FIELDWORK IN MEDICAL ANTHROPOLOGY:

THE CLINICAL SETTING

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As with other subfields in anthropology, medical anthropology may be studied in a wide variety of contexts. Clinical settings offer the opportunity to study social and cultural processes as they relate to sickness, health-seeking behavior, patient-practitioner interactions, and the healing process (Kleinman 1977:11). They provide the optimal context in which to study scientific medicine as an ethnographic category.

I would like to discuss some of the concerns that seem especially important in conducting fieldwork in a clinical setting, based on my own experiences in a private hospital in California. These concerns fall into four broad categories: strategical (including political), interpersonal, ethical, and personal.

Often people have difficulty gaining entree into institutions such as hospitals to conduct social science-oriented research. Administrators and medical professionals may express disinterest in or even animosity toward academic research. The question often is: what's in it for us? Therefore, two important rules seem to stand out: (1) don't go in with the misconception that you're in control; and (2) try to show that your project will benefit them in some way. This involves learning something in advance about the institution, in terms of both its politics and its problems. Before I requested permission to do my study, I was employed at the University of California which had spent approximately two years going through various committees before gaining approval to do a study involving this hospital's patients. (Convincing the doctors of the need for psychosocial research on their patients was a near-impossible task; even in-house projects with this focus have trouble.) My job brought me in contact with people from the Administration, the nursing staff, and the medical staff. When I subsequently proposed doing a study of my own there, the fact that I was already known and trusted was an enormous help. The experience also showed me that medical anthropologists must learn to take advantage of opportunities to interact with the medical "community," even if the research benefits are not immediately apparent.

Another fortunate circumstance for me was that both the Nursing Administrator and the Assistant Hospital Administrator were interested in my research and perceived it as being useful to them. (This was strictly unintentional on my part.) I proposed to study

the meaning of cancer from the staff's perspective and was told, at the time, that the Administration was particularly interested in the problem of staff turnover in cancer nursing and in any light that could be shed on it. They asked to see a concrete protocol--i.e., questions I would ask, consent forms, and so on--which I showed them and which they approved. Later, paradoxically, these same administrators made it very difficult for me to have access to any actual statistics on nursing turnover. They finally agreed, but only in the hospital, and only under certain conditions.

Part of the problem for the anthropologist in a clinical setting is his/her relative powerlessness. An important thing to remember is that a hospital is a work environment, with its own hierarchy. The independent researcher is not a part of this hierarchy, although the highest ranking members have a more generalized notion of their status and of the value of their time. When I introduced my research to a surgeon on the hospital's Oncology Committee and said that I wanted to interview doctors as well as nurses, he laughed and said, "You're a real dreamer!"

Furthermore, because it is a work environment, your presence is necessarily an inconvenience. My approach was to proceed very slowly, beginning with the nurses (with whom it was easiest for me to gain rapport) and oncologists; only after six months did I work my way to the surgery floor. Because it is a work environment, staff tend to be extremely busy, and their work is pressing. Often appointments are cancelled at the last minute, or simply forgotten --even after being confirmed a day or two in advance. This tests both the patience and the flexibility of the researcher, not to mention the sense of humor. Letting them know you are flexible, that you will wait until you can catch them at a time that is convenient for them, is crucial. On the other hand, people may be surprisingly willing to talk once the opportunity is eventually found. Two head nurses (who, being head nurses, could take the time) each spent about three hours talking with me about their jobs. Similarly, doctors, seeing me on the floor, dressed as though I belonged (in the white coat I was asked to wear) and introduced to me by their staff, agreed to talk with me.

Of striking importance, in my experience, is the development of interpersonal relationships. The number and strength of these may well determine the kinds of data one can obtain, and their depth. Such relationships are difficult to establish in a work environment, where people are usually busy with concrete tasks and under severe time constraints. One's presence as an observer there may cause discomfort--for them as well as for you. (Roy Wagner [1975:7] calls this "anthropologist shock.") In a hospital-based study of leukemic children, Myra Bluebond-Langner mentions the staff's "paranoia" at her note-taking behavior in their presence (1978:243). One way of coping with this that seemed to work fairly well was to introduce myself and my research at staff meetings, and then conduct private interviews with people early on, to get to know them and familiarize them at the outset with my concerns. This kind of listening also

provides a valuable form of reciprocity, as Joan Ablon has mentioned in discussing fieldwork among middle class Americans (Ablon 1977). People like to talk about themselves, especially if they feel frustrated, and are flattered to have their opinions taken so seriously (cf. Powdermaker 1966). This, in fact, may be a potential bias to watch for; those who are more frustrated may tend to talk more than those who are not.

In general, there was a predictable concern among the nursing staff: they are normally observed in order to be evaluated. In speaking with the head nurse before my introduction to staff, she suggested that I emphasize the non-evaluative nature of the study and the fact that I was not a "spy" reporting to anyone--Administration, head nurse, or otherwise. There was nervous laughter and relief when I stated this explicitly during the meetings.

Physician concerns are somewhat different. While doctors have the most status and control, they also know that they are widely criticized by the general public these days. Furthermore, since cancer is a particularly sensitive area for both them and their patients, it is crucial to show a recognition of and respect for this. Of course, physicians are also extremely busy, and it is difficult to connect with them. Hours of waiting may be required to get a ten-minute interview. As I said, I chose to proceed slowly, and in this case to have the head nurse or the Oncology Nursing Specialist introduce me to those I didn't know. Entree on the formal level was only the beginning; it was on the informal level that the real "approval" must be obtained--and this was maintained only through constant effort.

Interpersonal concerns lead inevitably to ethical considerations; and these persist from entree through writing up. In working with health care professionals, one feels a high degree of accountability. In a sense they are colleagues, and they are people with whom you may want to work again--in this or some other capacity. I have been asked many times about the results: will they see them? Such interest has been expressed chiefly by the nurses and the Administration. I have promised them a written report for their library.

Concerns about privacy and confidentiality, in particular, are heightened in this setting; people are afraid that what they say may reflect badly on them--especially if their comments contradict the standard ideology. People are also very reluctant to discuss conflicts that have taken place among staff in the past as well as those occurring presently, and this discretion must be honored.

One of my biggest difficulties was coming to terms with something quite different from the interpersonal and ethical issues: that is, my own emotional responses to patients and their conditions --the shock of viewing a particularly gruesome tumor, the sorrow and poignance involved in caring for dying patients and their families. I have realized, too, that my feelings often parallel those of the

medical personnel, so that they may be used to deepen a sense of compassion for them and the work they do. Recognition of my own limits, and my need not only for emotional outlets but also for some philosophical framework in which to place these events became necessary for continuing my work.

While I lack cross-cultural, community-based research experience on which to base a comparison, I have read accounts of fieldwork in more "traditional" settings (e.g., Beattie 1965) which reveal striking similarities in terms of the difficulties involved. Working in an urban American hospital, one doesn't face many of the tribulations associated with settling into a totally foreign environment; the culture shock is only partial, making it perhaps a bit more difficult to "see" what is there (cf. Wagner [1975] for instance, who says, "Culture is made visible by culture shock . . ."). But it seems to me that the issue of training for anthropological fieldwork is not so much that the traditional methods may not be useful today, but rather, that this training has never been sufficiently pragmatic. This is perhaps more readily apparent when one is working in a milieu where people have high expectations of methodological sophistication. Because anthropologists work on different problems and in varied settings, the question is how to train people in methodology, yet leave room for this flexibility. In addition to courses on research design, some concrete methodological skills could also be taught, such as strategies for gaining entree into institutions (in general), interviewing techniques, and methods for observing and writing field notes. There is a literature available, largely from medical sociology, to use as a beginning. Kleinman (1977) also suggests learning some interdisciplinary skills in order to work with medical professionals. Certainly, gaining familiarity with medical and institutional procedures, and with potentially sensitive issues in the medical field, are a necessary part of this training.

REFERENCES CITED

Ablon, Joan
1977 Field Method in Working with Middle Class Americans: New Issues of Values, Personality, and Reciprocity. Human Organization 36(1):69-72.

Beattie, John
1965 Understanding an African Kingdom: Bunyoro. New York: Holt, Rinehart, and Winston.

Bluebond-Langner, Myra
1978 The Private Worlds of Dying Children. New Jersey: Princeton University Press.

Kleinman, Arthur
1977 Lessons from a Clinical Approach to Medical Anthropological Research. Medical Anthropology Newsletter 8(4):11-15.

Powdermaker, Hortense
1966 Stranger and Friend. The Way of an Anthropologist. New York: W. W. Norton & Co., Inc.

Wagner, Roy
1975 The Invention of Culture. Englewood Cliffs, New Jersey: Prentice-Hall.