Practising in the Field: A Narrative of Public Health Research

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The following is a narrative of a medical researcher and her experiences in the field[1]. Una Lynch, a resident of Northern Ireland and currently a lecturer in the School of Nursing and Midwifery at The Queen's University Belfast, has engaged in extensive public health research using both qualitative and quantitative methods. Though historically, as anthropologists, we have valued the contributions fieldwork has offered to our understanding of culture, personality, lifestyles and behaviours, we seldom encounter fieldwork within other facets of academia. How is ethnography used, therefore, within other disciplines? What contributions has ethnography brought to knowledge outside the borders of anthropology? Lynch, in her work based both in Bolivia and in Cuba, offers those in anthropology, as well as those within the health sciences, insight into how ethnography can be applied to public health. Though coming from a medical and nursing background, Lynch has experienced living and working in the field. Her experiences thus echo those of an anthropologist and are useful to the discipline because they describe a fieldwork experience conducted under a public health model, not within an anthropological framework. Furthermore, her research is vital to those working within medical fields because she reiterates the social and cultural issues affecting health care and medicine.

Lynch's experiences have been described to me in the form of a narrative, included in which are descriptions of her childhood and schooling, her emotions while working as a nurse and as a Health Visitor, and finally her engagement with ethnographic field research which eventually led her into her current career. The use of narrative has been a popular form of qualitative research over the last several years, especially in terms of understanding illness experience and health care (see for example, Crapanzano 1980; Good 1994; Mattingly 1998; Radley 1999; Skinner 2000; and Rapport 2004). As Radley writes, narrative accounts 'have been considered to be journalistic pieces, albeit ones that seem to be creating a new genre, or answering what might be a previously unmet need among the public to know about illness experience' (1999: 778). It is through the narrative lens that I write this article, paying close attention to Lynch's personal difficulties and triumphs, and her experiences dealing with both the ill and those who care or 'manage' the ill. By writing in the narrative form, I hope to convey the intimacies of Lynch's career, her difficulties in conducting fieldwork, and the benefits ethnographic research has brought to her discipline and her personal life.

Narrating the Field

Una Lynch grew up in a Portadown, Northern Ireland, and from an early age knew that she wanted to be a nurse, perhaps as a consequence of witnessing the home care of her grandmother. She entered nursing school in 1981 and was placed in inner-city Belfast during her training, awakening an interest in public health. She recognised, from an early stage of her training, the obvious hierarchy that existed in hospitals at

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that time and remarked that the hospital lacked 'a culture of questioning'. Frustrated by hospital nursing and the emphasis on treatment of illness, Lynch quickly moved on to the study of midwifery, hoping for a career as a health visitor. In 1988, Lynch moved back to Portadown to work as a health visitor. In 1990, she answered an advertisement in the *Guardian* newspaper for a public health position in Bolivia; as she had always had the 'itch' to go overseas and especially to do development work, she applied.

Lynch was hired by the United Nations Associations International Service organisation (a U.K. NGO) as a health worker and soon found herself in Bolivia. This was to be the beginning of Lynch's experience with fieldwork as she was stationed in a small village without electricity or running water, 55 miles from Santa Cruz. Facing many of the problems common to fieldworkers, including initial ostracism and distrust by the community, Lynch set up a health clinic in the village and began to practice as both a midwife and a public health nurse. Equipped with only a saucepan, a kettle, a mosquito net and a mattress, she was, for the first time in her career, without her equipment, and as she mentions, a vital part of her professional identity. Despite the difficulties, Lynch was able to gain entry into the village, after her first successful labour and delivery of the infant of a 16-year-old mother. Lynch remembers that they were in a tiny room, shared with harvested 'monkey nuts', and that the labouring mother did 'just beautifully, as nature intended', squatting at the end of the bed to deliver the child. After the delivery Lynch cut the umbilical cord with a knife and tied it with a piece of string taken from a sack. Reflecting on the birth, Lynch makes the comment, 'that's where I really learned about public health'. Like so many fieldworkers before her, she was without local knowledge, a strong grasp of the language or a sense of how she was perceived by those around her. Yet it was through the 'process of doing' (which is at the core of anthropology) that she gained the knowledge and trust so essential to her work in the field. After the first successful birth, people began to come to her for consultation. She remarks, 'that was my entry into that village, if that delivery had not gone well (for whatever reason) I would have had to leave then and there. From that day on a stream of people began to come because "the *gringa* [foreign woman] … she didn't speak Spanish very well but … she knew something"'.

As she became integrated into the community, Lynch noticed other prevalent social issues, beyond the realm of health care. The first was the lack of literacy in the community and shortly thereafter a team from Santa Cruz was called in to help with the situation. In addition, there were high levels of tetanus in the community, leading to infant deaths, which was being spread unknowingly by a local woman attending births, but using a dirty knife to cut the umbilical cords. In response, a village-wide tetanus vaccination was carried out among all women, though the locals were at first suspicious of the vaccinations, associating them with a sterilisation operation carried out by the Peace Corps some years ago. Eventually, Lynch was able to identify two women who were prominent and well-trusted leaders of the community and trained them in deliveries and in treating minor injuries. Lynch comments, '[b]y living in the community and going very, very slowly, you started to see the reality of their life'.

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After two years in Bolivia, Lynch returned home to Ireland where she worked on the European Poverty III initiative in 1993, and subsequently finished a master's degree at Trinity College Dublin. She eventually took on a job lecturing part-time in University College Dublin on public health nursing: later, at the University of Ulster, she did some work for the Irish organisation *Trocaire* in Honduras to study the effectiveness of their response to Hurricane Mitch. Upon returning she worked for ten weeks on a ministerial conference concerning nursing

and midwifery with the World Health Organisation in Copenhagen. After working for a short while on public policy in Dublin, she eventually moved to her current position as lecturer at Queen's and thereafter applied for her doctorate degree.

> Lynch's doctorate degree has focused specifically on the Cuban health system and why it has proved to be so successful. Last year, as part of her doctorate, she travelled to Cuba to spend 4½ months researching public policy and medicine—for her this was to be another fieldwork opportunity. The interesting thing about Cuba, according to Lynch, is that economically they are a 'developing country' yet their core indicators, such as infant mortality and life expectancy, are similar to those of the U.K. In addition, they are dealing with the same medical issues as most developed countries, such as an ageing population, accidents, cancer and heart disease. Again, Lynch found herself in the field and mentioned that she thought she would have learned from Bolivia, but she went through the same problems again. The first two weeks went belly up. I had problems with my Visa, where was I going to live … I couldn't link up with the people I had contacted.… I thought, 'I only have so much time, I am never going to get it all done'. Then I realised it would take time … For the first two weeks nothing happened.… Cuban has a sort of Latin American attitude, a very relaxed attitude toward time … and I had to settle into that. I thought, I have two choices: I could either become really stressed out … but if I started to get stressed I would alienate them and be seen as a difficult foreigner. So I am going to have to put faith in the process, go with it and whatever is going to come will come.… Things unfolded and by the end of the fieldwork I had more than I would have imagined. To experience the real culture you need to go there, you need to get to know them, they need to get to know you; it's often in the unplanned moments that things come out, and in fact the first phase of fieldwork was really a learning exercise, a fact finding.

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Lynch's fieldwork included attending several different health care venues, including maternity wards, GP practices, polyclinics (dealing with outpatient care, emergency care and complimentary care such as acupuncture), and interruption of menstruation clinics (early-stage abortion clinics). It was then that she noticed the difference in how medicine is administered in Cuba compared with Northern Ireland. She remarks that communication is essential to the process, and that the communication between the doctor and patient was 'key' to understanding their health care system. For example, 'there was much less awe' for the doctor and the concept of equality between the doctor and the patient was much more prevalent. Interestingly enough, the concept of privacy was also different; for example, Lynch mentions that neighbours may sit in on your meeting with the GP: 'health is much more of a public thing, a shared responsibility'.

The mentality toward public policy concerning health care in Cuba is unlike that in Northern Ireland: for example, Lynch remarks, 'the Cubans say, '"this is where we want to go and how do we get there" (…) that might also be where we [Northern Ireland] want to go but because of "x", "y" and "z" we can't go there, so we'll go over here instead. But the Cubans are much more likely to stay focused'. Lynch attributes this focus to the revolutionary attitude toward citizens' rights to services. For example, in Northern Ireland there has been a recent trend of closing hospitals and centralising services, whereas in Cuba the general view is that Cubans living in a rural areas should have the same access to health care services as those living in Havana. The onus of providing these services is often put upon the physician. The doctor has a responsibility to teach and therefore needs to keep up to date, to keep on top of everything, and if he is not seeing enough patients he needs to transfer out. The citizens have a right to services, whereas here we would transfer the whole population out (…) this is not equitable service (…) whereas the Cubans say each person has a right no matter where they live and they put that philosophy on its head, and the responsibility on the doctor.

Aiding in the decentralisation process in Cuba is the multidisciplinary attitude taken toward medical training during postgraduate studies; as a result, there is a noticeable blurring of roles between doctors and nurses, as well as nurses and social workers. Lynch remarks that the 'demarcation that we would have [in Northern Ireland] is not there'. She describes a particularly interesting incident in which she was visiting a maternity ward where one senior doctor was attending a labouring woman: 'the doctor brought over the bedpan and the woman he was with squatted (…) and then he lifted it [the bedpan] and he took it back to the sluice (…) and it wasn't just Cesar [this particular docto]r it happened again and again (…) but that's the Cuban doctor, you are with your patient and if you can do it, you do it. (…. H)ere we have an idea of specialism'.

Lynch attributes this mentality to a 'holistic approach' taken towards medicine; for example, she remarks that 'when they are doing an assessment (…) the GP is taking a history (…) and they are seeing the entire person, they are seeing the person in the context of the life they are living. (…) we don't see that any more'.

While conducting her field research, Lynch visited an HIV/AIDS sanatorium, constructed during the 1980s at the onset of the epidemic in Cuba. The sanatoriums have been controversial because during this time if an individual was found to HIV-positive they were compulsorily placed in a sanatorium with no hope of leaving.[2] At the time, Lynch comments, it was mostly army personnel returning from Angola who fell ill with the disease and there was little understanding of how it spread; in response the government established these institutions to contain the infection. While some have described the sanatoriums as violations against human rights, others have rebutted, as Lynch states, by saying that 'at that time it wasn't a violation of human rights (…) the fact that we, in this part of the world [U.K.], did not act at the time caused a lot of unnecessary deaths'. Furthermore, Lynch remarks that because of the sort of liberated mentality that surrounds sexual intercourse and sexuality in Cuba, action needed to be taken. Many attribute the low HIV/AIDS rates in Cuba to the sanatoriums: in 2003 the prevalence of HIV/AIDS amongst adults was less than 0.1 percent; compare that with the United Kingdom, which recorded a rate of 0.2 percent in 2001, and Canada, with a rate of 0.3 percent in 2003 (CIA United States 2005).

According to Lynch, the sanatoriums continue to serve a purpose: 'if someone is diagnosed with HIV infection they are admitted, not compulsorily but most tend to come in for about three months. During this time they have a full screening done, a full health assessment and have full access to social workers and psychologists'. Moreover, those who are without the financial or physical means to look after themselves would be given a residence in addition to medical treatment. Lynch mentions that the sanatoriums are also used for nutritional research purposes, specifically concerned with vitamin supplements. In the following paragraph, she describes the life of one woman who has resided there for some time:

> There was a woman who was admitted in the early days, in the [19]90s, and she was staying there. Her son was visiting while I was there. She was a very vulnerable person, she possibly had a certain degree of learning disability and she doesn't want to leave. She is very safe in her little self-contained apartment. I had this idea that it was like a prison, but it isn't. It's outside of Havana in a lovely area (…) the patients live in self-contained flats, with a kitchen so they can cook for themselves or they can eat in the dining area (…) this was this woman's flat—this was her home. There were no restrictions on her. They can go out and go back (...).

Mandatory screening has also aided Cuba in its fight against AIDS. Screening is carried out on all people admitted to hospitals for minor surgical procedures, all pregnant women and all those who have been on overseas missions. Lynch also mentions that HIV/AIDS is

talked about openly, that condoms are readily available and people are encouraged to use them. In comparison, Northern Ireland is lagging behind. In the 1980s, states Lynch, AIDS was talked about to a certain extent. 'Now', she says, 'people will tell you the incidence of STDs is going right up, which is evidence that safe sex is not being practised—that's a proxy measure'. In addition to being open about discussing AIDS, Cubans have recently become self-sufficient in producing their own antiretroviral drugs, not a small feat considering they are part of the developing world.

Commentary

How does ethnographic research, or research stemming from living in the field, contribute to a wider body of medical knowledge? In Bolivia, Lynch was able to identify the needs of the community, but it was only through patience and a willingness to engage openly with those in the community that she became immersed in their daily lives. In living amongst them and witnessing the complex interactions between individuals, Lynch was able to identify the community leaders, eventually training them to carry out procedures when she was gone. She was also able to identify possible risks within the community, including the spread of tetanus due to unsafe delivery practices, as well as social issues, such as low rates of literacy. We often do not think of medicine being multidisciplinary in terms of methodology. However, Lynch's case identifies the benefits in qualitative, ethnographic research, especially in terms of creating health care policies.

In Cuba, Lynch was again faced by the difficulties accompanying 'living in the field', but following a period of patience she was able to witness and subsequently grasp the inner workings and ideologies behind a successful health care system. In embracing a holistic approach to medicine, in seeing the individual as being part of a cultural and social context, doctors in Cuba were able to care for patients in slightly different ways than those in the United Kingdom. In addition, the nationalist or revolutionary attitude taken toward patients' rights to health care ensured that the centralisation of health care services did not occur—an issue with which Northern Ireland is now faced. In terms of treating HIV/AIDS, Lynch brought home with her some important lessons. Though advocating compulsory admittance or institutionalisation would not be at the forefront of her argument, she recognises the successes Cuba has had because of its progressive approach to stemming a potential epidemic. Even more important is the need to provide HIV/AIDS patients with a proper place to live and sufficient medical treatment for any complications, especially if their social circumstances are affecting their ability to survive with the illness. In Cuba, the mentality that drives their health care system is one that identifies foremost with an individual's needs, despite their social status or regional location. This mentality has allowed for the equal distribution of health care services throughout the nation, noted in the social demographics and health indicators which place Cuba among the wealthiest nations in the world. Though Lynch certainly does not advocate a 'one-party' system of national government and recognises the disadvantages in having a communist government, she nonetheless envisions the Cuban health care system as a model which could be applied in other countries. In Northern Ireland, this model could be especially relevant as the area is in the process of centralising health services.

Fieldwork has much to offer in terms of our understanding of health care. While ethnographic fieldwork is certainly used in medical anthropology, it is less common to see this methodology applied in biomedical domains such as nursing, public policy and midwifery. What Lynch has demonstrated is that the process of doing fieldwork contributes to the intricate understandings of people's health and overall well-being. Lynch's career has certainly

illustrated the advantages in taking a multidisciplinary approach to medicine and understanding health care systems.

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Notes

1. The following is based upon a personal interview with Una Lynch, 27 February 2006.
2. For a synopsis of the sanatorium system in Cuba see Santana (1997).

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