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Scholarly Stretching and Meta-Ethnography in the Medico-Legal Borderlands

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By Chris Sanders and Laura Bisailon

We met some years back at a scholarly conference where we were both presenting papers on a common theme: health care in the service of the law. We bonded over our shared academic interest in Stefan Timmermans and Jonathan Gabe's (2002) "medico-legal borderlands" framework. As we came to realize, our research agendas were both conceptually situated within 'borderland' spaces. We discovered that common to each of our most recent (at that time) ethnographic studies was an overlapping issue: the ways in which state interests affect health care processes and provider practices.

Following this discovery, we began to envisage how to bring our studies together methodologically in order to arrive at more generalizable analyses and conclusions that could be helpful to sociological studies of health and medicine. In this essay, we have endeavored to deliver on this commitment, and in doing so, spark wider discussions about how state interests both structure, and create conflict within, health care settings.

Our approach draws methodological insight from U.S. sociologists George Noblit and Dwight Hare's (1988) use of meta-ethnography. This approach offers a way for researchers to generalize ethnographic studies through two moves: first, to identify common threads, and second, to synthesize findings arranged as broader themes. The aim of meta-ethnography is to create a strong analytic position from which to migrate findings to other contexts. Noblit and Hare advocate for the use of "organizers," which are conceptual anchors that thematically amalgamate qualitative research findings. Using this methodological strategy, we bring results from what appear, at first blush, to be unrelated studies into generative dialogue. Thus, works that ask similar research questions can be brought together to explore and critique how state interests enlist medical expertise and so affect health care provider decision making and practice.

Why make these scholarly moves?

Our position is that health providers' work is increasingly being organized by and within state interests and goals. This stance contrasts with, say,

the belief that health care services are being carried out in the subjective interests of patients. The empirical basis for our perspective comes from our ethnographic studies. On the one hand, Bisailon (2012) assessed the work of physicians conducting immigration medical examinations for applicants to Canada, where HIV status is a salient concern. On the other hand, Sanders (2013) analyzed the work of public health nurses who provide HIV risk-reduction post-test counseling as forms of care in Ontario, Canada. We both used methodological techniques and analytic concepts from Dorothy Smith's (1987) institutional ethnography approach, which is a form of inquiry focused on the social production of knowledge. We were each interested in understanding how extra-local state interests affect the provision of health care by practitioners working in direct service.

Using meta-ethnography to reflect upon the overlap between our projects was an energetic and fruitful process. This strategy opened up the possibility for us to identify four unifying questions about health care provision. These are: 1) What extra-local state interests are at play, and what are their consequences? 2) How do these arrangements shape the ways that physicians and public health nurses work with patients? 3) What are the implications for health providers and their patients? 4) What local tensions and conflicts arise from these circumstances? In asking these questions, we have captured and also problematized how providers work in separate institutional settings. We can see and comment on how providers are being asked to deliver care to people, and the reasoning practices they employ. Importantly, we can pinpoint implications for provider practices and patient care in ways that stretch well beyond our individual field sites.

Studies in Dialogue

Together, our meta-ethnographic collaboration has revealed two trajectories of extra-local state influence on health care delivery. The first concerns how such interests structure local health care encounters, and the second points to conflicts arising from state influence. Within these two thematics, we identified six organizers that successfully illuminate how state interests influence public health HIV post-test counseling sessions in general, and specifically within immigration medical examinations (see Sanders & Bisailon 2018). In what follows, we draw our readers' attention to two of the six organizers: ethical conflicts and contradictions with the sharing of health-related data.

In both of our studies, we found that health professionals engage in textually mediated practices (e.g., written case notes and diagnostic procedure orders) that are intended to create a permanent record of what occurred during each encounter with a patient. Sociologically speaking, this indicates that providers' clinical documentation styles are being

directed, at least in part, by state interests rather than solely by their professional colleges. The influence of the state in professional provider settings thus sets the stage for sustained ethical conflicts regarding health-related data sharing practices at the local level and beyond.



Ethical Gray Areas

The first organizer of professional practice is what we describe as ethical gray areas in health care service. These emerge when providers incorporate shortcuts and employ procedures that are intended to accomplish state goals. During Canadian immigration medical examinations, for example, applicants are not systematically told that they are being tested for HIV/AIDS. If they test positive for HIV antibodies, they must sign a form confirming that they received counseling (as a form of care) at diagnosis, even though our empirical data reveals that counseling by the doctor is the exception rather than the rule. Applicants have little choice but to sign this form, since a finalized medical file and immigration application for someone with HIV must include this document. Moreover, the applicant, the immigration doctor, and an expert witness must all sign the form. The practice of having signatures reinforces the state's theoretical claim, that counseling occurs in the medical examination, is problematic for numerous reasons that are detailed elsewhere (Bisaillon, 2014). Through this signature system, a doctor's responsibility to patient care is diluted and sometimes altogether disappears, while the outsourcing of counseling becomes increasingly standardized.

In this same vein, public health nurses who meet with patients in a counseling setting frequently withhold or obscure information about the possibility of health records being subpoenaed by the criminal justice system. According to empirical findings, which are detailed elsewhere (Sanders, 2014), the reasoning nurses give is that since arrests for HIV non-disclosure are rare (and subpoenas for medical records even more so), it would be imprudent and alarmist to advise people about the

possibility of involvement of the law. Nurses reason that revealing this possibility might, and likely would, interfere with frank dialogue between provider and patient during the counseling session. That this information is typically withheld to avoid alarming people or deterring them from cooperating with the disease prevention goals of post-test counseling presents a palpable ethical contradiction in HIV counseling.

Both examples detailed above betray a level of misplaced trust in provider practices if one believes that the health care encounter is purely a patient-centered event.



Data Sharing

The second organizer concerns the matter of data sharing. Data sharing refers to the possibilities and processes by which medical data collected in the clinical setting hold the possibility of being repurposed in another moment in time and place within a state bureaucracy. When this repurposing does occur, it is often to the detriment of a patient's best interest. Thus, like practices in ethically gray zones, the circulation of personally identifiable medical data can fly under the radar until it is too late.

During Canadian immigration medical examinations, some forms of health

data are collected for exclusive use by the immigration department. While applicants are told that information being gathered will be part of their immigration file, they reported feeling surprised, distracted, and confused to learn that the data are not *also* for their clinical caring purposes—for their subjective interest as human beings. What is more, information, such as an HIV-positive test result, is attached to the above-noted form, which doubles as an affidavit that counseling services occurred (though, as per empirical reports, this is not the norm). This affidavit is then fastened to an applicant's photograph. This paperwork system and the ways in which doctors and state agents work within its requirements introduces an added possibility for a breach in confidentiality, among other ethical violations.

Further, in the post-test HIV counseling session between public health nurse and patient, the latter's nominally identifiable health care information might enter the criminal justice system if, say, the person is later arrested and charged for an offense of not disclosing their HIV status during sex. So, against this very serious medico-legal backdrop, it is reasonable that people getting counselling might be reluctant to discuss their sex lives, including past partners, given the obvious possibility for legal repercussions.

As sociologists, we are concerned with analyzing the existence of such data sharing from an academic perspective. However, we are also creatures living and breathing among people, connected within communities, and so we share concern about the potential harm that comes from the circulation of these forms of knowledge. We underscore that the 'rub' resides not in data collection, *per se*. Rather, that data have been, and continue to be, at this writing, repackaged and so applied beyond the sites and for other purposes than those for which they were first collected. This matters because it troubles the usual understandings and relations of confidentiality between patient and health care provider. There is also the possibility of data being re-formulated and making its way into courtrooms and other adversarial contexts. Where such is the case, the concern about refashioned data to be used *against* the very same person with HIV, has merit and should concern us all, whether we live with HIV or not, since there is legal precedent of this within cases of HIV criminalization in Canada (e.g., *R. v. Mabior*, [2012]).

In closing, this essay illustrates how meta-ethnography as an analytic strategy can be used to synthesize social studies to usefully generate broader insights about the ways that medico-legal borderlands are organized and operate in local clinical settings. We can attest to how this approach carries potential to broaden the scope of individual qualitative studies, while also enriching and expanding how we come to think through and about these projects. In our view, one of the results is that otherwise shadowy connections between medical and legal worlds practice are

made visible, which, in turn, renders Timmermans and Gabe's compound concept susceptible to scholarly stretching and change. It is with enthusiasm that we encourage fellow researchers and their students to experiment with meta-ethnography, using its organizers to embark on work that fleshes out the territory of medico-legal borderlands.

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