Urban diversity and the space of the clinic. Or when medicine looks at culture…

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This paper addresses issues concerning clinical practice in the context of urban diversity. While ethnicity, gender, class, and religion are all part of this diversity, culture, a priori that of immigrant clientele, crystallises a set of issues in everyday medical practice. Drawing on ongoing fieldwork in hospital wards of both general and subspecialty paediatrics, this article discusses the use of culture as an explanation for complex clinical situations. Examining relational dynamics central to interactions in paediatrics poses the clinic as a social space where a number of norms and values intersect, influencing the quality of the interaction and the care trajectory. Physicians, patients and families do not necessarily engage the same frames of reference and positively, or inversely, negatively sanctioned knowledge and practices acquire meaning within given contexts. Otherness simultaneously attracts and disturbs. This article will trace some of the processes involved.

[hospital ethnography, physician/parent/patient relation, urban diversity, culture, Canada]

Migratory movements, the globalisation of exchange, and the evolution of immigration societies elicit reflection regarding healthcare practices. This reflection concerns both local and global spaces. Undoubtedly, biomedicine occupies an important place in Western societies and elsewhere (Van der Geest & Finkler 2004), but pluralistic Western societies are also invested with several therapeutic traditions and diverse bodies of knowledge about the world, the body, and illness. This pluralism is due to a range of factors linked to migratory movements including diversification of national and ethnic origins, of religious affiliations, as well as of other variables also associated with social differentiation (Juteau 2003) and group hierarchies (Simon 1997) such as age, gender, and social class. The hospital environment, as an 'open door to the city' (Sainsaulieu 2003), is equally affected by this diversity, and healthcare units (hospital wards, external clinics, and emergency wards) are social spaces where caregivers, patients, and their families meet. As a context in which symptoms, diagnoses and treatments overlap, the clinic is also a place where multiple perceptions and representations intersect (Fainzang 2000, Strauss 1992).

It is as an anthropologist (and a faculty member of a paediatrics department) that I carry out research in a Montreal paediatric university hospital. This hospital environment is permeated by a number of phenomena, notably the diversity of its clientele with nearly 45% of client families born outside Canada (Gauthier 2004), and the development of clinical situations associated with technological progress (Lock 2002) and an the increase in chronic complex pathologies (Davis n.d.). Furthermore, the reform of the Canadian public health care system has also transformed the space of treatment (Cognet et Fortin 2003), most markedly by promoting patient care outside the hospital. This has had the effect of increasing "heavy burden cases" in the hospital, with the "lightest cases" leaving the institution, making room for more complex and often heavier cases in terms of care.

The urban setting is that of a pluralistic city, Montreal, with an immigrant population of 27%.[1] This metropolis welcomes nearly 90% of Quebec's newcomers (a predominantly French-speaking Canadian province) with an annual flux varying between 30,000 and 40,000 migrants originally from more than 100 different countries (Piché 2003). Canada is an immigration country with acquired naturalisation (*ius solis*, i.e. citizenship by right of land as well as birthright or law of territory) accessible after three years of permanent residence. This diversity, combined with a political agenda committed to an inclusive pluralism[2] and a double majority (French and English speaking) creates a cosmopolitan urban environment in which multiple languages and religions mingle (Meintel & Fortin 2002, Germain & Rose 2000).

Outline

Drawing upon on-going research (Fortin et al.), issues regarding clinical practice in a plural context will be explored.[3] After presenting the research context, the limitations of an approach to health that isolates its biological or organic aspects will be briefly discussed. The paediatric clinical encounter will then be presented as a triadic interaction situating the actors (the healthcare provider, the patient and his or her family) within a social space in which migratory and healthcare trajectories intersect. This triadic space is located at the crossroads of numerous norms and values, as well as social and cultural models, each of which colours the different perspectives observed within this study. The asymmetrical dimension of clinical interactions and the ways in which social relations intersect within the healthcare relationship will be evoked. The complexity of social and biological phenomena will be discussed as well as 'open' and 'closed' approaches to the Other in the space of the clinic. We will see how culture, *a priori* that of the Other, sometimes keeps the healthcare team from fully investing in the parent/physician relationship. Paradoxically, physicians are aware of the diversity of norms and values within their own practice and evoke the plurality of medical cultures. The notion of otherness and the limitations of references to phenotype or ethnic and cultural origin are discussed in conclusion.

Method

Ongoing since 2005,[4] this research has taken place in different units, including hemato-oncology, palliative care, and two spaces dominated by pathologies that are referred to as complex,[5] one offering curative care and the other long-term palliative care. It is within this setting that we examine clinical practices, particularly those of physicians, with a special interest in the caregiver/patient/family relationship. The approach is ethnographic, comprising observation in multidisciplinary clinical spaces and informal exchanges with diverse practitioners, patients, and families (spaced out over a one-year period); forty one-to-one in depth interviews with physicians (semi-structured, lasting between 90 and 120 minutes); and eighteen case studies with patients and their families. Cases were chosen on the basis of a strong team organisation (or the lack thereof), and of expectations not being met by the healthcare team or the patient/family, in such aspects as adherence to treatment, the involvement of parents, expressed therapeutic preferences, and so forth. For their part, physicians of various specialties were initially recruited (but not exclusively) on the basis of their presence in one or another of the observed units.[6]

A grid for observing healthcare units, physicians and intra- or multidisciplinary meetings has allowed us to compile a rich ethnographic corpus on patient-family-physician relational dynamics, on intra- and inter-professional relations, as well as on the contexts in which these relations take place. The study of departmental meetings has allowed us to follow the evolution of clinical histories from the healthcare teams' perspective, of the (variable) ways in which biomedical (diagnosis, prognosis, and treatment plan), social (family context and expectations by, or with respect to, parents) and cultural (norms and values expressed by the various actors throughout the therapeutic process observed) dimensions are taken into account.

Semi-structured interviews with physicians reveal, in addition to observed daily medical practice, the clinicians' perspectives regarding their practice and relational difficulties encountered. Individual socio-professional and demographic profiles have also been documented. Formal and informal interviews with families allow parents (and sometimes other relatives) to tell their story and that of their child, the illness trajectory and their perception of the clinical encounter (understood in a broad sense, often longitudinal).

This triple research method has the goal of documenting the daily medical practice of physicians (and other professionals), the world of the patients and their families, and the relational dynamics existing between clinicians and patients and their families. All that concerns the dynamics of the clinical encounter, how decisions are made, how the treatment episodes are segmented and, how those touched by illness react. Certain circumstances can aggravate mutual misunderstandings, particularly when serious measures related to managing the end of life are invoked, as it is the case in the settings in which I do research, notably in the course of palliative care. Indeed, these critical moments engender a "specific symbolic density" (Saillant 1999) and it is this perspective that has guided the choice of hospital settings. These places are also differently implicated in terms of technology and multidisciplinarity. They involve, variably, general-

ists and specialists such as paediatricians, intensivists, hemato-oncologists, infectologists, gastro-enterologists, clinical and liaison nurses, psychologists, social workers and religious (Catholic) counsellors.

Biological, social, cultural and minded bodies

Physicians and patients may draw upon different systems of reference in order to understand and negotiate the illness, the healthcare trajectory, and the decision making process. This possibility appears to increase (theoretically at least) in a context where social and cultural diversity is a daily matter. Nonetheless, the biomedical model based upon a biological vision of the individual dominates within Western medical settings (Kleinman 1995, Lock 2002) and imbues the training of healthcare professionals (Katz 1999, Laprise n.d.). This philosophy especially colours specialised care hospitals where the use of technology is important (Fiscella et al. 1997, Good 1998). Much attention is paid to the biological body, to organic disorders, often to the detriment of a more inclusive approach in which social and cultural dimensions are considered. These quite varied dimensions are then integrated to social relations (re)constructed through migration, modes of insertion into local society, family structures and individual resources (social, symbolic, and economic).

Functional disorders among adolescents, for example, will be dealt with differently by the physician according to the importance placed on the biological body, the social body, or the cultural body. The case of a young person suffering from a 'stomach-ache' or a gastric irritation with an intestinal obstruction will be rapidly taken on. However, if no organic cause is identified after medical investigation, the involvement in the case is less certain in spite of the presence of symptoms and pain similar to that of physical disorder. In short, in this schema, the patient, whose symptoms appear related to the dysfunction of an organ, will be interviewed and his or her distress investigated by a physician whose speciality is that area of the body or organ. From the moment that probable causes point to the minded body (*corps esprit*) and, as such, are attributed to various forms of stress, the patient falls into a zone of ambiguity. This ambiguity in clinical practice is not new in the development of biomedicine, which, since the 19th century, has progressively dichotomised the body and mind (Foucault 1963, Lock 2002a)[7] and, in a sense, poses the question of care (versus cure) as an inherent quality of the physician-patient relation (Good & Delvecchio Good 1993). Nonetheless, voices are being raised within the medical corps, decrying the limitations of an approach restricted to the biological or organic dimensions of a health problem (Fortin 2004, Leanza 2005).[8]

> For me, making a diagnosis is secondary. For me, it's important to know how I can best help the patient [facing me] and this family. So, often I will first ask [how I can help] in my interview. I think that that's the main thing. Then to… keep an open interview layout throughout the consultation and [remain] attentive […] to the family because often we realise that certain questions are not asked […]. And sometimes, it's precisely that… that can modify the compliance to treatment, the acceptance of a diagnosis, the follow-up, or
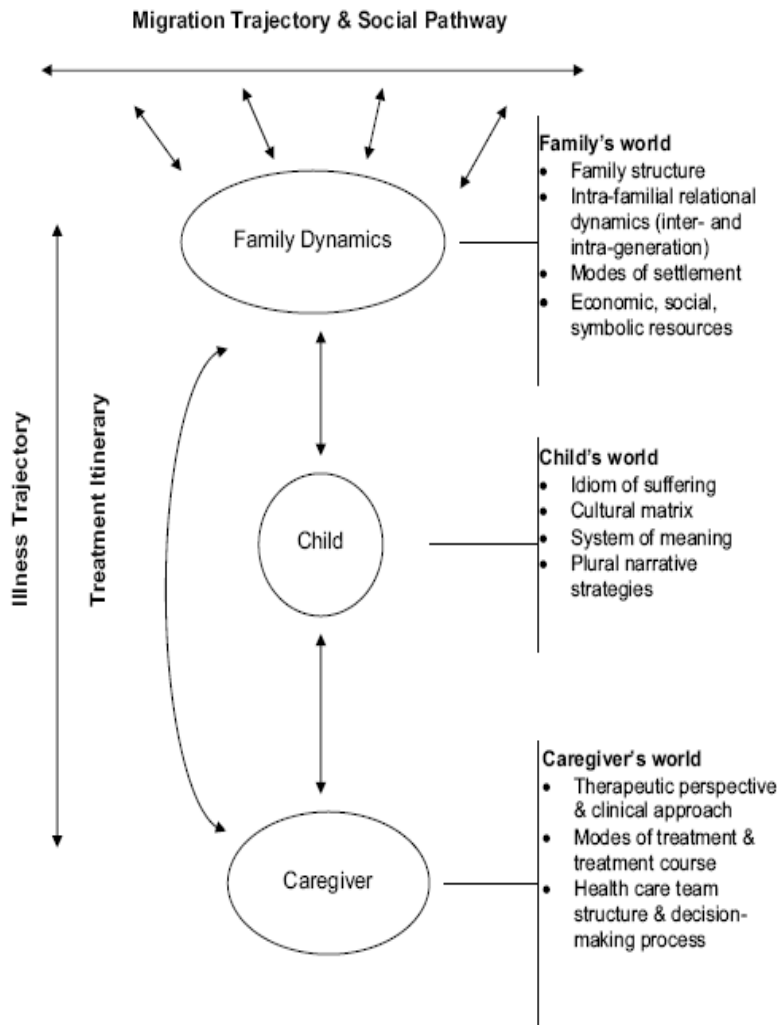
grasping the problem, etc. And I think that that's the most important thing, in the end. It's not that I have made X diagnosis, but how I helped those people (Physician, paediatric specialist, 15 years of professional experience).

The paediatric clinical encounter: a triadic interaction

Current urban pluralism elicits the question of the clinic as a key site for taking account of the human, social, and cultural dimensions of children and families, dimensions that should add to and articulate with other aspects of care (medication, technology, surgery). In this context, conceptualising paediatric hospital practice consists in conceptualising the therapeutic space based on a triadic interaction (Figure 1). The clinic is the crossroads of two trajectories, that of migration – or social pathways for non-migrants – and that of illness. The former, influences the place occupied by the parent and eventually the child (and sometimes other close relatives and other significant people outside the nuclear family group) in the clinical space, along with the expectations and expressions of each. The second trajectory positions the illness on a cumulative course. This allows us to extract the study of (chronic) illness from the framework of medical and psychological thought and to allow the researcher to take a reflexive stance that does not begin with disease – a biological phenomenon – but with the work, and all that it may entail, of managing this illness – as a social phenomenon (Strauss et al. 1985).

In the paediatric clinical interaction, three worlds (those of the physician, the patient, and the family) meet, revealing different ways to understand, express, and negotiate illness and the clinical relation.[9] This variability is itself incorporated within histories of family, social environment and (for some) migration. The ways in which illness is expressed or the reasons that bring a parent to consult can derive from a range of situations, sometimes quite removed from the organic order. As well, the migrant occupies a unique place that must be considered in the clinical space if his or her needs are to be meaningfully met. People who are suffering usually express their problems by resorting to various narrative strategies (Kleinman 1988) modulated by *idioms of suffering*, *cultural matrixes* and *systems of meaning*.[10] These narrative strategies are plural, engaged within a relational context where physicians, nurses, and other professionals intervene. Added to this world of the child is that in which he or she lives, that is, the world of the family (family structure, intra- and inter-generational relations, and available resources). As an evolving frame of reference, this world, in turn, is modulated by a migratory trajectory (or wider social pathway in reference to non-migrants), settlement patterns, social ties, and resources available to the family. The world of the healthcare professional completes this triad (Rousseau 1998) and includes, in addition to the individual and his or her own experience, the acknowledgement of a shared heterogeneity (gender, class and group identity), that of a professional identity with its norms and values, and finally, the acknowledgement of the inequality in the patient-clinician relation. Clinicians are solicited in their personal lives, from within their daily medical practice. They draw upon their resources – experience gained through clinical interactions – going well beyond their strict professional training.

The paediatric therapeutic space as a triadic relation

Migration Trajectory & Social Pathway

Family's world
- Family structure
- Intra-familial relational dynamics (inter- and intra-generation)
- Modes of settlement
- Economic, social, symbolic resources

Family Dynamics

Illness Trajectory

Treatment Itinerary

Child's world
- Idiom of suffering
- Cultural matrix
- System of meaning
- Plural narrative strategies

Child

Caregiver's world
- Therapeutic perspective & clinical approach
- Modes of treatment & treatment course
- Health care team structure & decision-making process

Caregiver

There are two qualities that we must have to work with these patients: one is to remember what we were [at this stage of the life cycle] and … [two] to be able to project oneself into [the world of] the other, not based on what we are as an individual, but on what that has as an impact [or stated otherwise, what we represent] (Physician, general paediatrics, 23 years of professional experience).

Technical skills and expert knowledge are indispensable, but they alone do not suffice. Increasingly concerned, the Royal College of Physicians and Surgeons of Canada acknowledges this, promoting, through a competencies program, an approach to medicine that (re)unites expert knowledge, central to the classical biomedical model, and relational competencies.[11] The latter is relational and cannot be taken for granted, especially not within a plural context.

> I am thinking of some patients I knew who refused one [a medical intervention] and who are dead, in fact, for cultural reasons because we were not able to transmit our enthusiasm [for this type of intervention]. … The differences in 'background' played a role in the healing process (Physician, paediatric specialist, 10 years of professional experience).

Clinical space as social space

Clinical practice brings social relations into play in connection with healthcare institutions; these relations take on meaning at the limit of wider social interactions (Fassin 2000, Rossi 2003).[12] Professional models are also enacted in this complex social space (Baszanger 1983, Hohl & Cohen-Émerique 1999). These models are optimal in a context where the 'partners' in the clinical encounter are located within the same explanatory paradigm. In situations where this paradigm differs because of norms, values, or social models, it becomes a source of reciprocal misunderstanding and the eventual failure of any therapeutic project (Marshall & Koeing 2000, Turner 2003). Consequently, the therapeutic itinerary or the evolution of the illness and the acceptance of treatments by patients and their families are closely linked to various elements, of which the quality of the therapeutic relation is a key piece (Haynes 2001, Desmond & Copeland 2000).

The anthropology of healthcare (Dozon & Fassin 2001, Fassin 1996, Fox 2000) shows clinical space to be a space of power relations, within which the political dimension of wider social relations is reconstituted. The migrant is usually assimilated to one or the other minority group[13] within local society. Often, he or she cannot manipulate, or simply does not possess, the codes in use or the resources (cultural, symbolic) necessary to demonstrate competency within the therapeutic space (Cognet & Fortin 2003).[14] This inequality can affect the representations of clinician or client, as can the recognition of lay knowledge by the healthcare provider or the place accorded to the parent as agent in the care trajectory.

> Case 1: A young child, recently arrived (from South Asia), is hospitalised for serious convulsions. The cause is not found and the convulsions cannot be controlled. This prolonged episode sends the child into a neuro-vegetative state; the child has no chance of cure and his imminent death is announced. The mother (who speaks neither of the country's official languages) is not very expressive while the father, who speaks only a little English, corresponds to behavioural expectations. He openly demonstrates his grief, be-

moaning the child's condition. The child eventually leaves the intensive care unit for general care, as no new intervention seems possible. The healthcare team evokes the 'good father' while the mother (the one who is present daily at the hospital) is progressively excluded from the provider / family relation. Therapeutic choices are made (affecting the life of the child), without informing the parent present (the mother is constantly by the child's bedside). The mother is not a preferred interlocutor, in spite of her availability. All possibility of participating in the decisional process appears to be lacking. Both parents cannot believe the fatal prognostic declared by the physicians; their child's heart beats, his liver and kidneys are functioning. The child is, to all evidence, alive. Nonetheless, the parents finally agree with the medical team and accept the proposed care. The extended family, having immigrated earlier, meets the healthcare team's expectations more closely: *The aunt and uncle are more well-adapted here. They are aware of the child's condition. The parents* (on the contrary), *again asked if he can hear*.

Many of the healthcare personnel comment on the mother's lack of tears, while the father and the paternal uncle cry without restraint. Another father (another case), from Europe this time, does not cry either. In contrast to the South Asian mother mentioned above (Case 1), the healthcare personnel acknowledge that *he suffers but he doesn't know how to communicate his feelings. It's cultural…* intoned another clinician. Some nurses also bring up, amongst themselves, the mother's attitude as she hardly touches the child. As it turns out, one of the many physicians involved in this patient's case warned the mother not to stimulate the child's senses as physical contact could bring on further convulsions. This 'distant' behaviour was attributed to the religion of the mother, which was presumed to be other than that of the majority of healthcare personnel. Here again, there is misconstrual as the family is of the same religious faith as the majority. At the time of writing, the child has been transferred to a long-term care unit for 'very heavy' cases, where curative care is no longer offered. Again, the mother remains invisible to the healthcare personnel and on the whole, the involvement of the team is mitigated. The prognosis remains, even if the initial time span was mistaken (near death was predicted 18 months ago). As the physical condition of the child deteriorates, the parents' acceptance of a fatal outcome grows.

A space of uncertainty and negotiation

For those who are called upon to act on short notice, to make decisions that can sometimes put a life in jeopardy, the incertitude that accompanies not understanding the Other is very uncomfortable. This uneasiness can increase when added to the many uncertainties of specialised medicine and complex pathologies. The notion of control, "to control the situation" recurs in physicians' narratives, as do references to the physician's role in the clinical encounter, whether asserted or ascribed as the expert. However, as is the case for many organic disorders, there is no one recipe to deal with the multiplicity of norms and values linked to many variables (including age, gender, social, and national origin). Perhaps 'taming the unknown' characterises clinical practice in a plural context.

Some physicians emphasise how *listening* is a significant element of an '*open'* approach to diversity, an approach that requires *internal availability*. In contrast, an approach guided by the sole evidence of measure in the alignment of the care trajectory can be thought of as a 'closed' approach : *Madam, you can think what you like, you can say what you like, [but for] me it's written there"* (Physician, paediatric specialist, 6 years professional experience). If the clinic is to be a space of negotiation and conciliation of different worlds, the closed approach is somewhat a dead end. There can be no alliance, cure is perhaps possible but not care. And in this specific example, there are neither. The mother refuses to comply with the physician's suggested course of treatment and eventually asks a "comprehensive nurse" if and when another specialist will be available at the clinic.

Let us mention, however, that the asymmetry in the clinical relation can sometimes extend to the acknowledgement of medical expertise by the family, as was the case of a physician of immigrant origin who was responsible for a child whose parents (non-immigrants) asked to change the doctor, contending that he did not understand them. He *wasn't from here*; he *did not acknowledge their opinion* as *physicians from here do*. Otherness is also activated as a denominator – this time to the benefit of the healthcare user. The patient, or rather his family, represents the majority in this context, and the physician is relegated to a minority status. The parents' attitude is later interpreted by the physician as being a means of "control" of a situation that escapes and is feared by them (their child is in relapse). Just the same, generally, and in spite of nuances, the clinical relation remains asymmetrical with respect to the status of expert knowledge, to that of the well versus the ill, and of the one who elicits a relation of trust in order to endure the trials of illness (Pellegrino, 2003). And precisely so, in the acknowledgment of this trust based relation as an essential element of the patient/physician dynamic, the 'rejected' physician will maintain, in this case, an indirect contact with the child through an acting colleague who's expertise is lesser in this specific area.

Multiple viewpoints

In addition, the meanings given to life, death, and suffering are not universal and crystallise personal and professional senses of belonging and patterns of expression. Where and how one dies, like birth, is one of the most invested 'universal' moments (De Plaen 2004). A 'good death' is accomplished according to norms expected within a given tradition, just as the ideal site for death is also related to a set of values. In the paediatric context, the expected moment of death always comes too soon – the life cycle is broken, and parents and healthcare personnel must mourn the children.

> Case 2: The case of an immigrant child, with a fatal brain tumour, escapes the 'control' of the medical team. The child is at home, in conditions that trouble the healthcare team (many children, cramped living quarters, conditions which are poorly adapted, they believe, to an end of life with little suffering). Does the child take the prescribed medication? Is this medication always adequate? The father refuses all homecare, which is perceived as an intrusion. The team has no contact with the mother. The child does not show

up for his periodic check-ups at the hospital. In fact, since the child has been in palliation, relations with the family have become strained, to the point of becoming non-existent.

The norms and values that guide practice do not coincide here with those of the family. The 'good' way to die thus comes under scrutiny. Why do the parents refuse the visits of a homecare nurse? The palliative care team discusses alternatives. Some recommend calling the youth protection agency (a public organisation with legal power which can, depending on the circumstances, revoke and replace parental authority), alleging the vulnerability of the young patient and the physician's responsibility towards him. Can a child die in such conditions (with the understanding that the child would be better off in the hospital)? Indeed, through team meetings and a deeper examination of the family environment and history, it turns out that the family had previously been visited at home by a health care or social worker who had deplored the family's living conditions (unsanitary conditions and cramped lodgings). Furthermore the father is marked by gender relations based on norms that differ from those of the hospital milieu and the caregivers are, in this case, all women. After discussing possible options, the treating physician asks a male colleague to intervene. This allowed for minimal contact with the family, which reconnected, though in a limited way, with the clinical team. The boy died at home with his family.

The notion of culture in healthcare: Void or scapegoat?

Medical professionals (at least in part) state the limitations of an approach focussed exclusively on the 'body' and hope that cultural and social aspects will be taken into account in day-to-day practice. But whose culture is being discussed and how it is imagined?[15] That of the treating physician or that of the patient / family? And even within the hospital setting, cultures are multiple. Intensivists, neonatologists, neurosurgeons and paediatricians do not necessarily share the same values, define the notion 'quality of life' in the same way, nor even agree on the concept of life.

In reviewing the evolution of biomedicine over the last few decades, an explosion of knowledge and technology that allow for extraordinary developments today becomes apparent. The reverse side of this explosion is an increasing fragmentation of clinical knowledge and care. In expressing her views on life support at all costs, a paediatrician with over 40 years of experience contends:

It's not because technology allows us to do something that we have to do it. Must we do all that we are capable of? The answer is NO! We can keep a person in a neuro-vegetative coma alive. Should we do it? […] What do we mean by life?

And quoting another paediatrician with 25 years of professional experience:

It's easy to do everything. It's much easier to do everything than to establish limits. You have to know when to set them. And often what we see – because work is very multidisciplinary – is that the progression of the medical team (intradisciplinary) does

not occur at the same rate as the progression of the family or of certain consultants (interdisciplinary).

This heterogeneity among members of the same profession closely reflects the disparity in points of reference for the immigrant and non-immigrant layperson. And these points of reference do not all have the same impact for practitioners, some having more value than others. On this theme of recognition and the sanctioning of practices, Pierre Bourdieu (1979) recalls that practices can be judged positively or negatively and either case involves a system of categorisation that is historically constituted, put into place by some and acknowledged by others.

> Case 3: A man complains about the care provided (that is, not provided) to his son, heavily handicapped following a chaotic illness trajectory. At the time of his hospitalisation, the corpulent child needs care in a unit where, generally, children are younger, the cases not as heavy. Nursing personnel seem unable to cope. The father complains. His son is poorly cared for. He perceives a lack of investment by the healthcare team and effectively, no one appears to want to take on the adolescent's case. Parents meet with the clinical team but the dialogue is weak and the therapeutic alliance compromised. The healthcare team evokes "cultural distance" to explain the aggressive and hostile behaviour of the father towards them.

Experiences of distress, entirely real for all concerned, reveal, certainly, a situation of miscomprehension. But does the explanation for this situation lie in "culture"? The father of the patient is Black, of immigrant origin, and speaks little of the local language of use. His group of origin is one that is little favoured in Montreal and his resources are limited. Practitioners, in this case, all White and from the majority group, stand in a relation of power towards this man who belongs to one of Montreal's minority groups. And if the father had been White, a professor for example, would his anger be perceived as the result of a cultural miscomprehension (related to ethnic background), or would other explanations for his distress be sought within the care trajectory? The father appears to lack the "appropriate codes" and the symbolic resources that would give weight to his arguments. By symbolic resources, I mean social recognition attributed to the individual, based on his or her social position and the value attributed to this position within a given context (Taboada-Leonetti 1994). The way in which he expresses his disarray towards the 'irreversible' condition of his son does not correspond to what is 'expected' by the healthcare team. As for the father, if his social and economic trajectory in the local society had been more favourable, if he had not belonged to one of the most discriminated groups of the local society, would he perceive the care received as discriminatory towards his son and himself?

In interviews (within our study), the father located his suffering elsewhere. He expressed his feelings of guilt, stating that it was he who had initially obliged his son to take a medication that was, according to the father, the root of the health problem that would transform the boy's life. In hindsight, he even questioned the position adopted by himself and the boy's mother with respect to resuscitation of their child. In fact, the mother, very religious, maintained that all must be done to keep her son alive, while the

team attempted to introduce the idea of non-resuscitation in case of respiratory arrest. This situation added to overall perceptions regarding the weak involvement of the healthcare team and constant changes in the treating physician (due to the structure of services according to which a physician is 'treating' for a two-week period, in alteration with other responsibilities – administrative, research and training).

Conclusion

Several of the fieldwork situations in this study revealed how Otherness can often be an obstacle to developing a therapeutic 'alliance'. In the context of palliative care,[16] all cases where healthcare professionals (part of the palliative care or another team) appeared to be less invested were also cases where 'culture' served to explain an incomplete, insufficient, or mitigated care trajectory with respect to the therapeutic relation. And so, when culture is invoked, it serves to demarcate Us and Them, creating a boundary linked to norms held by the majority group of the local society. It is, *a priori*, the culture of the Other, that of the Immigrant (and sometimes, that immigrant is the physician!). Apprehended by most practitioners as a bounded system associated to ethnic background, culture becomes an object in itself that must be 'mastered' (as the abundant literature on "cultural competency" in the health field demonstrates).[17] And even so, in a cosmopolitan environment such as this hospital's neighbourhood where the population immigrant (78%) is diversified ethnically, religiously and linguistically (Meintel et al. 1997), where does one start?

In an attempt to go beyond an essentialist approach to culture, caregivers can emphasize accessing the world of the patient (and the contexts in which culture is produced and evolves) by acknowledging the family structure and relational dynamics, social and economic resources and general social (and migration) pathways to better understand the ways suffering is voiced, the relation to the body, systems of meaning and in turn, the acceptance of or resistance to suggested treatments. This taking into account also involves a reflection on the ways interventions are carried out, the decision-making process (within healthcare teams) and the often inegalitarian dynamics of the clinical relation. These inequalities derive, in part, from majority-minority group relations in the local society but also, within the clinic, between the one who knows (the expert) and the one who does not, between institutional and lay knowledge and practice, between health and illness.

The *Nelson Textbook of Pediatrics* mentions how the culture-ethnic-phenotype association can serve as proxy for socioeconomic status rather than inform on specific cultures (Korbin 2004: 12). And yes, we can only regret that in many settings, the association of phenotypical traits (as Caribbean in Montreal or North African in Paris for example) with poor socio-economic conditions is not a theoretical abstraction. Furthermore, by looking at the clinical relation without examining the social context, cultural differences are reified along with status differences, which are closely associated with inequality in healthcare. The same can be said for the emphasis on culture.

Still, their can be no doubt that culture permeates our relation to health and how it does so is part of (medical) anthropology's quest. But this culture is "in the making" and to better understand it we must examine the social dynamics through which it is constructed, transformed, and brought to life. Of course, culture underlies ways of understanding and interacting, but nevertheless, its components fluctuate and are engaged differently according to the stakes at hand (Hannerz 1996, Clifford 1988, Barth, 1969). This contextualisation is a fundamental dimension of culture, as a phenomenon that covers a variable set of values, beliefs, and (acquired) modes of being which take on meaning within a particular relational and historical context (Cuche 2001, Galaty & Leavitt 1991).

> Cultural practices […], most often, are novel syncretic realities, resulting from the intersection of reinterpretations of cultural forms [from the milieu of origin] and models of the society of residence, according to what is at stake […]. And cultural identity for them [the migrants] as for others, is not a heritage from which they cannot escape, but rather is the fruit of practices of differentiation that they experience and put strategically into motion in their social interactions. From thereon, to reify these practices as an abstraction, baptised 'cultural tradition', would be to condemn agents of these practices to the social margins, making them responsible for it, as was the case, only yesterday, in a dominant way, of the thesis of the supposed racial inferiority of foreigners [*étrangers* as said in the French context]. The notion of culture works, then, as a euphemism for that of race (Giraud 1993: 45).

Equating national, ethnic and cultural group is pernicious in this sense, as though Italians, the French or Canadians are homogenous groups sharing the same culture. Aside from immigration, which creates a proliferation of identities among members of a national group, ethnic groups[18] do not have one single culture but several, with porous and fluctuating boundaries (Cowan et al. 2001). Decisive traits, which assimilate an individual to this or that national or ethnic group, are also mobile and historically constituted (Guillaumin 1972).[19]

> In reality, we haven't invented anything… because even in a cosmopolitan Montreal, the diversity goes beyond multiethnicity. We don't speak the same way to someone who comes from a well-off neighbourhood and whose name is Tremblay [a local surname] as to someone who comes from a rural region and whose name is also Tremblay. They are both Tremblays and come from the same country – but they do not have the same environmental and socio-economic realities. And in Montreal, we can go into a poorer neighbourhood. The verbal and non-verbal language is not the same as when we speak to someone from a well-off neighbourhood. […] So this is all pluralism, in addition to religion, skin colour, ethnic origin… (Physician, paediatrician, 18 years of professional experience).

We can also question the evolution of the roles of the physician and the patient in the present-day clinic. Of course, there is an increasing heterogeneity of patients associated with the diversification of migration in Quebec. But the 'model profile' of the patient is also modulated by an increase in educational level[20] and by the fact that

patients draw on multiple sources (especially the internet) in their understanding of the malaise for which they consult. Patients are described as "active", more autonomous (Olthuis & Van Heteren 2003) or "empowered" (Goodyear-Smith & Buetow 2001). As for professional models (that of the medical expert, the one-man-band, or the partner), they are not unanimously held, by patients or clinicians. Medicine and its practitioners evolve, and so do the patients.

Finally, whether through gender, class, ethnicity, religion, age or area of expertise, culture is constantly activated in the space of the clinic. However, the cases presented in this article related more generally to ethnic differences as put forth within the hospital. Other dimensions (notably that of religion and social class as well as Strauss' inspiring theme of 'social loss')[21] will be furthered elsewhere as yet other ways of understanding how care trajectories evolve (Fortin & Morin 2006).

Notes

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1   Source : Statistics Canada 2005. Community profile: Demographic statistics for Montreal (metropolitan census region) based on 2001 census data. www12.statcan.ca/english/ Profil01.
2   Pluralism is a pan-Canadian value and an important response to the demographic situation. See, among others, the work of Li (2003), Elbaz and Helly (2000), and Gagnon et al. (1996).
3   See also Fortin (2004).
4   The research team for this study includes S. Fortin, G. Bibeau (anthropologists), F. Alvarez (paediatrician), D. Laudy (ethicist) and research assistants M.E. Carle, G. Davis, E. Laprise and N. Morin. Funding has been granted by the Canadian Institute for Health Research (2005-2008) and the Inter-Cultural Paediatric Unit of the St. Justine University Hospital Centre.
5   By complex pathologies, we mean illnesses that are serious, chronic, evolutive, eventually debilitating, and sometimes fatal. These pathologies are multi-systemic or become so with time such as Duchenne's disease (muscular atrophy), scleroderma (chronic hardening and shrinking of the connective tissues of any part of the body), other systemic autoimmune diseases (dermatomyositis, vasculatis, lupus, rheumatoid arthritis, etc.), polymarformation syndroms and many pathologies and complications associated with prematurity.
6   All participation was voluntary. More widely, the study protocol was peer reviewed and met the requirements of the Ethics Research Committee of the Hospital where our research is underway.
7   Referring to the work of Damasio (1994), Lock (2002a: 97) writes : "Did René Descartes simply make an error when he created the disembodied mind […]? Or did he construct a lie, or at least practice self-deception, in order that he might create a science of the body, one that

troubled neither God nor the Church of the the day because it did not impinge on their realms?"

8   These voices are often those of primary care physicians who are more closely connected to patients' lives and the community (see, among others, Jimenez 2004, Julien 2004). In addition, numerous Canadian and Quebec studies have been carried out on primary care with respect to the availability, accessibility, and accountability of services, in contrast to third and fourth line care. However, the narratives collected in the hospital setting do voice a growing concern as well as reveal a heterogeneity within medical culture.

9   This triadic interaction is specific to the paediatric context and thus involves different narratives sometimes relating to an array of issues connected to and beyond the illness at hand.

10 "Idiom of suffering" refers to the way people talk about their illness and formulate their complaints (Fox 2003, Kleinman 1995, Kirmayer 1984). These modes of expression are varied, often polyphonic within one family according to age or generation, or social status, place of origin, etc. The "cultural matrix" is linked to the social and cultural environment from which these idioms emerge (Bibeau 1997, Hannerz 1993). "Systems of meaning" correspond to explanatory models of illness as formulated by the patient (Corin & Bibeau 1995).

11 As an initiative to improve patient care, the "CanMEDS" framework insists on the following competencies needed for medical education and practice: medical expertise (central to the physician role); communication (second in importance); collaboration; management; health advocation; scholarship; professionalism. "The competencies of this role [medical doctor as communicator] are **essential** for establishing rapport and trust, formulating a diagnosis, delivering information, striving for mutual understanding, and facilitating a shared plan of care" (Frank et al. 2005).

12 Here social relations (*relations sociales*) refers to observable interactions, in contrast to social interactions within the wider social context (*rapports sociaux*) (De Rudder et al. 2000). This distinction (*rapports sociaux/relations sociales*) is particularly significant when attempting to better grasp the issues at stake in concrete clinical situations. Individual relations, between practitioners and patients, while intersected by "structuring " intra- and inter-group relations, (ethnic, class, religious) at the macrosocial level (Fassin 1996) can also engender new configurations within the local context (Fortin 2005, 2002).

13 The notion of minority/majority, as put forth by Guillaumin (1972) does not refer to numbers or demographic weight, but to the group of reference, the one that embodies the norms in a given setting.

14 Freidson (1999, 1988) underlines the importance of reinstating individual clinical practices in a context of institutional, and more widely, healthcare system, politics. However, this preoccupation goes beyond the aim of the present text.

15 While an in-depth discussion of the notion of culture is not possible here, it must be said nonetheless that culture remains, for the author, an imperfect theoretical abstraction,: "As a deliberate abstraction it [culture] is there to help anthropologists conceptualize that ever-changing 'complex whole' (Tylor 1871) through which people engage in the continual process of accounting, in a mutually meaningful manner, for what they do, say, and might think. Culture thus exists only insofar as it is performed, and even then its ontological status is that of a pointedly analytical abstraction." (Baumann 1996: 11).

16 Data from other fieldwork sites are still in process.

17 We discuss this further in Fortin & Laprise (n.d.). See also R. Fox (2005) for an enlighting discussion on this topic.

18 The notion of ethnicity is often amalgamated erroneously with that of culture. However, it evokes a belief in common ancestors, real or imagined, and a subjective feeling of belonging to a particular group, marked by the belief in a common historical becoming. Barth (1969) has defined it as a form of social organization based on the classification of persons with regard to their supposed origin and validated in interaction by the manipulation of socially differentiating cultural signs. See also Poutignat & Streiff Fenart (1995), Weber, 1995 [1922], Juteau, 1999, and Fisher (1986).

19 In Quebec, for example, French was long associated with a particular group, that is, Quebecers of a French Canadian origin. However, over almost the last 30 years (1977), we have seen a "de-ethnicisation" of this marker, as children of immigrants of all origins are educated in French (Loi 101 on the francification of public life in Quebec). In the same way, Quebec identity was long associated with the Catholic Church, prior to being associated with the French language. (Meintel & Fortin 2002).

20 In Canada, between 1981 and 2001, the percentage of individuals over 15 years of age with a university diploma has almost doubled, going from 8% to 15.5%. Source: Statistics Canada, Table "Population 15 years and over according to the highest level of schooling (1981-2001 Censuses)." www40.statcan.ca/l01/cst01/educ45.htm.

21 According to Anslem Strauss' theory, the patients, for whom sickness is perceived by the caregivers as a "social loss" for family and professionnal peers, benefit from this and receive enhanced care (Strauss & Glaser 1964).

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