patients and practitioners. A prevailing assumption which is evident in the talk of practitioners at University hospital is that language ability and linguistic competency are firmly embedded within a hierarchy of ideals. The ideology of intelligence is a filter through which practitioners perceive their role as novice language learners.

Often the practitioners' shared notion of intelligence in relation to language ability embraces the dominant ideology of mediocracy in western society[24]. The wide range of opinions about the value placed on having competent language skills illuminates the practitioners' sense that his or her social position is not fixed but is in his or her view, determined by the varying judgements made of practitioners as linguistically competent interpreters of the world. The experiences of some practitioners for example, have led them to believe that linguistic competence determines a place within a hierarchy of intelligence which is inextricably interwoven with a position of status in the social structure of health care practice.

> **Nurse:** For myself, what I find people judge (pause) they make judgements be it well .... I mean patients can't understand all of this (treatment) so we'll superficially tell them what's going on. I mean, I don't think we give them the full benefit of the doubt because they're from a different background and there are a lot of different ways of doing things to ours... be it because the way they're dressed, be it because their language - be it because where they come from ... let's say they're coming from the mountains or from South America (pause) they're intelligent as any - your or I. I mean there's always a way of explaining. *But I found through my years in nursing, that if it's an immigrant or their language is poor, they're judged very quickly.* (12:8:12:1992)

> **Nurse:** I am Portuguese. I arrived here in '61 at the age of fifteen ... It was difficult because of the language of course ... people treat you differently when you speak with an accent ... I would say that because I'm Portuguese I sort of came into nursing with a different background (12:1:12:1992)

Some nurses argue that the mastery of linguistic skills is the means to a viable entrance to their professional peer affiliations.

> **Nurse:** It (nursing training) wasn't easy (pause) because I still hadn't mastered the language fully (pause) there was a big barrier (pause) with my nursing colleagues because of language. (12:3:12: 1992)

These notions of 'mastery' in terms of linguistic competency are also seen to manifest themselves in the way that practitioners must decide on their own what their individual language abilities in the clinical setting are and how to use them. Some nurses make the assumption of this 'reality' by placing themselves on a self-created evaluative scale of language proficiency. They measure their abilities on this scale in terms of a passing grade or what they describe as a skill of 'getting by' or barely 'managing the basics' (13:8:10:1992). Others appear to have chosen to place themselves much lower on the language competency scale. These practitioners argue a sense of helplessness or inadequacy and in so doing, place themselves amongst those with a failing grade:

> **Nurse:** It (the clinical test) was totally foreign to her (the patient). It was totally (pause) *I felt such a failure.* I couldn't do the translation and she couldn't understand or comprehend or (pause) *I don't know. I couldn't even talk to her* (pause) but just from her body language, I know that she was fearful about what was happening to her. I felt really afraid for her I could see that she couldn't understand why it (the clinical test) was being done (18:9:3:1993)

> **Nurse:** I manage very well. It seems I don't have such good English, I have an accent ... but even (the) Ukrainians understands.

> **Nurse:** I speak Ukrainian a little bit ... Russian a little bit. Hungarian I understand a lot of words too; Lithuanian a little bit, French and English. Well I manage to make it (language) understood, only the basics ... And *I'm capable* to pick up a few words and be able to make the global things understood. And there it's not a bad problem, *and they (the patients) are very pleased.* First when I don't know their language or some things like that I will say to them, how do you say hello and the next visit I will say bonjour and I say o.k., *that's the start.* And then I'm capable, even I have an accent ... to manage the basics. (13:6:10:1992).

Others see this notion of 'getting by' around language understanding not so much in terms of helplessness or a lower placement on the language scale, but more in terms of being able to tell patients "something meaningful" in terms of their care. They see this

form of interaction as being able to speak enough so "that in fact you do something personalised" (17:4:3:1993).

> **Nurse:** Now I think it is nice when people - caregivers are able to interact with patients in different languages. And I think that patients feel that, even if you know several sentences in that language that you speak, that you in fact do something personalised. So sometimes you really need the whole medical translation. But sometimes you just need to be able to tell them that there is something that you know which is common with what they know ... to make the contact, they just feel that they can trust you better, that they can ask you that you know something about them. (17:4:3:1993)

Other nurses claim that language translation ability cannot always function to "maintain a therapeutic or an informative (patient) relationship" (16:4:3:1993). These nurses argue that the problem of explaining treatment and conveying information isn't sufficient and cannot be solved with "understanding a number of languages" (16:4:3:1993).

> **Nurse Manager:** I think (there is) a point of contact. I think it is then probably difficult to, or we should not assume that this is enough, to maintain a therapeutic or an informative relationship with that individual. I mean if I were to say that I speak a number of languages ... then just because I have assembled the patient's history, *I certainly cannot tell the patient or explain to the patient, what I would like them to know. So I wouldn't be sufficient. I could just make the contact, but I wouldn't be sufficient* to be the interpreter for that interaction. (16:4:3:1993)

Other practitioners express pride in the sense of their successful management of language skills. Placing themselves high on the language proficiency scale, they see themselves as having achieved through life experience a high degree of multilingual competency. This they are able to insert into their routine practices and as such are able to successfully do their work.

> **Nurse:** I guess here I feel pretty capable as far as language ... I speak - my main language is English and I learned French when I came to Quebec. I also speak Chinese - 5 different dialects of Chinese and I speak the national language in Singapore as well, which is Malay and so (laughs) that's a lot. (12:4)12:1992)

In sum, practitioners not only take personal pride in their various abilities and proficiency in speaking and understanding the differing languages, they also know that these self-learned skills are a necessary attribute to the function of practice in University Hospital. Nurses realize that as practitioners they must be able to work collaboratively and accountably within the interdisciplinary professional mode of clinical daily work and they also know that the measured success of such collaboration is often also a function of having to make things work linguistically. Thus these aspirations of personal effort towards mastery of linguistic competence, according to these accounts, play an important role in the day to day workings of clinical life. These practitioners then see themselves as vital and responsible participants, as well as being an integral part of a team of linguistic mediators. Moreover, practitioners also know that they must maintain flexible work boundaries to allow for extension of their linguistic expertise beyond singularly focused clinical concerns.

8.1 Linguistic Collaborative Exchanges as "Normal Events"

What becomes central to these nurses' concerns around language proficiency is the way in which such skills are used in order to effect good collaborative practice. Learned multilingual competency is not only useful on an individual level, it is also useful as a working tool within the clinical community. Practitioners at University Hospital learn

about each other's language skills and in turn, know how to make these skills work for themselves on a collective level. They learn the utility of linguistic collaborative exchange and they learn to accept this phenomenum *as if* it were a normal event.

It becomes clear within the voices of nurses with respect to the process of linguistic 'coping' that these language coping inter exchanges are seen within the complexities of a network of multicultural practitioners as an integral part of their everyday world.

Practitioners who are considered linguistic experts within the hospital community, in that they have demonstrable fluency in languages, know they must *expect* and be expected to *work* as mediators and language translators for patients and families throughout the hospital. This is evident from the following two dialogues:

Dialogue (a)

> **Interviewer:** Do you find in your everyday practice that language is an issue for you?
>
> **Nurse:** I have been asked on several occasions to try and help patients out - my speaking five different dialects is limited in the way that I'm not good at translating medical terminology (pause) but I'm beginning to see more and more Chinese patients in the clinic who really don't speak anything except Chinese (pause) *I try very hard* (pause) I'm kind of looking into it now to get some help from experts who speak the language better than me and to try and get them to teach me some of the medical terms.
>
> **Interviewer:** So what kind of help uh ...?
>
> **Nurse:** It's amazing, a lot of Chinese don't know medical terms as well (pause) so, I've been (pause) I've come across a few people that I've known in the hospital who can really help me. So yesterday, I bumped into a patient who always has a translator, so I asked if she could help me

(pause) and she didn't know all the medical terms as well (pause) like (pause)

Interviewer: I'm not quite clear. Are you saying it is this patient who could help?

Nurse: No it wasn't a patient, it was the patient's translator. But I asked the patient, If her translator could help me ...

Interviewer: Oh, the patient's translator?

Nurse: (Yes) But she (the translator) didn't know, so she promised me that she's going to help me by looking into the dictionary and maybe calling me ... (11:6:2:1992)

Dialogue (b)

Interviewer: When is translation an issue?

Nurse: Well I find if I can get a translator (pause) let's say if o.k., I can't understand as if we both aren't connecting at all.

Interviewer: What sort of resources exist, if one did want a translator?

Nurse: Staff persons, other staff people *that I know* speak other languages, (you) call locating to ask for somebody, it's *not a problem if it's just for language.*

Interviewer: So if you were to call locating, what would the process be?

Nurse: I have someone who speaks say, Vietnamese for instance so I 'phone (the switchboard) and ask can you please page someone overhead if someone is available, if someone is available can they come down to my area if they could.

Interviewer: And that happens?

Nurse: Yes, I think if they have someone Vietnamese (pause) whoever it is, someone will come (12:8:12: 1992)

Thus the notion of 'informal practice' or 'ad hoc' coping with the necessities of understanding treatment and care, arises out of the immediacy of the health care context. Patients and practitioners then collaborate to *"normalise"* an organized system of 'makeshift' or 'ad hoc' language practices.

> **Nurse:** Like this morning, there was this Chinese patient who came in with her son - her son is a little handicapped (pause) and I said why are you here with him today? When I met her in the corridor and she said she had to make an appointment and I said well, you could call instead of coming here and she said "because I don't speak the language ... You know, so they feel very insecure in that sense - that's why I told them next time call me and if I'm here I'll help you instead of you know travelling quite a distance ... But they felt reassured ... just to see the receptionist. To get the card to say that the appointment is there - I think they feel more secure. They feel if they had spoken on the phone there would be a misunderstanding (11:10:12:1992)

> **Nurse:** The Asian patients have to come towards me because they tend to ask me questions - because some of them like I say, don't speak English. So they come to ask questions and then when I answer their questions and then they will always be phoning me, calling me for information ... As for the other patients, if I was the one who started their treatment, as a primary nurse on there, then it's ok ... But when the clinic have a new patient - *they want me to take their case*. They want me to go down to the clinic ... They don't understand the treatment there. I find that patients tend to come towards me and are sometimes very fearful ... (11:8:12:1992)

> **Nurse:** No I don't think it's necessarily if I'm not there .. the world goes on. It's ... I think it's just that when they (Asian patients) have questions they probably think you're probably understanding them better in the sense of the cultural (11:9:12:1992)

And here it can be seen that the instant accessibility of 'linguistic expertise' is made easier by the assumed flexibility of everyday working conditions which allows practitioners and health care workers to adjust and re-adjust their working roles. The

perception of the practitioners account constitutes a reality of what is accountable as a normal sequence of events. The practitioner asks the patient if a translator (found by another practitioner on a previous occasion) can be made available and it is on the basis of whether or not the patient agrees the reality becomes accountable for this practitioner. What does not figure in the account is the sequence of events which has led to the ad hoc action of looking for what is perceived to be the incidental, yet normal, occurrence within the health care process. Moreover, what is also missing in the account are the time-managed conditions of the process of seeking out the 'accidental', thus what is of primary concern here are the social relations within which these actions and practice are embedded.

Strategies of learning on the job or learning the ropes of linguistic accessibility then serves the ultimate purpose of adhering to clinically accountable care.

> **Nurse:** Yeah, I mean what was good with that patient was that once we had found somebody to help us translate we could do a proper evaluation (15:7:10:1992).

> **Patient:** They try their best for me (pause) they want to help (pause) sometimes I don't understand what he (doctor) is telling me and he doesn't have time (pause) but, well yesterday was good, that lady over there (patient in next bed) she helped them because she knows to speak my language (9:9:3:1993).

Health practitioners then work up strategies for what serves the practical purpose towards achieving the objective of treatment and care. As long as the ultimate planning of care functions smoothly, vagaries then remain in the background. Thus there is an evolving but continuous 'ritual' solution which allows the problem to become normalised.

Many practitioners see their 'ad hoc' arrangements to accommodate language needs as an expected, taken-for-granted aspect of their work which falls *outside* of the domain of their own primary clinical caseload.

This tension is particularly evident when practitioner and patients are known by others to be from similar cultural backgrounds. Practitioners describe the various ways they are able to make themselves available or accessible even during the most casual encounters:

> **Practitioner**: Well then I met S. in the hallway and she said, oh there you are, I was looking for you in the cafeteria. Do you have a minute? We have this patient in endoscopy and she doesn't speak any English and I told her sure in five minutes I'll be right there (14:3:12:1992).'

And when the "norm" of ad hoc language collaboration is called into question, the reality of the account remains the same. For example, in the absence of a "staff" translator, rationalisation for the breakdown of the ritual takes varying forms. For example, the breakdown of the system of calling the switchboard or getting someone through 'locating' they argue is just a case of "the wrong people being on duty at the wrong time".

> **Nurse:** Well, if well you know, the units have a lot of different staff who speak different languages ... sometimes it is just a matter of the wrong people being on duty at the wrong time.
>
> **Interviewer**: So if they are not on duty?
>
> **Nurse:** If the staff is not on duty on the day you need the translation then it's more of a problem.
>
> **Interviewer:** How so?
>
> **Nurse:** Well in this hospital we are always exposed to different cultures, I mean you have (pause) S. actually speaks Italian, K. speaks Vietnamese

> and we had a nurse who floated with us who spoke Portuguese and *so we said we were pretty well covered* in the sense of language ... So that's why when I came here to the clinic, they said "oh K, good that you are down here because we have so many Chinese patients."
>
> **Interviewer:** So it's almost always well covered ...
>
> **Nurse:** Yes, most of the time and like I said before, sometimes it's just a matter of the right person being on another schedule that day (11:9:12:1992).

And when external 'problems' arise these ritual solutions involve drawing on 'ad hoc' rules of thumb. There evolves a parallel progression of thought and deed which stems from the need for both patients and practitioners to remain in control.

> **Practitioner:** I told Mrs. S don't worry, we'll get someone to help (pause) to explain the treatment better than me and she really seemed relieved. She didn't know what we were going to do and that we have to do that I/V in ten minutes ... (11:7:12:1992).

Practitioners seek to salvage their 'own' knowledge of the system in order to act *knowingly* before admitting confusion and lack of control, since this would detract from the expediency of the action and ultimately the need to maintain accountable care.

This need to act *knowingly* is expressed in a variety of ways as evidenced by the voices of these nurses:

> A Chinese nurse tells us:
>
> I'm *beginning to see* more and more Chinese patients *in the clinic* who really don't speak anything except Chinese. I'm kind of looking into it now to get some help from experts who speak the language better than me. (11:6:12:1992)

But in other views practitioners, while acknowledging the varying needs for linguistic competency which arise in their daily encounters, also concern themselves with the language of the 'professional' culture. These practitioners raise concerns that "no

matter what the language of the culture is there is a problem with the terminology we use" (17:4:3:1993).

> **Nurse Manager:** The terminology we use when we discuss things (pause) with patients. And sometimes we speak to the patient in exactly the same terms as we would give a lecture to the residents and by the time we're finished, the patient has absolutely no clue what they've said (pause) they don't understand half of the words they are saying. Now if this is something that we do all the time, at least we can try to validate whether the person understands what we are saying. (17:5:3:1993)

And these worries become extended to the feeling that differing levels of language comprehension have the potential effect of creating barriers between patients and health practitioners:

> **Nurse Manager:** The fact that they have to understand what I am telling them in my professional language and then they have their language which is their day-to-day language and then there is their language that they can understand. Again, if I don't validate that they understand me, the barrier is there. (17:5:3:1993)

A further set of excerpts from interview data examined below illustrate that many 'on the job' aspects of the work process which are systematically excluded in formal health care practices are nevertheless included in the daily activities of University Hospital. Indeed they are considered by practitioners to be central to the functioning and management in the everyday, individualised workings of the hospital setting. They are fundamental to an understanding of how all practitioners construct a common-sense understanding of their own individual practice as an integral part of their clinical day. By making visible the firmly embedded nature of informal work tasks, such as strategies for language translation discussed below, I want to show that formal health policy learning objectives do not stand on their own merit for all cultural health care practices, thus

aspects of policy making may be called into question. However, it is not the intention here to address congruency issues of health care theory and practice, but to demonstrate the way in which delivery of health care takes place in a process of textual mediation which is organized and defined by the state.

8.2 Ensuring Language Understanding: "A Very Creative Endeavour"

A major challenge which many physicians know is that they must expect to and are expected to practice 'accountable care' within the fixed criteria of objectives prescribed by the health care which is taught through the curriculum. A further challenge is to make possible the fulfilment of these requirements, as well as including the necessity for what many practitioners term "commonsense experience" on the job.

The most prevalent issue related to cultural understanding that emerged in my daily interactions with practitioners in the practice setting was the problem of how to get help for the needs of patients. This came to be called "identifying resources" which practitioners saw as a very "creative" endeavour. While this "creative" endeavour of knowing how to identify multicultural resources persisted throughout all practitioners' accounts and actions, a large part of it came in relation to the many complex and varied language needs of their multicultural patients and families at University Hospital. For instance, at one multidisciplinary health team meeting that I attended, ten out of the twelve patients whose cases were being discussed spoke neither French nor English as a first language. It also became clear that when the need for language translation arose either for understanding diagnosis or treatment, practitioners saw the time needed for

meeting this requirement as their own "personal responsibility" (41:6:4:1993). They saw this as something which frequently needed "creative" innovation and a special form of know-how in order "to find someone" (40:2:4:1993). One group of physicians explained the range of possible options. As they put it, they would have to "find someone amongst ourselves ideally", "find someone over the hospital loudspeaker, which usually worked very well" or "just try to manage without" (40:2:4:1993; 41:4:4:1993). Many talked about these language resources as vital to the assurance of quality patient care, which was also referred to as accountable care.

Maintaining "accountable care requirements" often meant that procedures, treatments and clinical actions had to be fitted into an orderly required work schedule. It therefore depended on the practitioners' ability, wisdom and skill to know how to obtain translation resources on an informal level. Not only did practitioners' resourcefulness exist in addition to the broader scope of their duties of maintaining accountable care, it was vital to its functioning. This broader scope knowledge of their duties manifested in their varying skills to think up solutions for working with culturally related concerns and in being able to insert 'common-sense' decision-making into their day to day practice interactions. In particular, the 'creative' work of finding a translator was seen by practitioners as one of the most routine and necessary tasks that goes on in a multilingual hospital environment. While this routine was evident in all my interactions, with practitioners, one area where it was particularly noticeable was on the wards and in clinic areas where patients were being treated for cancer. The following dialogue between myself and a physician at University Hospital illuminates these issues.

Interviewer: Do you think practitioners need to know (multiple) languages to practice here. Is that an issue?

Physician: Well, I think that's the ideal but clearly there's a limit to how many languages you can know. *I think ideally you identify as many resources as creatively you can because so many languages are represented in the patient population.* Particularly as our patients get older. Cancer is more frequent as one gets older and it is the older members of the family who tend not to have gained either English or French.

Interviewer: That's interesting. You mentioned resources. Can you talk a little bit about the kinds of resources there are. How does that work?

Physician: *Well I think within the professional team it's important to identify who speaks which languages so that we can use each other as interpreters as far as that goes.* Again, I think that when we're dealing with sensitive issues of coping with loss, where each member of the family many have a different coping mechanism. It can be difficult asking a family member who's struggling in their own way to translate and identify what the issues are with other family members. So it really is helpful to have an objective neutral party involved who is able to translate with the patient. *I think where we benefit is having a large volunteer team and this team really expands a great deal on what we'd be able to do with just a professional team* in terms of coming from different cultures and backgrounds. We haven't looked at that in any detail lately but many years ago we did do a survey on the background of our staff and of our patient population and our volunteer population and found *that there was a much better match (linguistically) in terms of diversity between the volunteers and the patients than between the staff and the patients.*

Interviewer: So in the sense of needs for language, it's sort of a pulling on the informal resources.

Physician: That's right, I think so. The more usual situation of course (for getting a language translation) is that you have a Portuguese patient for example and you ask for an interpreter and you get the Portuguese painter in the hospital. And of course it varies, but it usually works that way ...

Interviewer: Could you give a particular example?

Physician: Well of course, we do learn how to work with the language because we feel stymied by the language. But then some of the cultural psychosocial issues aren't dealt with by one direct translation either. For example, one elderly patient I know with a - tumour with metastasis - is

> experiencing a great deal of pain. And I think there's also a tremendous amount of anxiety and fear involved there. And so you end up very often having to have several translations. (24:3:1:1993)

What becomes clear in this latter dialogue is that this practitioner, knowing that there is "a limit to how many languages you can know" also knows that in order to deal with the reality of many variations of cultural care, in this case language understanding, she must expect to *insert into* her clinical practice her common-sense and *creative* skills in order for her patients to be able to know and understand the nature of the care they are receiving. This practitioner knows at once that she must expect to make additional time beyond her clinical duties when a patient's need for translation requires it. She also knows that she must allow for the time-managed conditions of "creatively" selecting a meaningful language "match".

What also becomes apparent as we hear more about practitioners varying attempts to find needed translation resources is their taken-for-granted assumption of resources that are *not* needed. In the taken-for-granted busyness of everyday clinical working life and in the urgency of each clinical moment practitioners *expect* to find working solutions. They also know that they are *expected to* find 'working', 'ad hoc' solutions in order to adequately account for their practice.

For example, another physician is heard to express pleasure in finding a sense of teamwork collaboration of linguistic sharing in personnel from the multidisciplinary team. This practitioner finds in the available exchange of language resources by working practitioners, a system which "works very well". What is not visible in his talk are the

time-managed conditions which must be accommodated to allow for these additional practices to take place:

> **Physician:** *I am blessed and fortunate to work with an excellent team. At any given moment we can call on someone ... people on this team are multicultural* so we have, well, an Italian nurse, a Chinese nurse, a Portuguese nurse, *so it's a delight ...*
>
> **Interviewer:** There's almost a natural exchange of resources?
>
> **Physician:** It works beautifully. It works very well. (31:8:9:1992)

In another account, a practitioner argues that the unexpected clinical moment in patient care is in itself, a justification for the creative seeking out of informal resources:

> **Interviewer:** Is it (language translation) do you think, an *informal system*?
>
> **Physician:** *It has to be I think, because the time to have chat is when the time is right and so you have to call up whatever resources you can find at that time, particularly with a (critically ill) population* where today one is able to talk and to plan to be able to talk and plan next week is totally uncertain. *So you really have to capture the opportunity when it arises in so far as you're able to do that.* (24:3-4:1:1993)

The preceding excerpts of interview data take into consideration the concept of 'modified cultural learning' as a basic and integral premise of the clinical experience. It shows how an independent health care reality is organized, achieved and managed through the conditions and the requirements of clinically accountable care. A particular version of culturally responsive knowledge is produced and reproduced through the clinical experience. The reality of 'identifying language resources' outlined by these practitioners is straightforward. There is nothing natural about this reality, although practitioners make claims to what they understand to be normative representations of that reality. Rather their reality of language organization is produced and reproduced by the expected regimes of

accountable medical care and nursing care. These are the regimes which sustain and exclude the 'stuff' of which formally defined cultural care such as language care is made. What is invisible in the preceding exchange is the way in which these physicians in general are initiated into a sub-clinical method of working with language/culture which is essential to an orderly work process. This is a necessary and yet formally unaccounted for piece in the overall workings of their day. Physicians know that they must creatively 'capture opportunities' and add in whatever is necessary to accommodate formal clinical requirements. They also know that this involves the "active suppression" of individual work needs in the clinical process. Thus, having to *work into* practice a common-sense understanding of 'how to identify resources', subordinates practice and ultimately patient care, as the answerable outcome of practice to the end of achieving 'accountable care'. This in turn is attributable to a regulation of learning and practice formally sanctioned by the policies of the provincial health system at large.

Conclusion

This thesis has examined how cultural understandings are generated and transmitted in a Canadian multicultural teaching hospital. It has explored how issues of culture are addressed formally and informally in the daily practices of nurses and physicians.

Using the approach of an institutional ethnography, emphasis has been placed upon informal strategies of cultural care as a taken-for-granted practice in hospital life. The central idea informing this approach has been that personal life experiences are constructed within a complex set of organized social practices. This thesis has sought to make visible how the pressure to learn culturally sensitive care seeps into the fabric of daily hospital life and how cultural learning and practice is constructed within an organized set of social practices.

This thesis has shown that the practice of multicultural health care is not simply an issue of whether or not a policy exists which states multicultural intentions. It has argued that one must go beyond policy formulation and stated intention, and consider the day to day issues of clinical life in hospital settings. It has attempted to show how cultural understanding has less to do with a formalised set of beliefs around preconceived models of cultural understanding, and more to do with a health system which at a broad level is organized to accommodate orthodox western health care within a complex set of social and economic practices. It has been argued here that managing cultural practices is subsumed within regimes of formal adherence to the western orthodoxy of technology and

scientific medicine where legitimate space for health care is occupied predominantly by this paradigm.

I have tried to show that clinical practices are grounded in formalised notions of health care that are intricately interwoven, not just within formalised notions of models for practice, but in every small, day to day clinical moment. Practitioners are a part of a complex and ever changing clinical environment which encompasses each practice moment in the day to day decision-making of clinical life. Practitioners know they must make sense of the situation they face in practice, using both their formal training and the numerous idiosyncrasies that make up the fabric of daily living.

At the present time, health care education is focused on the priorities set by an objectified world of scientific specialisation. The central tenets underlying these formal paradigms have an impressive history of contributions towards the health and well-being of patient populations. However, in order to better serve its recipients and practitioners, legitimate claims to health do not formally encompass culturally sensitive learning and practice in day to day clinical life..

The models of training which inform both medical and nursing curricula assume scientific concepts of illness and health. Practitioners must position themselves in their everyday world of caring and treating to support and prioritize these science-based models. Moreover, the infiltration of western frameworks for care requires adherence to a discourse which is legitimised as if there were no negotiated alternatives. Formal models of care result in a socially determined form of objectified reasoning, which is fully manifested in the processes of everyday talk and communication.

On a theoretical level, it was argued in Chapter Three that ordinary wisdom, common-sense understanding or everyday life knowledge around alternative health care are not formally included in practice, nor are they seen to fit within the scientific demands for rational, precise measurement routinely associated with professional expertise. However, it was also argued that practitioner expertise is in fact, often a kind of 'know how'; a particular common-sense understanding or wisdom which permits us to interpret our everyday world. Practitioners experience a personal response to any given situation, which reflects their personal knowledge, and precedes cognition, and which is called upon in day to day clinical life. The day to day decisions made by practitioners at University Hospital draw heavily on this subsidiary knowledge. Yet, clinicians are taught a process of deductive reasoning which assumes that tacit or subsidiary knowledge must be subsumed within the orthodox medical authority. Thus, clinical work occurs with the inherent assumption of giving priority to the model.

The informal moments of clinical decision-making during which practitioners rely on their personal responses are very apparent in the realm of giving culturally responsive care. They happen most readily outside of and invisible to the orthodox disciplines for practice and the standard frameworks of teaching. While practitioners bring to their work a kind of knowledge which is deeply personal and which transcends formal learning, it is not as rewardable as the body of legitimate knowledge that has been realised through the ideals of our current health policy framework. Cultural learning and practice happens as an outcome of the assumption that all learning proceeds *as if* by nature, and as if multicultural learning was accidental in its development.

It has been shown how a particular change in the need for care and practice in the health care climate at University Hospital also creates pressure for practitioners to attain differing kinds of knowledge and expectations. This evolution of the need for a differing response to care in the form of multicultural care is embedded within a process of restructuring which is not always visible in the day to day moments of caring and treating patients. Practitioners, we are told, express their practice experiences in a variety of ways; they adapt their responses and attempt to "get by" when misunderstandings and difficulties arise at a given clinical moment.

Drawing on the voices of patients in Chapter Four, I have tried to make visible the grounded experiences of sick people and their families. Their perspectives are located in the experience of their suffering and also within the specific organization of day to day health care practice. Many patients appreciate the care they receive, while others struggle to make sense of the process of giving and receiving treatment in terms of personal and lifeworld understanding. These patients must cope with the complexity of meanings attached to their illness and care. Not only do patients perceive that they must cope with personal meanings of pain, they must also attempt to comprehend the dominant health culture on several levels of understanding. They must cope not only with the semantics and mechanics of language translation, but also with the complexity of technical and scientific meaning which moves beyond simple day to day translation. What is evident in their accounts is the evolving presence of a legitimate claim to systematic, recognisable cultural learning which is necessary, and yet is absent from health practice.

In chapters Five and Six it was argued that culturally responsive practices occur in the daily experiences of practitioners against conflicting concerns around the theoretical assumptions which formally define the professional discipline. Among nurses, within the theoretical ideals of the profession there has been a formal attempt to move away from the reductionism and mind-body dualism integral to positivist frameworks of practice. Amidst several models of nursing, two basic theoretical assumptions are that nursing is interpersonal in nature and that nurses view individuals as part of a whole. Underlying these assumptions is the belief by nurse scholars that nursing not only considers symptoms and disabilities, it also encompasses the psychological, social, emotional and spiritual aspects of an individual.

But it was also seen in Chapter Six that in hospital life, nursing practices adhere to an orientation which exclusively embraces the concepts, laws and theories informed by the scientific paradigm. The increasing demands for proliferation of medical and scientific technology pervades nursing leadership priorities in terms of health policy education and cost effectiveness. Thus models of training which inform both medical and nursing curricula often assume quantifiable, rational practices of caring and health experience. Day to day nursing practice experiences are often seen as antithetical to the actual decisions that practitioners make to arrive at culturally sensitive care. A clear example seen at University Hospital, is that the way learning is organized so that competent nursing workload measurement practices are achieved, entails learning skills of precision, rigor and accuracy around mathematical formulae. Thus nurses must expect to hone their

skills regarding taxonomic learning, objectify their patient assessments and ensure accuracy in the quantification of patient care needs as units of work time.

In the everyday hospital world, their kinds activities are perceived and rewarded as legitimate. It is seen as learning which leads to accountable practice. Therefore nursing decisions which are considered legitimate on a day to day level are specifically those which are the outcome of highly developed quantitative skills. Such an embodiment of nursing interest however, while it represents and maintains the existing social order of the health care world, has the potential to misrepresent and ultimately mask, the actual realities of the way in which the needs of the multicultural clientele are met.

In these circumstances, multicultural health care does not occupy a legitimate space in health care practice. 'Uncertainty', variation in terms of time and effort, as well as cultural variations are formally unaccounted for. When nurses surreptitiously *work in* ad hoc care which does not fit precisely into the workload measurement formulae, there is no question that they do practice multicultural health care. But these efforts of nurses are neither the outcome of federal or provincial multicultural policies nor health education policies, and as such they are not legitimised. These efforts of nurses to 'fit in' the practice of multiculturalism are implicitly interwoven within the formally legitimized orthodox health practices. While these ad hoc efforts of *working in* multicultural health care are clearly to the credit of the professionalism and integrity of individuals, they also contribute to the papering over of opportunities for increased systematic support for legitimately defined multicultural health care practice.

In Chapter Seven I have argued that physicians exercise ad hoc health care practices in much the same ways as of nurses do. Although the biomedical model provides a way of organizing information and incorporating implicit values of reductionism, physicians' claims of experience in practice are that not all clinical encounters can be measured in terms of measurable tests, or by reducing the whole to its smallest unit. And while physicians will affirm that scientific-rationalism dominates their learning about the diagnosis and treatment of disease, they will also affirm that they must exercise a personal form of practitioner 'know how' which works outside of the formally defined learning models in order to function in their daily encounters. From the talk of physicians at University Hospital, we hear that while they acknowledge adherence to the dominant medical model, they must also work beyond the model in order to accommodate the cultural needs of their patients. During the many culturally defined idiosyncrasies that form a part of each clinical decision, physicians report that they 'work in' or modify the regimes of practice which are their guides. Thus their clinical work skilfully observes the very moments of tension which need to be made conscious.

An additional aspect of ad hoc culturally responsive care is apparent at University Hospital in the efforts of physicians and nurses to foster and maintain a network of informal resources. This can be seen in their efforts to accommodate language needs for illness and treatment understanding. Practitioners manage to maintain and adhere to the requirements of scientific accountability to practice by their ability, skills and wisdom in 'knowing' how to obtain ad hoc translation resources on an informal level. In consequence, the particular form of culturally responsive knowledge which is produced

and reproduced is of an unpredictable quality and is also unrecognised as a legitimate requirement of standard care. In turn these processes are attributable to a regulation of formal learning and practice which is sanctioned by the policies of the provincial health system at large.

Implications for Practice, Education and Research

Canadian health institutions servicing multicultural populations should ensure policy-making procedures at all administrative levels that include a specific commitment to recognize, understand and take into account cultural, racial and linguistic differences. Education policies which prescribe formulae for teaching and practice could more visibly reflect the practice needs of the multicultural populations which they serve. If these goals are to be achieved, Canadian federal and provincial policies could give specific recognition to the practice and learning needs of health practitioners working in multicultural health populations with the full range of language and human rights. Furthermore, at all levels of individual institutions, policies could include the principles of equality of status of all cultural and ethnic groups within provincial and federal health care sectors. This includes the freedom of all individuals and communities to retain their cultural beliefs in the context of health care education and practice. It also includes equality of access by individuals and groups to language services and support - not only in their spoken language but also in the language of the professional culture.

Moreover, both patients and practitioners from multicultural health populations could enhance multicultural care by participating fully in the decision-making processes

around health education, practice and policy making. They could inform the health care system of the particular mechanisms which serve to most fully recognize their cultural beliefs concerning illness and treatment.

In the area of future research on culturally sensitive care, questions need to be directed not only by the standard notions that are part of the formal discourse of scientific medicine, but by the way health practitioners make sense of their everyday world, and their practices within that world. Of vital importance is whether the research is structured to accommodate the perspective of the practitioner and patient in their everyday moments and experiences of cultural care. That is, multicultural research needs to be concerned with the perspectives of people in the day to day working moments of hospital life.

Research is also needed which concentrates on the intersubjective perspectives of participants in their everyday local context. Research also needs to place health experiences within the culturally grounded context of everyday work and health care systems, entertaining the principle that there are multiple forms of knowledge in the everyday context. In this way, research broadens to include the multiple representations of reality in the context of the political, social and economic health care sphere.

In the area of health practitioner education, reforms are needed not just through issues of dominance, but also in terms of the hows and whys of the way in which the best intentioned structures maintain the system. Health education reform should also address the underlying ideologies that structure and order the orthodox discourse, so that calls for change in curricula are made with full consideration of what needs to be changed within the political administrative regime of education. Moreover, those fundamental practices

that serve to mask and render invisible the humanistic and intuitive practices of health care personnel need not only be exposed, but also fundamentally challenged.

In the area of health care practices, in order to effect realistic change in everyday care, reform is needed that avoids the traditional dichotomies between orthodox health care paradigms and alternative healing methods and which considers seriously the concept of complementary or partnered treatments. Multicultural patient populations need a realistic opportunity to fully comprehend the health care and treatment options they have chosen. Thus existing dichotomies between physicians and healers using complementary medicine need to be bridged. In this regard, federal and provincial health policies must address not only education and practice issues around complementary medicine, but also issues of legality. For regardless of what scientific paradigms of thought have achieved, if the notions of multiculturalism and cultural understanding, as intended ideals, are to enter the reality of day to day Canadian health practices, the formal contextualisation of complementary knowledge needs to be enshrined as an institutionalised resource in policies of health care learning and practice.

Ultimately, viable solutions are to be found in the formal recognition of "negotiated" health care knowledge which is fully visible and legitimate in the daily practice of settings which serve multicultural populations. In this way, health care knowledge and practice would be acknowledged as a 'reciprocal' exchange of mutual rights and obligations. Finally, as a special addition to the process of culturally responsive teaching and practice, clinical applied educators, anthropologists and cross-cultural practitioners, knowledgeable in the organization of medical and nursing knowledge, need

to be involved in developing new policy formulations and health practitioner education programs. In addition, community and lay caregivers might also work with professionals which, in turn would assist in negotiation, cross-cultural interpretations and meanings associated with health care.

Providing effective health care to all segments of Canadian society requires structural changes in health education policies and practices. Policies which support cultural understanding need to address the disjunctures between 'effective ideals' and existing ideological knowledge in order that all are ensured optimum health care.

Endnotes

Chapter Two

1. The notion of "constructed reality" has been discussed in the context of a naturalist approach to methodology by Egon Guba and Yvonna Lincoln. Based upon the notion of a unity between knower and known, Guba and Lincoln describe people's constructions as subjectively created realities. As they put it: (Constructions) do not exist outside of the persons who create and hold them; they are not part of some "objective world that exists apart from their constructors. They consist of certain available information configured into some integrated systematic, "sense-making" (Guba & Lincoln, 1989, 143).

2. In actual fact, Egon Guba outlines three broad categories for the purposes of policy research: policy-in-intention, policy-in-action and the definition which I am choosing to follow here, policy-in-experience. Guba's central concern here is with the choice of methodology which he argues, must be determined by the researcher's understanding of the definition of policy (Guba, E. (1984).

3. Positivism refers to the development of a scientific method of studying the world which began with the early ideas of Auguste Comte in the nineteenth century. Borrowing concepts from the biological sciences, Comte aimed to develop a body of knowledge which would closely parallel that of the pure sciences. His central aim was to 'legitimise' the study of society which would then allow sociology the same recognition as that attributed to the pure sciences.

   For primary sources see: Martineau, H. (Ed.) (1896). For a readable explication of the positivism of August Comte, see Coser, L. (Ed.) (1971).

4. Contemporary phenomenology is indebted to the early ideas of Edmund Husserl (1859-1938). The fundamental tenets underlying his work were primarily concerned with philosophical questions on the nature of reality. Husserl asked questions such as how is it we know that we really exist in the world and if we accept that we do exist, how is it possible to know that. Challenging the notion of positivism, Husserl argued that it is the "lifeworld" that constitutes reality for human beings. He argued that we can only know the world through our own consciousness which is inextricably interwoven with our lifeworld and if this is so, then it is not possible to objectively measure the world. Husserl's central ideas form the current basis for modern phenomenology and ethnomethodology.

For further reading on the basic ideas of Edmund Husserl see: Husserl, E. (1965). For a readable general reference on phenomenology see Berger, P. & Luckmann, T. (1966).

5. It is beyond the scope of this discussion to fully explicate the phenomenology of Alfred Schutz. The following primary sources allow a comprehensive reading of his basic idea. (Schutz, A. (1932, 1962 & 1964).

   For an understanding on the relevance of Alfred Schutz in relation to the Sociology of Knowledge formulated by Dorothy Smith, the reader is directed to the following source: Smith, D. (1987).

6. Peter Berger and Thomas Luckman offer a highly readable explication of the notion of multiple realities as two sets of consciousness in the course of everyday life. They explain: "different objects present themselves to consciousness as constituents of different spheres of reality ... Among the multiple realities there is one that presents itself as the reality par excellence. This is the reality of everyday life. Its privileged position entitles it to the designation of paramount reality (Berger, P. & Luckman, T., 1966).

7. Doing the 'stats' in health care language usually means ensuring the process of a rapid completion of necessary tests, which are in turn given priority for analysis by the diagnostic testing technicians.

8. This concern with the way people's beliefs are upheld and the way in which activities make sense to members within a setting in the face of multiple possible realities is central to ethnomethodology. However, the method does not articulate a link between people's visions of realities and the social organization which structures and defines them. For example, Garfinkel examined and outlined the production of two types of "facts" related to Agnes' gender in that two types of facts were made available from his research interviews. However, the ideological health care knowledge which structured the health care system was not illuminated. Garfinkel did not attempt to explicate the way some of the "facts" were organized and produced. Thus the research concerning Agnes, became limited to the varying perceptions of respondents involved in the case (Garfinkle, H., 1967).

   For a secondary source and explanation of Garfinkel's work, see Warren Handel, (1982).

9. For a detailed discussion on the notion of a guiding orientation versus an open 'objective' approach to research analysis on "talk" see Furlong, V.A. & Edwards, A.D. (1985).

10. The quotations throughout this chapter and those following, which are identified by month, year and code numbers are extracted examples from my institutional ethnographic research work with patients and practitioners in a large university teaching hospital in Canada. They have been cited to allow for clarification of the theoretical material.

11. Dorothy Smith uses the concepts of "governed", "ruling", "relations of ruling" and occasionally "ruling apparatus" throughout her work. However, Smith has clarified that she is not concerned so much with the traditional notions of state and class (such as Navarro would formulate in relation to health care) but more with a conceptual understandiong that grasps the pervasive structuring of organization and regulation in modern society. As Smith puts it: "When I write of "ruling" in this context, I am identifying a complex of practices, including government, law, business and financial management, professional organizations and educational institutions as well as the discourses in the texts that interpenetrate the multiple sites of power" (Smith, 1987, p. 3). In contrast, Navarro (1978) sees health purely as a commodity and health care delivery as a requirement for profit and efficiency. Here there is a tendency to see illness for example, in strictly economically-oriented terms, which effects direct exploitation and alienation of the health care population.

    For a detailed explication of these ideas see Navarro, V. (1976). See also Waitken, H. (1983).

Chapter Three

12. There are a number of varying definitions associated with the term medical model. It is frequently referred to as the biomedical model (see M. Lock & D. Gordon, (Eds.), 1988). However this definition does not take into account disciplines within the medical field which are not strictly informed by the biological sciences, such as psychiatry. Use of the term 'medical model' here refers to any body of health knowledge informed by paradigmatic scientific-rational thought. It should also be clarified that while the association with this term frequently applies to formal medical training, its use here is equally associated with any segment of the health practitioner population practicing science-based care.

13. These assumptions originated with early enlightenment thought which focussed on a separation or disenchangement with nature and viewed the world as an entity composed of physical matter obeying natural mechanistic law. Enlightenment philosophers viewed the world from a strictly materialist perspective - a fixed stable entity. These thinkers were united in the idea of a human perfection. Whether rationalists of French philosophy, sensationalists following Locke or materialists following La Metrie, enlightenment thinkers were united in the belief

that man has no 'divine soul,'is an object in nature, but is capable of self-improvement through education. Moreover, when men are released from the restraint of superstition and irrational beliefs it was argued, it is then that they may fully develop rational thought and thus progressively attain full perfection. See Frank E. Manuel. (1965).

14. A good example of the notion of common-sense understanding has been offered by Basil Bernstein (1964), who has explained this phenomenon in relation to the relative absence of necessary verbalisations in low-income British families. As Bernstein puts it: "If you know someone very, very well an enormous amount may be taken for granted; you don't have to put into words all that you feel because the feelings are common" (quoted in Prince, 1993, p. 18).

15. The concept of paradigm is taken here to mean a series of perspectives or orientations that guide theoretical formulation, rather than the classic notion of paradigm developed by Thomas Kuhn. Kuhn defines paradigm as an entire repetoire of beliefs, laws, principles, verified theory and methodology which assumes research consensus about theory, methods and techniques. See Thomas S. Kuhn. (1970).

Chapter Four

16. I have used the terms curriculum, model, framework interchangeably throughout this thesis, although using a definition exclusive of these concepts would place limitations on the overall thesis. I want to point out that the issues at stake are more complex than practice models or frameworks for care. For example, the concern is not only with decision-making around nursing or medical course content, but with the social practices by which all western health care content is organized and designed.

Chapter Five

17. Incontinent means that the patient does not have control over his or her bladder or bowel functions.

18. Psycho-social needs are the social support, teaching and intervention needs of the patient and family or significant others.

19. Primary care nursing means that a nurse is assigned to oversee the complete care of the patient and family from the time of admission to the moment of discharge and follow-up as necessary.

Chapter Six

20. Accountability in nursing has been described in terms of the concepts of authority, responsibility, and autonomy. It has similarly been described as an obligation to be answerable for one's decisions and actions to someone recognized as having the right to demand explanation and information (Snowdon, 1993).

21. A factor value is the value in points, designated to a nursing action/intervention as identified by the patient classification system.

Chapter Seven

22. For example, Kleinman (1992) has argued that:

> The monotheism of the western tradition has had a deterministic effect on biomedicine, even as it is practised in western societies, that distinguishes it in a fundamental way from Asian medical systems ... the development of concepts is toward proof of the validity of a single version ... of the body of disease and of treatment.

23. The practice of referral is usually taken to mean a process of consultation by which physicians may formally request clinical consultation with a colleague in a specialty area other than his or her own. In this particular case, the practice of transferring a patient between physicians of the same specialty is referred to.

Chapter Eight

24. For a detailed study of this notion of intelligence as an ideology of mediocracy, see Luttrell, Wendy (1985).

    As part of this work, Luttrell makes a fine distinction between women's perceptions of formal school knowledge and the notion of common-sense as something which is developed outside the middle-class institution of school. The women in Luttrell's study claimed that common-sense knowledge is focused around the ability to "use what you know" as opposed to repetition, regurgitation or memorization from what someone says in a book". Luttrell situates this line of inquiry within a socially defined ideology - a process of formal schooling which is "judged by people from a high class or with more authority." (pp. 101-119)

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