

## INTRODUCTION

### When the field is a ward or a clinic: Hospital ethnography

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In 1930 Michael M. Davis, commenting on public investment in American hospitals, wrote:

[To the sick person and] to the family of the sick patient, the hospital is a battlefield between life and death, the focus of intensive anxieties and hopes. To the physician, the hospital is an institution for the practice of medicine and a central agency through which the study of disease is pursued, the boundaries of medical science widened, and medical skill increased. From the standpoint of the businessman and taxpayer, the hospital represents a financial enterprise. (Coser 1962, 3)

It is one of the earliest observations we know about the multiple meanings of hospitals and could be read as an invitation to hospital ethnography. But, for a few exceptions (e.g., Caudill 1958; Fox 1959; Goffman 1961; Coser 1962), institutions like hospitals attracted little attention from ethnographers. Social scientists who were interested were mainly sociologists (e.g., Parsons 1951; Freidson 1970) focusing on structural and organisational aspects of hospitals as institutional systems. Ethnography was still widely regarded as something carried out outside one's own culture. Hospitals were too near and familiar to raise the interest of potential ethnographic researcher and few thought it worthwhile to study everyday life within the 'culture' of hospitals. It was not until post-colonialism moved the anthropological focus from the exotic of the Other to shine a light on the exotic of the Self that hospitals became of interest to anthropologists.

However, it was not only anthropological interest that was necessary to forge a relationship between ethnographic method and the hospital or clinic as a field site. Any relationship requires that interest be reciprocated, and hospitals, as highly structured, protected and exclusive/excluding institutional spaces (Foucault 1975) were not at first easily accessible to ethnographic enquiry. As is evidenced within the growing body of literature on hospital ethnography, barriers can arise to an anthropologist accessing a hospital or clinic space, and access cannot be taken for granted. It is a delicate relationship requiring much sensitive nurturing.

One of the first ethnographic studies of an 'ordinary' (American) hospital was Rose Laub Coser's (1962) *Life in the Ward*. Interestingly, the author declares the hospital an

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'exotic' place by calling it a 'tight little island' (3); as an island, it cuts its inhabitants off from the 'continent', the world where 'normal life' takes place.

While the patient lies in his bed in the ward, the outside world recedes from view. Through the windows, if any appear within his range of vision, he can only see the roofs of surrounding buildings, all part of the same hospital. . . . Even his relatives drifting in at 1 p.m., may come to seem 'strangers,' divorced from the main problem that faces him now: the problem of cure. Family and friends belong to past or future; and wear an air of unreality. (4)

In his study of a Bangladeshi hospital ward, Zaman turned the idea of hospital-as-island on its head, by studying the hospital ward as a place invaded and shaped by the values, rules and ideas of the outside world. A Special Issue on hospital ethnography was conceived from a similar viewpoint. The two editors posed two premises:

First, contrary to a commonly held notion that hospitals are nearly identical clones of a global biomedical model, anthropologists are beginning to describe and interpret *the variety of hospital cultures in different countries*. . . . Second, and related to the first, is that *biomedicine, and the hospital as its foremost institution, is a domain where the core values and beliefs of a culture come into view*. (van der Geest and Finkler 2004; original italics)

These two approaches, hospital-as-island and hospital-as-culturally-embedded, echo early anthropological studies of island and village communities. An understanding of complexity and multifaceted relationships is essential in these endeavours, and ethnography delivers a methodology with which to collect and analyse data on this complexity, rendering it invaluable in portraying the richness of hospitals.

With Davis' earlier comment that a hospital is 'a battlefield between life and death, the focus of intense anxieties and hopes,' we are reminded of the multitude of films, novels and stories that portray the deepest human concerns in the setting of a hospital ward.

The South African writer Marlene van Niekerk (2006) situates her novel *Memorandum* in the small world of an intensive care unit. The main character, J.F. Wiid, a rather boring civil servant, who is waiting for his operation finds himself between two critically ill patients, who engage in an animated but incomprehensible conversation throughout the night. Wiid pretends he is sleeping and memorises that weird exchange, including many terms he did not understand, such as '*army-kist-mors/mot-iets*' (*amicus mortis*) and '*pas-sa-kal-lia*' (*Passacaglia*). He spends the days after that strange night deciphering the conversation and slowly discovers that these two men were reaching out to another in the face of death. The 'memorandum' he writes about the experiences of that night turns him into another person. Hospitals are places of intensity, of life-and-death drama, creating moments of truth, self-discovery and rites of passage. In being removed from 'normal' life, a patient is frequently given the opportunity – or confronted with the necessity – of taking stock of kinship, friendship, meaning, finitude, mortality and other core issues of life.

Rites of passage are a staple site of inquiry for ethnography. Universal in all human societies, rites of passage mark the movement of a person or group of people from one physical and/or social identity to another. These are often life-cycle events, such as birth, death, marriage, graduation or initiation. Rites of passage involve three stages. Firstly, there is removal or dis-integration from the old social category. Secondly, there is the liminal stage of being 'betwixt and between', belonging to neither the old or new category, and yet at the same time belonging in each. In the liminal stage old identities are broken down, in order for new identities to be forged. Finally, there is reintegration into the new social identity/category (Turner 1977).

Hospitals are ultimately liminal spaces, where people are removed from their day to day lives, taken into a betwixt and between space of being diagnosed, treated, operated upon, medicated, cleansed etc. For many people, hospitals are places in which their previous identities as a healthy person, as a mobile person, as an immobile person, are stripped bare. New identities, such as a cancer survivor, a more mobile person with a new hip, a rehabilitated person with one less limb are forged. In many societies, rites of passage are the domain of religious experts. As Foucault (1975) powerfully points out, scientific and medical expertise has in many areas of industrialised societies competed with and driven out religious expertise. In hospitals, medical experts determine the rites of passage undertaken. Hospitals have claimed the domain of the beginning and end of life rites of passage, with people in many Western societies birthing almost exclusively in hospitals, and increasingly dying in hospital or clinical-like spaces.

Religious or semi-religious dimensions of a stay in the hospital have been the theme of various anthropological contributions to hospital ethnography. Comelles (2002), for example, relates his own hospitalisation after a terrible accident that almost killed his wife and made his own hospitalisation a hell of fear. Belief in miracles arises in this centre of reason and science. Hospital workers too resort to religious terms to rekindle hope and combat despair among patients. In Comelles' account religion is added to the medical dimension, but more happens. Science and technology themselves assume a religious stature in posing as ultimate truth and road to salvation. Medical treatment is viewed as sacramental intervention and gift of grace and new hope (cf. van der Geest 2005).

The hospital, in short, is a place where questions about ultimate concern and encompassing meaning present themselves with more urgency than in the routine of everyday life. In other words, hospital life represents a condensation and intensification of life in general.

That goes for religious experiences but also for other fields of social and cultural experience, such as kinship, power and social inequality, and economic behaviour. Yet, we should not lose sight of the fact that at the same time the hospital is indeed an island where patients undergo another regime, dress differently and inhabit other roles.

Ethnography should take into account this ambiguity of the hospital and clinic. The very notion of hospital ethnography infers socio-cultural settings in which there has been an intervention of some form of biomedicine albeit different forms in different cultures and societies. Until quite recently the literature has emphasised the social relations between clinicians and patients. There has been very little ethnographic research about other interfaces or stake-holders in complex medical contexts e.g., of those exclusive of the patient, of clinicians and their teams, or other kinds of hospital workers.

The articles in this Special Issue focus on broader interfaces of ethnographic endeavour and the clinical setting. The anthropologist has been seminal in constructing this interface but not always well received nor respected. Hemmings (2005) argues for the need for anthropology to provide greater relevance to doctors and patients: we would extend this to advocate the usefulness of anthropological insight for an even broader range of stakeholders in clinical settings, to include nurses, health managers, allied health clinicians, and patients' families, friends, advocates and support groups.

Zaman (2005), who published a moving description of daily life on a huge ward in a Bangladeshi hospital, told one of us that medical students often asked him what the practical value was of his work. They recognised and confirmed the problems of poverty, extreme hierarchy and professional contempt for patients and relatives, but what next?

Hemmings laments that anthropologists do not engage with medicine and vice versa. Shand (2005) disagrees, arguing that there is a significant growth in 'anthropology *in* medicine', that is 'anthropologists working alongside medical practitioners and whose work should have practical implications, and therefore be shown to be of direct clinical importance' (106). Like Shand, we argue for the recognition of contributions made by collaborations between anthropologists and their clinical colleagues, including, for example, Bardram and Bossen's (2005) groundbreaking work in video ethnography, Rapp's (1999) long-term and on-going engagement with amniocentesis and its social and clinical implications, and Warin's (2003) contributions to understandings of anorexia treatment. In projects headed by a health organisation expert, Rick Iedema, and two of the co-authors of this Introduction (Long and Hunter) have undertaken ethnography in collaborative research projects working closely with clinicians, in which practice improvement outcomes were high priority for our clinician colleagues (Long et al. 2006; Hunter et al., forthcoming). As these researchers and others have shown, ethnography is uniquely placed to interrogate the complexity of clinical environments (cf. Cassell 2005; Iedema et al. 2006).

This collection contributes to the literature on what Shand and others termed Anthropology *in* Medicine, and illustrates the extent to which ethnography is being fruitfully applied to hospital and clinical environments. In our view, the distinction between anthropology *of* and *in* medicine makes sense to a certain point only. In the end, each intelligent description or analysis carries with it implicit suggestions for action. It is only the degree of explicitness of practical recommendation that varies and – of course – the formal position of the researcher, within or rather outside the medical team.

The instigation for this collection emerged from a conference panel on Hospital Ethnography, at the Australian Anthropological Society Annual Conference 2006. The response to the call for papers was overwhelming. The panel ran over two days of the three-day conference, and included 16 very high quality presentations on a broad range of current ethnographic projects. It should be mentioned that this response is especially significant in the Australian academic climate where units of study, let alone full degree courses on medical anthropology are scarce. One of the most exciting aspects of the panel was the depth of engagement between ethnographers and clinicians, both within the research projects presented and amongst the panellists during presentations and discussions.

The clinical settings discussed in the conference panel included hospital wards in spinal, rheumatology, neonatal, paediatric rehabilitation, oncology and intensive care units, an operating theatre, a nursing home and a mortuary. Health education and preventative health, drug and alcohol rehabilitation, health management and policy, women's health, alternative health and medical education were the other topics addressed in the context of the panel presentations. This impressive depth and breadth of engagement between anthropologists and clinicians appears to be only the tip of the iceberg of new collaborations that are being undertaken within medical anthropology.

This Special Issue brings together five of the articles from this panel. It is international and cross-cultural in scope, including research undertaken in urban and rural Australia, Kenya and Denmark. We chose these five because of their ethnographic quality and broad-range of interest. Others articles, also of high quality, are already in press in a Special Issue of the *Journal of Contemporary Ethnography*. Hospital experiences that coincide with different life cycle points are illustrated and the articles address a diversity of

actor-interaction and experience, with contributors looking at patient/clinician, clinician/clinician, patient/family and clinician/family inter-relationships.

In her article 'Negotiated Interactive Observation: Doing Fieldwork in Hospital Settings', Gitte Wind interrogates one of anthropology's foundational concepts: Participant Observation. She queries whether it is indeed possible, as an anthropologist or as a clinician-ethnographer, to ever truly participate in a hospital context. 'Doing the patient', 'doing the visitor', or 'doing the nurse' (or doctor) were not options for her. She chose to 'do the researcher'.

Her reflection on the limitations of participant observation is crucial and shakes the very foundation of hospital – and any – ethnography. She rightly questions the complacency and naiveté of ethnographers who claim to understand 'the other' because they practise 'participation'. Particularly with regard to pain and suffering, we should be cautious and critical towards our achievements. In a recent book, Kleinman (2006) expresses embarrassment over his earlier claims of understanding the suffering of those who sought his help. Experiences of pain in his own life have since made him wearier about 'understanding'. Wind suggests the term negotiated interactive observation to describe what ethnographers most usually do in hospitals.

Yet we should not lose faith in the anthropological approach. Its strength, certainly when it attempts to come closer to the experience of pain, illness and suffering, is not that it can pride itself of capturing exactly what the other experiences. Its strength, rather, lies in its modesty and in the awareness of the incompleteness of the attempt. There is no better option.

In 'Untangling the Web of Critical Incidents: Ethnography in a Paediatric Setting', Cynthia L. Hunter, Kaye Spence and Adam Scheinberg illustrate the extreme complexity embedded in two incidences that the clinicians involved saw as less than optimal practice. The article discusses both medical and social-cultural dimensions of complexity, and how these are, in fact, inseparable. Although neither was reported as an adverse event, both incidences were discussed and reflected upon by clinicians, leading to possibilities of positive learning and future practice improvement.

Richard Chenhall's article 'What's in a Rehab? Ethnographic Evaluation in Indigenous Australian Residential Alcohol and Drug Rehabilitation Centres' further illustrates the value that an ethnographic lens can offer to the complexity of health care. Questioning the standardised, generalised and quantitatively based measures used for evaluating outcomes in drug and alcohol rehabilitation, Chenhall shows that the multiple levels of meaning that are elicited by qualitative evaluation can offer more accurate methods for measuring rehabilitation outcomes.

In 'Patients' Perspectives of Hospitalisation: Experiences from a Cancer Ward in Kenya', Benson A. Mulemi undertakes classic patient-centred ethnography, to elicit patients' understandings of their disease, treatment, management and prognoses, which are often quite different to medical understandings. He highlights both material and non-material needs of oncology patients in a developing country hospital setting.

The final contribution, Philomena A. Horsley's 'Death Dwells in Spaces: Bodies in the Hospital Mortuary', explores the idea of 'death spaces', and the disruptiveness of dead bodies in a place dedicated to healing. Traditionally, anthropologists have been fascinated by death ceremonies; the hospital mortuary adds a completely new dimension to the rituals of death and dying (cf. van der Geest 2006; Brysiewicz 2007). Horsley brings this fascination home, in an analysis of what she terms the 'sentiment, science and spirit' of a western hospital mortuary.

Together, these articles illustrate the depth of insight available when the ethnographer enters the hospital and anthropology is firmly placed *in* medicine. The value of the dual anthropological lens of emic (insider) and etic (outsider) perspectives becomes evident when the collection is read as a whole. Whether working collaboratively with a clinical team, as is the case in Hunter et al., or as a more traditionally placed observer, such as Horsley, in each article emic and etic perspectives are blended to offer new and exciting insights into what may often be considered to be well-known terrain. Ethnography maps the impact of events on a wider variety of stakeholders than most interrogative methods: by reading Chenhall we understand challenges faced by both staff and residents in rehab, thus allowing us nuanced understanding of the challenges for those individuals who cross the boundary, as residents-who-become-staff-like.

Mulemi's research shows how, even when focused on patients' experiences, gathering data while they are in hospital can lead to a less confrontational analysis of patients' interactions with biomedicine than the more usual way of gauging patient satisfaction in industrialised hospital settings, i.e., by way of post-discharge interview. By putting patients' distress and dissatisfaction in the context of the realities of the ward, ethnography allows for a greater depth of understanding than, for example, interviews with patients and their families outside of the hospital. As in Anne Fadiman's (1998) classic 'The Spirit Catches You and You Fall Down', this understanding of the complexity of multiple perspectives has much to offer both medicine and anthropology.

Wind's article demands that we engage in refining anthropological method within hospitals. Her insights offer food for thought for all ethnographers, irrespective of their fieldsite. By examining the specificities required by an ethnographer working within a biomedical institution, Wind has raised queries that apply to broader ethnographic endeavour. As anthropologists increasingly gain access within hospitals, and as clinicians and health managers increasingly engage with ethnographers, we will continue to hone our tools for engaging in and applying ethnography in hospitals.

Two decades of 'critical' medical anthropology (cf. Singer and Baer 1995) and 'medical dominance' (Starr 1982; Coburn, Torrance, and Kaufert 1983; Larkin 1983; Willis 1983) have sensitised ethnographers to many aspects of biomedical culture. In advocating strongly for patients' and families' experiences to be heard in an environment where they were often muted, these discourses opened up new terrain for socio-cultural enquiry. However, the patient-advocacy stance of these discourses, as necessary as it was and still is, often leaves little space for complexity and nuance, and may demonise medical/clinical staff in its very valid attempt to understand patient/family experience. Research in this terrain is often poorly received by clinicians, who experience it as 'doctor bashing'. The value of deeply embedded hospital ethnography is that it offers a new and exciting level of data with which to synthesise critical medical anthropology. As is demonstrated in this collection, hospital-based ethnographic work offers a collaborative approach in which the ethnographer, of necessity, must take into account a broader range of experience of a hospital encounter. In this way we can be relevant to patients *and* clinicians, to families *and* managers, rather than advocates for one interest group as opposed to another. By positioning ourselves within hospitals, ethnographers can reflect upon a wide array of issues faced within these extremely complex institutions. The articles in this Special Issue offer a sample of what is happening at the coalface of hospital ethnography.

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