
References

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Diversity, Conflict, and Recognition in Hospital Medical Practice

The hospital is a place of encounter between health care providers, patients and family members, the healthy and the suffering, migrants and non-migrants, as well as social and cultural minorities, and majorities of various backgrounds. It is also a space where multiple conceptions of care, life, quality of life, and death are enacted, sometimes inhibiting mutual understanding between caregivers and the cared for, a scenario that in turn may provoke conflict. Through the lens of conflict, we explore in this article the theme of Otherness within the clinic, basing analysis on an ethnographic study conducted in recent years in three cosmopolitan Canadian cities. Daily practices and—on a larger scale—the social space of the clinic become material here for reflecting on recognition (and non-recognition) of the Other as actors in the clinical encounter. The examination of structural and situational conditions that contribute to the emergence of conflict offers an understanding of the diversity of values that pervade the clinic. By way of conclusion, we argue that recognition of diversity, at least on the part of practitioners, is a key condition for the emergence of a pluralist normativity in the social space of the clinic.

Therapeutic relationships; Diversity; Otherness; Recognition; Conflict; Ethnography

Introduction

The hospital is a place of heterogeneous logic and temporality, a place of care, hope, expertise, and of organizational and professional cultures, while simultaneously being a space of interaction between caregivers and the cared for. It is also paradoxical, being a place of both proximity and distance enacted in its rules and codes (Freidson [20]). Once conceived of as an island (Coser [12]) and as a “total institution” (Goffman [21]), the hospital has been seen more recently as a window onto the city (Sainsaulieu [43]), if not the capital of the mainland itself (van der Geest and Finkler [48] ; Zaman [53]). However, it remains an ambiguous place with porous borders that are permeable to its environment, functioning according to its own logic. For Street and Coleman ([46]), the hospital is a heterotopia, at once real and imagined, isolated and permeable, specific and common, a mirror of a locality while equally a particular venue in and of itself. From this perspective, while being a milieu where symptoms, diagnoses, prognoses, and therapeutic projects are entangled, we propose that the hospital clinic be seen as a social and relational space (Sauvegrain [44] ; Fortin [16]) that is often asymmetrical, a place of tension between art (namely, the art of medicine)1 [1] and technology, between universal knowledge and the specifics of the singular, between doctors and patients (Masquelet [35]).

In a public health care context, the hospital is a place that is formally open to all, regardless of social status and background, and whether or not it is rooted in a local community. In being open, it is a bridge between here and elsewhere, between the intimate and the unfamiliar, a bridge that reveals the complexities of hyper-diversity (Hannah [24]). This hyper-diversity is inherent to dynamic and cosmopolitan social environments, where ethnic, religious, and class markers are in a state of flux (Good DelVecchio et al. [23]). These milieus are also penetrated by a diversity of ways of thinking about the world, the body, disease (Bibeau [3]), and care (Saillant and Gagnon [42]). In turn, this diversity spreads to various norms and values in relation to life and death, to what quality of life means, to what affirming the best interests of others entails, and different expectations arising from these regarding health care services. Not surprisingly, this heterogeneity may foster misunderstandings and give way to conflictive relationships between health care providers, patients, and family members.

Stemming from an interest in the updating of clinical practices to the growing reality of urban diversity within the hospital, we have aimed to study daily practices and observable relationships between distinct actors within this space, exploring in this text the theme of Otherness through the lens of conflict within clinical hospital settings. To do so, we introduce the concepts of conflict and recognition, before turning to specifics of our study's methods and diverse contexts. We then address the health care provider-patient-family relationship as observed through conflicts that occasionally arise in interactions between these actors. This brings us to explore the emergence of conflict in the clinical space as well as the clinicians' perspectives on socio-cultural diversity in the clinic. Finally, we argue that acknowledgment by health care providers of the many challenges inherent to diversity in their workplace is a key feature that promotes an open, pluralist normativity better suited to operate in a pluralistic setting. If the space of the clinic is to be plural (Kirmayer [27]), the norms that guide action and the many processes of cure and care are too, to be plural.2 [2]

The Hospital as a Place of Cultural Mixing, Conflict, and Recognition

In a pluralist setting, the hospital is a place of "métissage" composed of diverse actors making up the community in which it is located. However, the resulting mixity may "not so much entail fusion, cohesion, or osmosis, as confrontation and dialogue" (Laplantine and Nouss [31] [1978]:9).3 [3] Confrontation may give rise to dialog that might not otherwise happen between distinct actors, much the same as conflict may contribute to socialization. We find reason for this perspective within classical social thought:

> If all reciprocal actions between men are acts of socialization, then conflict […] must be regarded as socialization. It is the causes of conflict that are truly elements of dissociation. Once conflict breaks out […] it is, in fact, a movement of protection against dualism that produces distance […] In itself, conflict is already about resolving tensions between opposites […] (Simmel [45] [1908]:265).4 [4]

According to Simmel, there are three possible outcomes to conflict: victory (which includes the submission of one party), compromise, and reconciliation. As some have argued, within a clinical setting, this reconciliation is possible if, in spite of a contested situation, trust prevails between parties (Payot et al. [37]). Ricoeur ([40]) describes this relationship of trust as a "delicate pact" involving a mutual commitment to promoting wellbeing, which in turn calls for recognition of the Other as a partner in care (e.g., taking into account their perspectives, experiences, concerns, knowledge).5 [5]

Recognition here suggests a relationship to the performance of the Other (Ricoeur [40] , [39] ; Fabian [14]), meaning that recognition is a process of "validation of the Other" through a relationship of reciprocity that stems from the "mutuality of exchanges." In his Parcours de la reconnaissance (2004), Ricoeur proposes milestones for achieving recognition, briefly summarized as follows: (1) agreeing to recognize without knowing, (2) dissociating recognition from judgment, and (3) dissociating recognition from knowledge.6 [6] On this last milestone, recognition becomes possible only when failure to understand another's point of view or behavior is actually acknowledged.7 [7] For Lévinas ([32]), this knowledge is only possible when it is acknowledged that every encounter is, first and foremost, an encounter with Otherness. Recognition is also conditional to the fact that the doctor-patient encounter is a moment of exchange, where actively listening to the patient, their experiences, and their knowledge (Lévinas [33]), gives rise to the co-construction of a therapeutic project.8 [8]

In turn, Meintel ([36]) emphasizes a distinction between collective and individual identity processes, the latter having a dialogical and reciprocal character. Again, this "mutuality of exchanges" makes of recognition a relational process. Similar to Appiah's vision of ethics in a world of strangers ([1]), recognition does not in itself imply a convergence of values, and it may even give rise to local accommodations to the situation at hand. In this perspective, dialog does not necessarily foster homogeneity or a community of shared values. Not unlike with Fabian ([14]) mentioned above, Meintel invites us to think beyond the paradigms of identity, ethnicity, or culture, to consider the spaces of interface between the individual and the social that extends beyond them.9 [9]

Our Study

Set in Canadian pediatric hospital settings, this study (2003-2011) addresses clinical practices in pluralistic contexts.10 [10] We have aimed to identify the constituting elements of a hospital practice attuned to diversity (i.e., social, cultural, ethnic, religious) in the clinical environment, through a better understanding of encounters between caregivers, the cared for, family, and in particular decision-makers at key moments in therapeutic trajectories. We were attentive to conflicts observed between health care providers and the families of patients (e.g., mothers, fathers, and other significant family members) as well as how these conflicts were put into words by those who experienced them in pediatric hematology-oncology and intensive care wards. These units also present specific acute and chronic time scales, as well as very different contexts and logics of care that are emblematic of contemporary hospital settings (Fortin [17]).

The analysis presented here emerges from 175 in-depth interviews conducted with 94 physicians, 55 nurses, and 26 other relevant health care professionals, more than 2 years of observations in care units, and over sixty case studies conducted with families visiting these units during the period of data collection. As a multi-sited study, we successively incorporated three Canadian pediatric hospitals from three distinct cosmopolitan cities. Together, the host cities of this study—Montreal, Vancouver, and

Toronto—welcome 69 % of all immigrants in Canada, respectively with 31, 46 and 50 % of their inhabitants born outside of Canada.11 [11]

On average, the semi-structured interviews with clinicians lasted 90 min and covered an array of themes, from contemporary clinical practices to daily challenges encountered with regard to urban pluralism.12 [12] As for the physicians, who compose the main reference group informing this article, there were as many men as women, and two-thirds were born in Canada. The most part of the remaining third was born in one or another country of the Commonwealth (or from French-speaking European nations for migrant physicians practicing in Montreal). Phenotypically speaking, as much as 85 % of this migrant group could fall under the majority Caucasian population. In all, only 14 % of all physicians taking part in our study considered themselves to be of a “visible minority.” The common spoken language was English for the majority of physicians, Montreal being the only French-speaking city in the study.

Observations, including informal interviews, were conducted in an in-depth and continuous manner over a period of 4-6 months in each of the indicated units at each hospital location. The daily settings of each unit were documented, its routines, uncertainties, intra- and inter-professional relational dynamics, as well as dynamics with children and their parents; medical rounds, life at the patient’s bedside; and diverse team meetings, notably in regard to therapeutic approaches and family meetings (when relevant to our study). We also shadowed specific professionals one-on-one during the performance of their daily routines. This ethnographic data complements interview material and case studies. The latter incorporate observations, informal and semi-structured interviews with families (i.e., parental couples or either parent) conducted either at the home or in the hospital, at their choosing. From our observational data, we were able to target families with an overall positive therapeutic relationship with the health care team, as well as those families with a more polarized relationship. We did so in a subjective manner, based on how families and clinicians referred to one another and how family/patient cases where discussed in team meetings. Families were also categorized by age of patient, according to those with very young children-patients, school-age children, and adolescents. We collected children’s histories, of their illnesses and encounters with health services, their hopes and disappointments.13 [13] Half of participating families were of Canadian, Commonwealth, or European ancestry. Together, the remainder originated from the near or Middle East, Asia, the Indian sub-continent, the Caribbean, and North American First Nations. One-third of families belonged to a visible minority group, as well as a linguistic minority.

The data were analyzed both intra-corpus (i.e., with each interview analyzed on its own, by professional category, unit, and location), as well as inter-corpus (i.e., triangulating the interviews, observations, and case studies) according to an analytical framework incorporating initial research themes. The latter were also assessed in light of events and dynamics emerging in the study itself.

Otherness and Conflictual Situations in the Clinic

When does otherness become a silent but active feature in the caregiver-cared for relationship? An essential structural element of this relationship, and in particular, the doctor-patient-family relationship, is the application of biomedical thought. Practitioners often explain deviation from this applicability by referring to untrained knowledge, reflected in culture, religion, and a presumed misunderstanding of science. When parents tend to diverge too much from what is considered as an acceptable attitude to adopt in the therapeutic space, they are identified as being “a problem” (from the health care provider’s perspective). It is in these circumstances that culture, ethnicity, social class, and religion (primarily minority faiths in the Canadian context) can become stereotypic explanations among practitioners for unfamiliar behavior or beliefs (Vega [49] ; Hannah [24] ; Willen [51] ; Cognet [10]). As a result, the presence of symbolic resources14 [14] among parents for functioning in the clinical space becomes assets, such as having a strong understanding of the child’s medical condition, a mastery of medical language, and affirming “proper” forms of parenting (from the caregiver’s point of view). In our observations, the ability to draw on such resources has a bearing on the perception that a care team will have of a patient’s family, and in turn relationships that may ensue. As well, from the health care provider’s perspective, as long as the “Others” beliefs, values, and practices lead to compliance, minority cultures and religions are seen as positive assets. When parents express reluctance or oppose a therapeutic approach, leading to designation by medical staff as a “difficult” family, religion, or culture are often presented in negative ways, as explanations for therapeutic non-compliance.15 [15] Thus, Otherness becomes an issue when families and the medical team do not share common ground.

In what circumstances does conflict emerge? Our data suggest a convergence of key elements favoring the polarization of the health care provider-patient relationship, captured in the non-adherence by families to the medical team’s proposed plan of care. Such polarization frequently affects the trajectory of care and decision-making processes that bind parties throughout hospitalization. Schematically speaking, these key elements are (1) lack of understanding among family members about biomedical issues that motivate a therapeutic approach, (2) sustained desire by a family member or a practitioner to pursue non-consensual treatment (whether curative or palliative), or by contrast, to stop curative treatment, and (3) discontinuity in care and in the practitioner-patient-family relationship, with ensuing loss of trust. Additionally, perceptions among clinicians of unequal gender relations within families are another key element that frequently leads to polarization, especially when such perceived inequality occurs in the presence of religious and cultural markers that are frequently associated with minority groups. Perceptions of this nature also undermine a positive investment in the therapeutic relationship on the part of hospital caregivers, especially when the practitioner is a woman (Fortin and Le Gall [19]).

Amana’s Story

Amana’s story highlights some of these processes.16 [16] It touches on the theme of loss of confidence and discontinuity in the relationship between health care provider-patient-family. Amana was the only child, preschool aged girl, hospitalized urgently upon her arrival to Canada with her parents (as landed immigrants). Her condition was critical and ‘aggressive’ treatment was undertaken, with mixed results. After an initial 3 months stay in the intensive care unit (ICU), she was transferred to a “step down unit” for several weeks and later returned to the ICU. At the time of our observations, she had been in ICU for the last 4 months with a very bleak prognosis. Amana’s surgeon, the father’s main interlocutor from the very beginning of the hospitalization (and treatment process), was now scarcely seen in the unit.

[The intensivist] acknowledges that she and [the surgeon] feel helpless regarding the inefficiency of [treatment]. She says that the surgeon doesn’t take the time to meet with the parents because he has no other treatment to offer them.

(Observation notes, ICU)

The caregiver/patient/family relationship developed into an antagonistic one as Habib (the father) became very critical of every action taken in regard to his daughter. As witnessed in the unit and reported in team meetings, he questioned every gesture and accused some staff members of racism and of being resentful toward him. In this unit, parental collaboration (or a "good parent") refers to a compliant parent who provides comfort to his child, a non-invasive parental presence in a confined space where technology plays a prominent role. On the contrary, in Habib's experience (inspired by the practices in his place of origin), the parent who raises his voice or is known by the medical staff is likely to get the expected care more easily. However, in the migration context, this attitude can lead to a very different outcome.

During meetings, several members of the team evoked the fear of being attacked by the father that has been described by some as "authoritarian," "demanding," and "sexist." His "culture" is sometimes put forth by staff members to explain these tense gender relations. Yet, a staff nurse from a nearby unit who occasionally intervened with the father reported: I have no problem with this man, with this family, I tell him exactly what is going on, where we stand, and he lets me do my job. And while some nurses stated that Amana doesn't do anything to get better, others talked of her suffering and of the parent's great concern. The situation deteriorated to the point where some staff members suggested calling the police to limit or prohibit Habib's access to the ICU.

This story highlights some of the circumstances that lead to conflict. It portrays many differences among the health care team and between the team and the patient's father. The caregivers disagree on many elements, including the validity of Amana's tests results or the relevance of furthering aggressive treatment (namely organ transplant) Habib does not fully understand the current care trajectory and the medical decisions. The caregivers' inability to agree on a therapeutic strategy and offer a clear line of action as well as the loss of the father's (prior) main interlocutor further cultivates his mistrust. This difficult relationship is also tributary of the differences in institutional cultures of care and a tense international political context (in a post 2001), where recent migrants from specific regions and of minority religious background are often stigmatized in the local society. The father's reading of the care path colored by distress and apprehensions that are in some ways rooted outside the hospital contribute to this tense situation where no bond of trust allowed those involved to reach a common ground.

The "bad or difficult"17 [17] parent deviates from an expected behavior in a given space. When attributes such as a different ethnic origin, language, religion, status, or practice are present, the signs of "Otherness" provide meaning to health care practitioners for making sense of this perceived deviance. Questions related to religious values, modes of expression, difficulties with communication, and distinct understandings of what is going on intervene in the negotiation (or non-negotiation) of norms and values mobilized in different clinical situations. This negotiation can take place with or without confrontation, yet the recognition of challenges posed by social and cultural diversity within the clinic seems to be a trigger for this negotiation. In the absence of recognition and eventual negotiation, universal values of "respect," "openness," and "shared humanity" give way to an often empty discourse, where the relationship between health care provider, patient, and family suffers.

Doctors Facing Diversity

Throughout our interviews, doctors mentioned varying levels of comfort and discomfort with working in an environment of social and cultural heterogeneity, drawing on their life histories (including their ethnic origins), their migration experiences and living environments, the experience of a minority status in Canada or abroad, and experiences of professional practice. From the outset, they were likely to associate “heterogeneity” with “ethnicity” when describing the perceived Other as “Haitian,” “Arab,” or “Chinese.” A minority of physicians elicited enhanced expectations of this Otherness, expectations that reach well beyond ethnic origin and are rooted in perceptions of difference in social status, age, and gender. In turn, these life histories and perspectives of Otherness suggest three ways of thinking about the patient (and their family), the clinical relationship, and diversity in a hospital context. Schematically placed on a continuum, we find at one end a reification of culture as an explanatory phenomenon of distinct positions characterizing the clinical encounter. Patients’ family members are seen to take a given stand because of their belonging to specific religious or ethnic “groups.”18 [18] This stance was found in many testimonies of physicians, when asked to describe what challenges are brought on by practicing in a pluralistic milieu:

It’s not that we hold it against them, it’s about acknowledging how people are. I’ve noticed this with time. Certain communities are always late, its normal, its predictable. Its not racism, its predictable.

(Pediatrician, general pediatrics)

Or,

(…) if you’re speaking with a Canadian who is educated here, born in Canada, you explain more in detail what’s going on, more in detail how to (fix up) treatment. If you speak to somebody from another cultural background, for example from XXX, if he’s new to this system, you will limit the depth of your information because first of all they… if you give to much information, they probably won’t understand it (…)

(Physician, Oncology)

At the other end of the spectrum, a so-called universalist approach prevails, where Otherness is overshadowed by sameness. In this case, beyond their differences, all patients are seen in the same light, making it futile and unnecessary to seek to understand their beliefs or ways of thinking about the world in order to improve the therapeutic relationship. As one physician puts it: I have never found that race or religion has any effect overall in my experience, humans are pretty much the same beyond our differences, we are all human (Physician, ICU). In this perspective, biological, social, and cultural bodies are separate entities. As voiced by an ICU physician:

The first way that I try to deal with this is to, our job is to make the best of the situation, which is survival and best quality of survival for the child. And if good quality of survival is the likely outcome, then essentially everything is going towards dealing with that issue. And often, actually, I won’t say ‘ignoring’, but [I put] to one side many of the cultural processes that one needs to be dealt with […].So, I tend to deal with a very clinical, personally I deal with a very clinical approach to it.

Between these reifying and universalist views, we find an approach which is often called humanist, where differences are contextualized. Physicians with this approach often have a complex understanding of diversity:

Medical practice is more complex today than previously. But [20 years ago], caring for someone from xxx [rural region] and caring for someone xxx [urban region], or poor versus wealthy, was quite a challenge. You needed to know who you were dealing with in terms of social, economic and cultural background, or else you could be out of touch. So I think the challenge of multi-ethnicity is the same, its just more complex. How can we answer this? Competence and knowledge, recognizing that we don't know everything, but that we can try to understand the social experience of the patient without being a sociologist, the family experience without being a family therapist.

(Pediatrician, general pediatrics)

In this perspective, the individual is at the center of care, and social, cultural, religious and ethnic diversity is part of the clinical encounter, rather than an explanatory phenomenon. In other words, we work with it. Each situation is specific and demands that the child and their family be embraced (or tried to be embraced), as a complex entity, calling for interconnected recognition of the biological, the social, and the cultural bodies at play.

The reification of culture and Otherness, as well as a universalist posture, are polar foundations on which conflict often arises in the clinic. For the "humanist," conflict is seen to lead to compromise and sometimes even reconciliation between opposing actors. Our interview, observational, and case study data illustrate that a "contextualized" clinical approach, often referred to by the medical community as bio-psychosocial (Engel [13]), may override individual moral values related to diversity. In this context, the patient and their family become the locus of the encounter, as well as actors within it.

Dalia's Story is an Example of this Contextualized, Humanist Approach

A young adolescent of Jewish faith had acute leukemia. In light of her specific situation, the medical team suggested palliative care rather than aggressive treatment. However, after consulting with their Rabbi, Dalia's parents wanted to further these treatments. Life was the core value that guided the parents' decision, even if it meant that their daughter would suffer. They refused to sign the DNR (do not resuscitate form) while the medical team did not want to intervene should Dalia stop breathing. Dalia's oncologist called upon a Jewish friend to better understand her parents' perspective and later shared his discussion with them. In so doing, they were comforted by the doctor's quest for understanding. Although the parent's decision was unaltered, what was initially a conflicting relationship gave way to a mutual understanding, emerging trust, and a somewhat more peaceful death for all.

By contrast, a clinical approach guided primarily by evidence-based data, where contextualization of the patient and their family is set aside or relegated to the field of care (usually meaning to the nursing field) can become explosive when combined with reifying or universalist postures toward Otherness. Pathways to compromise or reconciliation are no less complex. Only, instead of seeing conflict as the expression of a value in itself—a value or behavior ascribed to an imagined or existing ethnic, cultural or religious community—it is set in connection with the family and its social course, the child's medical condition and the care trajectory (Fortin [16]). In sum, the problem encountered does not necessarily result from a "different" form of belonging, but rather from a particular trajectory that recognizes Otherness as a reality of the clinic.19 [19]

Recognition

Ideally, a clinician’s ethos remains the relief of suffering, restoration of the patient’s integrity, and a quest for balance that fosters a patient’s ability to reach their full potential (Pellegrino and Thomasma [38] ; Ricoeur [40] ; Benaroyo [2]). Practically speaking, this ethos calls for a common understanding, between patient, doctor, and family, in order to develop a care plan for the patient. As Dalia’s story shows, this common understanding becomes possible when, on both sides, there is recognition. Very differently, a reifying process of the Other (as in Habib’s case), or one of sameness where no differences matter, negotiation (or compromise according to Simmel), and recognition become difficult. In these later stances families are often left unheard:

No, pluralism poses no challenges in my practice. Maybe I’m wrong… There are certain colleagues who are from a different ethnic group and say to me “it’s important to know the religion of the person, to know what he thinks and how he is.” But I don’t really want to know[…[Working alongside many migrants] indeed, understanding is sometimes uncertain. In general, I try to make them repeat what I just said, I make them repeat what I said.

(Pediatrician hematology-oncology)

This same hematologist, in a situation of conflict, where the mother would not comply with his recommendations, was observed stating:

Madam, you can think what you want, you can say what you want [but for me] it is written here (referring to evidence-based data). If you do not follow my instructions, your child will die.

Nevertheless, these postures are not fixed and evolve over time, and conflict can also be a source of learning. Sophia’s story testifies to this, fulfilling Ricoeur ([39]) process of recognition, whereby recognition and judgment are incompatible and the former is possible only when failing to understand is actually acknowledged.

Sophia’s Story

Sophia was a 2-year-old toddler hospitalized in the ICU for several months. Her parents were originally from Southeast Asia, having migrated to Canada 10 years earlier. Shortly after her birth, Sophia faced important health problems and a congenital heart disease was detected. Her condition deteriorated rapidly and she was forced to undergo several major medical interventions. Sophia’s therapeutic course was full of pitfalls, which included operations postponed several times, as well as critical post-operative complications. The relationship between the medical team and her parents was tense, to the point where the latter were often referred to among the former as “bad parents.” These parents expected their daughter to recover, a healing process which was slow to come, as her condition worsened throughout the course of her hospitalization, leaving the family with little comprehension as to why.

The surgery… it was OK, but after 10 days, she was not OK. She was, like, really sick, and then September she had the second surgery, and then November 3rd they decided to send her to xxx [another city]. And then, I heard that they told the nurse that they don’t know what to do anymore, like they are giving up, and then, there is a nurse that said: “But you have to do something! You can’t just leave it like that,” because I didn’t bring her [here] very sick, you know? Like, I brought her here OK, and they just wanted to fix it [her heart].

(Sophia’s mother)

The team believed it had exhausted all therapeutic resources, while Sophia’s parents still hoped for a cure. Desiring the expertise of a second medical team, the child was transferred to another hospital (in a different city) by the initial team. Medical personnel hoped the parents would perceive this gesture as a testimony of their commitment to Sophia’s welfare and as a quest for further potential therapeutic avenues. Instead, the parents interpreted this transfer as a withdrawal on the part of the health care team and lack of interest in their young child.

Communication problems were at the heart of difficult relational dynamics that characterized interactions between parents and the medical team. Many members of the team insisted on linguistic barriers that complicated communication. Some also claimed that Sophia’s parents were not sufficiently present at the bedside or involved in their child’s health care path. Nevertheless, other factors complicated the transmission of information to the parents, as the unit had problems with continuity of care with frequent medical staff turnover and lack of communication within and between medical teams. For instance, Sophia did not have a primary doctor, meaning that her parents did not have a privileged resource-person to which to turn. They often felt that information concerning their child was withheld. Meanwhile, some hospital caregivers acknowledged the fact that on several occasions, information was not shared with parents.

And that has been an issue […] for us [intensive care workers]. We know sometimes […] the surgeon and the cardiologist who are to meet with the parents before the operation to get a truly informed consent, and then go on with the operation, […] I think often the consent really isn’t truly informed, I don’t think they go through enough of the issues with the parents.

(One of Sophia’s ICU physicians)

Sophia’s mother sometimes expressed herself with difficulty in the local language of the hospital. Nevertheless, she understood it well and could take part in discussions (our interview with her testifies to this).20 [20] That being said, medical rounds were held during the day, though the child’s parents were more present in the evening due to availability outside of work. Her parents’ questions seldom found immediate answers and were often relayed to caregivers via intermediaries.

[…] it is a tragedy really that they have kept her in hospital for six months and sent her to (another city) and back, gone through all these surgeries and that family is of another culture entirely, from xxx. [Her] mom and dad both work in a sausage factory, they are not sophisticated, they are quiet, they are sweet. They are, you know, their culture is that they are very deferring to doctors and people in charge. They are now, only now after about six months of hospitalization and ups and downs,…[with] their little girl’s medical situation, only now are they starting to get vocal.

(Social worker, ICU)

The parents’ deferential attitudes were perceived by members of the health care team as a lack of involvement in their child’s situation, while the parents referred to patterned relationships witnessed in their homeland where medical hierarchies overruled any patient or family doubts. It was only after several months of hospital stay in Canada that Sophia's parents discovered the "codes of practice" to better voice their concerns.

Again, this story portrays many differences among the health care team and between the team and the patient's parents, while reflecting recognition on behalf of an ICU physician and social worker. This story also affirms how health care teams are multiple—with conflicting values.21 [21] Medical uncertainty surrounding the child, the organization of the unit, the absence of a primary doctor for a patient with a very complex medical condition, and the absence of determined channels of communication with the family engender difficult relational dynamics.22 [22]

If the clinical encounter remains an asymmetrical one between the healthy and the sick (Fainzang [15]), and between those who have the capacity to recognize and those who do not (Ricoeur [39]), perhaps the common understanding Benaroyo, Pellegrino, Thomasma and others call for is not always possible. Nevertheless, in Lévinas ([32]) and Ricoeur ([39]) terms, this understanding becomes possible when Otherness and misunderstanding are acknowledged.

I think I deal with certain cultures better that other cultures. […] I think there're some cultures that we don't listen to very well because it is so, so, I mean so far from our understanding. [...) I think [of] the [xxx] culture [for example], it is very different […], a very different comprehension system we often don't even get past the language barrier to understand why they're reacting, what's important to them.

(Physician, ICU)

Conclusion

The hospital is a place of healing, of hope, of loss, and a place of medical hegemony. It is also a place of negotiation where norms and values constantly interact. These values are contextual, historic, and cultural. They evolve and change. Certainly, expert knowledge is predominant and the norms of the majority group prevail. Nevertheless, biomedical knowledge is not univocal, nor are the norms and values related to it. As is the case for patients and families, hospital caregiver frames of reference are also continually in the making, meaning that culture is not only a patient or family issue (Fortin forthcoming).

The negotiation of perspectives is a key dimension to a normative open space, to the co-construction of norms (Cognet [11]). Arguably, the absence of negotiation and conflict should inspire greater fear or concern, not because it suggests the absence of dissent, but rather because it suggests the construction of tighter, less flexible boundaries. Here, recognition takes on its full strength, not only as recognition of the Other within the clinic, but also recognition of challenges that surround medical practice in a cosmopolitan environment. Recognition invests the clinical encounter within a broader relationship, where Otherness does not set itself as an obstacle and is not obscured by difference, but on the contrary becomes yet another element in the comprehension that the clinical caregiver has of the cared for. Consequently, it contributes to the "co-construction" of a therapeutic project that binds these parties. It would seem that recognition is, therefore, a prerequisite for the emergence of a pluralist normativity within the clinic, and in this it may be a way toward a clinical space aligned with the locality in which it operates.

Medical training must insist on the social features of clinical practice; some university curricula reflect this. However, most training programs treat almost exclusively “expert” knowledge as a certain “technicality” of the medical practice. Yet, the hospital seen as a space of “métissage” requires individual will to inclusively treat patients in the context of daily, relational uncertainty. With this in mind, such mixity requires political and economic will that goes beyond individuals, to foster an environment of care and hospitality open to all. Certainly, this is a question of training, but also one of planning for care and of resource allocation. After all, diversity is here to stay.

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Compliance with Ethical Standards

Conflict of interest

Sylvie Fortin declares she has no conflict of interest. Serge Maynard declares he has no conflict of interest.

Ethical approval

This study received approval from relevant Ethics Review Boards at all participating institutions. All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent

Informed consent was obtained from all individual participants included in this study.

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Footnotes

1 *In line with Weber's (1946:155) predicament regarding medicine's bureaucratization, Cassell (2005:40) discusses this issue, where the "art of medicine" (associated with clinical expertise) evolves into the "delivery of medical care," which refers to a form of scientific medicine where evidence plays a vital role, distancing "care" from the medical role.*

2 *This pluralist normativity is inherent to different moral worlds (Boltanski and Thevenot 1991). In the clinic, we could further argue that this plural normativity calls for an internormativity approach (Rocher 1996), where power relations and modes of interactions between different normativities are taken into account.*

3 *Authors' translation.*

4 *Authors' translation.*

5 *Saillant and Gagnon (1999) point out that the concept of care is plural, referring to a variety of representations and expectations for both sides. Worms (2012:8) emphasize its political nature: "its moral and social function, its share of violence, its dimension of justice and institution, its creativity […]".*

6 *See The Course of Recognition (2005) for the English translation (David Pellauer), Harvard University Press.*

7 *In this sense, recognition precedes knowledge and is achieved through an asymmetric relationship between persons who recognize (or have capacity to recognize) and persons who "deserve to be recognized" (Ricoeur 2004:155). See also Honneth (2004) on this topic.*

8 *According to Clifton-Soderstrom (2003:459): "The need for patient voices is a response to modern medicine's imposition of a scientific language on illness experiences which universalizes persons into general categories before understanding their specificity." Similarly, almost 30 years ago, Kleinman (1988) and Good (1993) highlighted the importance of patient narratives in the doctor/patient relationship. More recently, however, Kleinman (2013, 2012) has questioned medicine's capacity to do so.*

9 *This is unlike Taylor (1992, 1994), for whom recognition in the Canadian multiculturalist context involves group relations, putting culture and ethnicity at the forefront.*

10 *After an exploratory phase (2003-2004), the study Clinical practices in pluralistic context was supported by the Canadian Institutes of Health Research (CIHR 2005-2011) and conducted in a collaborative fashion with anthropologists, doctors, nurses, ethicists (S. Fortin [PI], G. Bibeau, F. Alvarez, D. Laudy, F. Carnevale, M. Duval, F. Gagnon - University of Montreal, McGill University and CHU Sainte-Justine) and many health care providers from the different hospitals taking part in the study (Montreal, Toronto, Vancouver).*

11 Source: Statistics Canada, 2007. 2006 Census, Community Profiles.

12 We worked with an open-ended interview guide where probing questions gave way to more detailed inquiry as interviewees revealed their experiences and insights on major topics related to practicing medicine (or nursing) in contemporary urban settings. In regards to urban pluralism, our initial questions were: "Montreal (Toronto or Vancouver—depending on research site) is a pluralist city. Do you meet many migrants in your practice? Where do they come from? Does this bring on specific challenges (such as—communication or gender issues, decision making process, consent [and the notion of informed consent], other [end of life, quality of life]—)?". And in regard to the city (life outside the hospital), "what can you tell me about the social/ethnic relations (or immigrant/non-immigrant relations) in Montreal (Toronto or Vancouver)?".

13 Unlike Bluebond-Langner's (1978) seminal work and Bonnet's (2011) more recent study, we interacted with the children on only rare occasions, either because their conditions were critical or they were very young.

14 By symbolic resources, we understand the social recognition of the group to which the patient (and his family) is thought to belong, and the value of this position within a given setting (Taboada-Leonetti 1994).

15 Compliance understood as consent to a plan of care (Carle 2013).

16 Participant names have been changed to ensure anonymity.

17 These two qualifiers are used by caregivers, the word "difficult" being mentioned more often.

18 This recalls the work of Kirmayer (2012) who highlights that culture is often thought of as a set of features, values, beliefs, and attitudes equally shared by a circumscribed group. This approach favors a reification of difference (or its negation) at the expense of the contextualization of the patient, their history, and their experience of the disease.

19 The clinic understood as a social space for meetings between the healthy and suffering, migrants and non-migrants, minority and majority groups (the latter being normative in a given environment) of diverse backgrounds (origins, social status, and faiths).

20 Our interview with Sophia's mother was conducted in English. Throughout our encounter, she was able to convey her questions, doubts, and frustrations quite clearly.

21 See Marie-Anne (forthcoming) on this issue.

22 While the organization of intensive care responds to acute care situations, it is quite another situation for "acute chronic patients," who depend on reanimation technology and who remain in a very different trajectory of care (Fortin, forthcoming).

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