


Certainty in Uncertainty: Our Position on Culture, Focused Ethnography, and Researching Older People

International Journal of Qualitative Methods
Volume 16: 1–9
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sagepub.com/journalsPermissions.nav
DOI: 10.1177/1609406917734471
journals.sagepub.com/home/ijq


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Abstract

This article discursively discusses our position on culture adopting a translational paradigm and on focused ethnography (FE) that helps us construct our evolving understanding of the older people, their illness experience, and dying and death. This work reveals our struggle to understand our position (philosophy) and our use of a methodology to inquire about a phenomenon that is plagued by ageism and the “one-size-fits-all” mentality in health care. We assert that these problems of ageism and standardization together ignore the contextual and cultural realities of older people’s experience in health and in dying situations. In our attempt to find the best fit between what we ask (research question) and how we answer (methodology) the question, we discovered with certainty that our own understanding of what counts as “cultural” and how FE will help us define such a culture is uncertain until we clarify our own ideological stance regarding the phenomenon in question.

Keywords

culture, ethnography, older people

What Is Already Known?

This paper discursively discusses our position on culture adopting a translational paradigm and on focused ethnography that help us construct our evolving understanding of the older people, their illness experience and dying and death. This work reveals our struggle to understand our position (philosophy) and our use of a methodology to inquire about a phenomenon that is wrapped with debacles of ageism and the ‘one-size-fits-all’ mentality in health care.

What This Paper Adds?

This manuscript adds understanding on ‘culture’ as a focal point in understanding age-specific illness experience and situations. In addition, it elaborates on how such understanding led the authors to decisively use focused ethnography after clarifying their position on what counts as culture, the concept on the older person and on ethnography as a concept and a methodology. Researching older people may pose a great amount of ethical concern but not with no possible solution or remedy. The older people’s involvement in studies about health and illness will give rise to more interesting use of focused ethnography. More specifically, an interesting change is expected to unfold as this methodology finds itself more

useful not only in providing better context-specific or grounded knowledge than other grand theories. It also has the potential later to relate to macro discourses such as generational issues as we are facing a wider, perhaps the widest gaps between generations of ‘baby-boomers’ and ‘millennials’, both if not together, are consuming health and co-existing within one health care systems.

Introduction

Research on older people has interested many scholars and service sector managers because of the new demands for services and delivery structures for this population. Age-specific issues challenge service delivery systems, particularly for the health sector, and change the dynamics in the health policy formulation as well as the structure and processes of health service delivery.

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With all these changes happening around the world, studies on older populations have become inevitable and so are the risks that go with researching older people. Obviously, there are ethical and practical issues that confront recruitment and retention of older people, particularly the frail and the dying, but the need to study them is too imperative to ignore. Methodological concerns that expose older people to undue stress and harm have been the ongoing debate and work of most Ethics Review Committees (ERCs) whose duties are to scrutinize procedures and to advocate for older people's protection. However, despite the risks inherent in most research methodology is the growing interest of many scholars, academics, and social services workers in the use of qualitative methodologies that will probe deeply into the lives of the older population. Often, ethnography, as a methodology, is used for age-specific studies to understand the cultural makeup of a specific age-group and determine preferences in terms of health services and service delivery structure that will meet their age- and condition-specific requirements (Atkinson, 1995; Higginbottom, Pillay, & Boadu, 2013; Savage, 2006).

But while the use of ethnography to study culture is not new in the health-care sector, the continuing debate regarding culture and how it is defined in different contexts impact on the understanding of how ethnography is positioned, in addition to how it is used in health research of older people. A thorough explication and clarification of the definition of culture is imperative in justifying the use of this methodology. Thus, this article reviews and analyzes the concept of culture and explores the fit of ethnography for investigations involving older people and their health and illness experience.

The "Culture" That We Know and We Say It Is

Culture sums up everything that defines people in one specific context or situation. The old concept of culture per Kroeber and Kluckhohn (1966) is that:

it consists of patterns, explicit or implicit, of and for behavior, acquired and transmitted by symbols constituting the distinctive achievement of human groups, including their embodiment in artifacts; the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, on the other as conditioning elements of further action. (as cited by Agar, 2006, p. 357)

Reflecting on this tradition of culture, Stuart and Nocon (1996) asserted that it is cognitively defined as facts to be learned and stored, thus the notion of culture as knowledge and culture as skills, or both. These notions of culture may connote a static product or form that may be objectified. However, in more recent literature (Erez & Gati, 2004; Liddicoat, 2002; McLaughlin, 2013), discourses about culture mirror a more dynamic approach such that the notion of culture is a "second acquisition": A view that reflects culture as a process that is part of living and being in the world, necessary for making

meaning (Agar, 2006; Stuart & Nocon, 1996). This interpretive stance in defining culture signifies a more open position and destroys the concept of culture as tangible but rather as something that is shaped by the process of interaction and meaning-making (Hong, 2009).

Another interesting view on culture is the idea that it is derived from noticing differences. Michael Agar (2006) referring to Kundera's work in 1984 made this inference:

All we know at first is that something we didn't understand caught our attention. It signaled a difference between us and what was going on at the moment. (p. 6)

To Agar, a cultural phenomenon is noted when a pattern of events or behaviors is different and not immediately understandable to outsiders like us. He called this a "rich point," an idea that it is probably cultural. Something that enables a group to communicate, relate with each other, and do certain actions, which is uniquely or may not be easily understood by any random stranger outside the group. The assumption that culture involves "shared meanings" in a context that is unknown to an outsider, typically by an ethnographer, connotes that culture is a translation. This stance on culture is consistent with the idea that culture is a second acquisition or "a third space," where interpretation occurs as the researcher's culture interacts with a different culture, thus meaning-making happens.

But this idea of culture as a translation or second acquisition is not entirely new. Geertz (1973) introduced the idea of culture as "thick description." An experience with another culture that is framed around the "meta-cultural awareness" of one's own culture as a starting point. A third space is created to mean a conceptual space that recognizes the intersections of cultures, and it is predicated by a difference between one's own and that of the other culture (Artiles, 2003; Bakhtin, 1981; Dudgeon & Fielder, 2006; Kramsch, 1993).

In other words, as Agar (2006) puts it, "the assumption that translation is both necessary and possible makes sense of rich points, a classic ethnographic problem" (p. 6). These rich points have meanings or contexts that are unknown to the "knower" and raise a question begging for answers. A typical fit for ethnography since it is known to yield a product of translation—from ethnographic product to translation to culture. Therefore, culture is what eventually explains meaning or context to a given phenomenon.

Culture is dynamic because it is recreated when a new member of the group is added. Because it is translational, it is only visible when differences emerge from the experience of the new member. As it is a process more than a product, the experience within the so-called third space clarifies the boundaries between cultures, but it does not diminish differences. In fact, the argument that communities now have cultures signifies the coming of the era of understanding behaviors or events as multicultural. These events have deep connection to people because these so-called traditions that they share grew from their day-to-day practical activities defined by a specific

context and shaped by meaning they all share. Hence, the antiquated belief that culture is tangible and therefore can be objectified and is emanating from a closed, coherent system of meaning and action where one only participates (Agar, 2006) is slowly being replaced. In fact, the idea of culture that is more processual, open, relational, and interactive and continuously evolving as people negotiate their identities within the conceptual space creates rich points for “new” culture to emerge.

Ultimately, the challenge to every health-care professional is to understand the concept of culture and the nature of culture as “plural.” The multitude of cultures within a given context or social space stirs the debate about cultural sensitivity—to have the capacity to recognize differences and uniqueness—as well as cultural safety—to accommodate with respect during health care encounters the customary practices and in some other situations where patients express the need to feel respected and their knowledge and cultural traditions acknowledged.

Our Understanding and Use of Ethnography

The complexities of human connections that create the space for culture to unfold and where behaviors, events, and actions are translated into shared meanings and contexts ushered the birth of ethnography.

Historically, ethnography was originally developed in anthropology and later grew in application in social sciences and even in areas like health. The hallmark of ethnography is in its ability (as a method) to provide interpretation of culture as Geertz (1973, p. 17) states “behavior must be attended to . . . because it is through the flow of behavior (or more precisely social action) that cultural forms find articulation.”

As a concept, it is strongly tied with culture. Agar (2006) asserts that ethnography is about making sense out of human differences in terms of human similarities. Ethnography is more about “being in the world” to understand the human connections that form a culture. Within the complex relationships of people connected and sharing common meanings of their actions and behaviors lie an interpretation, a reflexive process (Hammersley & Atkinson, 2007; Palmer, 2001), and a translation created from a conceptual space of two or more intersecting cultures. The product of this translation is what we usually label as culture of a defined group. But we also recognize that this is a meta-cultural phenomenon unfolding as one experiences and interprets these patterns of behaviors or social actions. Consequently, one’s own culture may shift to assimilate the product of translation as one is exposed to another culture.

As a methodology, ethnography has a cross-disciplinary heritage, and according to Pickens (2009), many regard it as an intuitive way of understanding something we want to know about. This characteristic matches with the more current conceptualization about culture as a product of a translation (process).

Collecting information and presenting information through extensive field experience typically define “ethnography.”

Contemporary approaches to ethnography are far more innovative from its original form and application to traditional subjects of ethnography, for example, in analyzing organizational behavior or cultures and even areas where understanding people’s preferences and choices is necessary for the organization’s core business (Goulding, 2005; Moisander & Valtonen, 2006). These emerging applications of ethnography tend to show less rigid and more adaptable utilization, since the closed, unknown societies, which were the traditional subject of ethnographic work, started to become less visible in present times (Pickens, 2009). Frohlick and Harrison (2008) added that the contemporary ethnographers now work with systems that are open, and the key focus is about developing ways of understanding how to make sense of the presence of outsiders (like the researcher) and interrogating “in-group” relations.

Despite the change in the approaches to ethnography and its utilization as a specific methodology to understand culture (as a dynamic concept), the essence of ethnography lies in the “duality” of describing how people and their world are seen both by the people and by the one studying it. Indeed, culture as a product of translation makes sense through an approach (and a tool) that is ethnography.

The “Old,” the “Sick Old,” and the “Dying Old” as Backdrop of Our Inquiry

For us to begin an inquiry about older people and their health and illness experience, an examination of social constructs on the subject matter is imperative. This is a necessary step to enable us to define our position and perhaps our philosophical bases in inquiring on the topic. This is also relevant since we argue from the very beginning that our use of a methodology is directed by a certain belief or conviction affecting the way we objectively approach the field. The equally contentious issue aside from culture is the concept of “old age” and of being a “sick” older person that has an implication on the way we construct dying and death in old age.

The concept of the sick role was first introduced in the writings of Talcott Parsons (The Social System, 2013) to connote the idea that sickness is more than just a biological concept but also a social construct. His earlier work about illness and the role of physicians (Parsons, 1951) put forward the idea of illness as deviance and that being ill meant acting different or having deviant ways compared to the norm. Hence, the idea that illness requires social control and that sick people must be enabled to perform their social roles is rooted in functionalist perspectives to maintain social order.

While the functionalist relationship of illness and social control was strongly criticized by sociologists due to its many limitations, this theory seems to fit snugly into the view of the situation by a health sector whose self-understanding suggests they “fix” people. In fact, being “old” according to Pilcher (1995) is when people become helpless and dependent rather than when they have lived for a particular number of years. It was only during the Industrial Revolution that the concept of “age” became linked to “employment,” which simply implied

that the young were not yet employed and the old are no longer employed. This combined with the steep rise in life expectancy to create three life stages, namely, the young, the midlife, and the old. Consequently, different social constructs of being old emerged and were strongly linked to latent “malfunctions” of dependency, weakness, and helplessness (Giddens, 2006). In other words, the concepts of being old or being sick are tantamount to not being able to work.

These stereotyped ideas of illness and old age paved the way for the medical profession to become an important occupation in society. These have also influenced how health care is organized and delivered even up to present time. In fact, society has created health care not only as an institution that looks after the needs of people who get sick and prevents people from getting sick but also to make sure that everybody gets back to work as fast as possible and works as long as possible. It is also interesting to consider that old people who are not sick, are supposed to be “active,” which (it seems) means that the old people in question still “do” a lot in society, including “spending a lot of money” (Vincent, 2006, p. 687). These social constructs of health, illness, and old people created and influenced health care in general and made it into a very powerful institution and catapulted the health-care providers to a privileged position over others (Zola, 2001).

The state of being old and having an illness carries a social perception of dependence. However, Hockey and James (1993) argued that the elderly can be much more independent than society allows them to be. The social construct of the “sick role” as part of being old in this modern world disadvantages the elderly due to the natural impact of physiological and psychological changes. Additionally, both media and politicians keep talking about the problem of an “aging society,” which negatively influences old people, whose only “problem” is that they no longer “work” but still want to “consume.” It also seems that the existence of older people in the community is perceived as an economic burden and an added pressure to the health-care sector. Meanwhile, Cumming and Henry (1961) originating from an optimistic paradigm of *disengagement* from social roles argued that the process of older people assuming more dependent roles is necessary and is beneficial to society. Either way, these views still suggest the idea of dependency, which puts health care in an important position of being the panacea for society’s burden with the elderly.

There are two opposing views gleaned from the situation explaining why older people need health care and should be cared for by the system. On one hand are the traditions of medicine as a “life prolonging” and “curing” apparatus to keep people healthy and live longer, for political or economic reasons. On the other hand, are the inconvenient truths about medicine as a social control that minimizes, if not eliminates the impacts of the sick older people in society. For instance, measures that either remove them from the social and economic activities, that is, institutionalizing elderly in the guise of health-care service needs or demands, or aggressively treating their conditions that would only make them more frail and live shorter for capitalistic benefits (Navarro, 1986).

Meanwhile, understanding the latent concepts of dying and death from the perspective of old age compared to how health-care professionals see this phenomenon and their roles in dying and death scenarios will generate insights about health care. In general, health care is slowly moving closer to death than it traditionally did. Previously, doctors separated themselves from the scene of health care when they could not do anything anymore to leave the patients to “die in peace.” With excessive focus on treatment and the lack of attention to “good death” by medical science, consequent behaviors of people about dying and death have also changed significantly (Gawande, 2014).

How people die has changed and this phenomenon seems to indicate that even health-care professionals are struggling with the idea of “watching over” death or how one ought to be in the “presence” of dying and death (Marsh, 2014). The bias of medicine toward preserving and prolonging life and the historical divide between medicine and the church (wherein the previous will attend to the biological aspects while the latter on the spiritual aspects) explain the reluctance of medicine to come close to dying and death, even in old age. Thus, health care excessively focuses on prolonging life and moving the place of death (e.g., home to intensive care unit or hospitals) that in turn makes dying, even in old age a messy and complicated experience (Reich, Signorell, & Busato, 2013).

Preferences in the place of death have been overshadowed by how the health-care system behaves and organizes their services as well as the general attitudes of health-care providers. By and large, dying in hospitals is most frequently occurring in Europe specifically in Switzerland where most chose to die in the hospitals and nursing homes (Reich et al., 2013). In Asia particularly in Japan (Hayashi et al., 2011), health-care providers’ opinion and decision strongly influence the place of death. In the Middle East, death in Qatar hospitals persisted even if the patients indicated previously their preference to die at home (Mohsen, Haddad, Allam, & Hassan, 2014). Moreover, ethnic minorities whose end-of-life (EOL) preferences in United Kingdom were documented to include hospital as a place of death (Koffman, Ho, Davies, Gao, & Higginson, 2014), while the Institute of Medicine’s (IOM) paper in 2014 entitled “Dying in America,” African Americans are less likely to receive palliative care instead more likely to get aggressive treatments at the EOL. In other words, these changes have a lot to do with how health care is situated in the consciousness of people and how the providers’ disposition shapes the general public’s understanding of dying and death, which in turn influence their preferences about how and where to die.

Moreover, in terms of dying in old age, there seemingly is an apparent reluctance to examine the experience of aging and of dying. Instead, the focus shifts to old age and the disease process. This resulted in the lack of attention and concrete measures that address how old age dying and death situations should be handled by the health-care system and how the providers in this scenario approach the individual needs of the patients and not the disease state. According to Gawande as cited by Longman (2014), this reluctance to understand aging

and dying does not only increase the suffering and harm to older people but also denies them the basic comfort they most need during this period.

Most importantly, health-care professionals particularly, doctors, are noticeably uncomfortable with death (Gawande, 2014). It is an unsettling experience every time they are confronted by patients with problems they cannot solve and death they cannot prevent. Most of training, if not all, centers on curing and prolonging life, and there is very little attempt, if any, to learn about aging, or frailty or dying (Longman, 2014). This also explains the dwindling number of practitioners specialized in this area and age-group.

There is the danger that health-care institutions could control social order through their expertise and specialized knowledge and skills. As Zola (2001, p. 407) suggested that “medicine is becoming a major institution of social control, nudging aside, if not incorporating, more traditional institutions of religion and of law,” Illich (1976) noted that people are becoming unable to cope with sickness, pain, and death, as these are already considered abnormal and to be avoided even if these are integral to the human condition. Hence, the choice to simply give comfort (palliative care) or provide aggressive treatment and intervention, with the advent of high-technology medicine, might be impacted by the dominant prescription of the health-care professionals and the power structure inherent in doctor–patient relationships.

Health-care providers are specifically trained to treat or cure illnesses, prolong life, and alleviate suffering through symptomatic management of the disease. But inside these noble intentions is the implicit mind-set of an expert that puts the providers on a pedestal allowing them to “prescribe” and/or direct decisions and actions. Following Illich’s (1976) observation:

the so-called health professions have an even deeper health-denying effect in so far as they destroy the potential of people to deal with their human weakness, vulnerability and uniqueness in personal and autonomous way. (p. 18)

But the hard reality about the present time may not reside in the excessive power of the health-care institutions but more on the readiness of the health-care providers to respond to the increasingly challenging population of older people. Elderly people are often those who have survived and lived through the worst infections in the past decades, wars, and even drastic environmental and climate changes. The lack of contextual understanding about older people by many health-care professionals neglects the needs of this age-group. Authors suggest we do not limit our society’s appreciation of the natural or normal courses of life, simply by not knowing how to help elderly and their families to die better.

As a response to the pressing need to improve EOL care, the IOM’s report in 2014 recommended strategic steps in EOL delivery and education. As well, the ELNEC or End-of-Life Nursing Education Consortium (1997, 2016) disseminated the EOL competency standards of care based upon the precepts and assumptions of peaceful death. But while the progress in this

area is very optimistic, ELNEC in the same report recognized that the implementation remained inconsistent and the continuing efforts to put in place quality EOL care is not without challenges. Thus, the need for more quality studies involving older people is necessary to inform best practices in the specific management of this group (Dent & Clemons, 2005; Herrera et al., 2010).

In addition, the increasing need for age-specific health care and the aging population is two of the driving forces that attract interest in research on older people. Ethical debates have been raised owing to the potential harm and practicality involving seniors and even frail older people in not only risky trials but also studies of qualitative genres like ethnography.

Studies about culture, in particular subcultures of specific age-groups, for example, older people, would have a strong impact in bringing to the fore the demands for more specific and population relevant health care. Likewise, studies about older people, on older people themselves other than their carers or family, are needed to inform the current health-care policy and practice. An essential host of knowledge about their population, their experience, and their expectations of the current health care set up as well as their preferences as a subculture consuming health care is imperative to guide delivery of care. Thus, studying this population is crucial to informing new policy and approaches to reach their sector.

Resolving Uncertainty With Focused Ethnography (FE)

The idea of ethnography is associated with long-term fieldwork where researchers attempt to “go native.” It is also tightly connected to goals of understanding specific cultures and thus the confusion as to whether it is a process or a product, a methodology or just a written account. The dilemma about using ethnography is in its use of many methods and data sources to achieve the “thick description” of a culture being studied. To many researchers and even funding bodies, these are the very concerns that make ethnography less attractive. It is especially so as studies on traditional culture are becoming more challenging as people move and communicate faster than decades ago. Even how culture is conceptualized is also slowly moving away from its traditional stance to a more dynamic and interpretive position.

The above explains why researchers use ethnography with some modification particularly in terms of its focus (from macro to micro culture), approach to implementation (from experiential to data orientation), changes in the researchers’ role (from participant to field observer), and the means of knowledge generation (from subjective understanding to conversation or interactive knowledge; Higginbottom et al., 2013; Knoblauch, 2005). In recent years, scholars in health and social science have explored the use of ethnographies that deliberately chose an approach which can be called “focused.” Perhaps, the pluralization of lifeworlds and the enormous specialization of professional activities created the demand for more detailed descriptions of people’s way of life and their increasingly specialized and fragmented activities (Knoblauch,

2005). Hence, the birth of FE with the understanding that the term ethnography can be applied to small-scale social research that is carried out in everyday settings (Cunliffe, 2010; Maynard, 2003; Pope, 2005; Savage, 2000). For example, according to Knoblauch (2005) and Ybema, Yanow, Wels, and Kamsteeg (2009), an FE can study the workplace to explain human behaviors and describe their culture in that specific environment and it is also of importance in studies of highly differentiated division of labor and highly fragmented cultures.

FE, in contrast to conventional ethnography, is carried out in relatively short-term field visits. Although short in terms of length (extension) of field visits and the intensity of the subjective experience in the “field” may be less, FE relies on the collection of large amounts of data and in the intensity and scrutiny of data analysis. Moreover, FE employs collective data sessions, and the focus of the analysis is on communicative activities and experiences by communication rather than the field.

A critical step in FE, as in most qualitative studies, is the importance of examining the researcher’s “roles” vis-à-vis other roles to disclose positions (Manias & Street, 2001) and to promote rigor through reflexivity (Hammersley & Atkinson, 2007). This is an important step to establish the validity of the phenomena being studied and to convey that the writing is not just an expression of the researchers’ ideology (Schwandt, Lincoln, & Guba, 2007). Through this step, the researcher engages in a critical examination of his own taken-for-granted assumptions, “things that are so engrained and ‘automatic’ that we perhaps fail to realize their impact on our individual and societal or collective experience” (Draper, 2015, p. 38).

FE was also deemed valuable to researching health-care issues because of its ability to link macro and micro as well as between everyday interactions and wider cultural formations through its emphasis on context (Savage, 2006). Fetterman (2010) added that it is suitable for exploring subcultures with a specific area of focus or groups of people within complex and pluralistic societies. Thus, as Savage (2000) and Pope (2005) posited, FE’s strength is in its detailed way of witnessing human events which is particularly useful in health care in terms of understanding patients’ and clinicians’ worlds.

The typical application of ethnography in health care (often referred to as medical ethnography) is tied with the goal of generating a cultural perspective of an illness rather than to study a group or community. Authorities like Magilvy, McMahon, Bachman, Roark, and Evenson (1987) and Morse (1987) as cited by Higginbottom, Pillay, and Boadu (2013) supported the use of this approach to a full-scale ethnography when studying specific beliefs and practices of an illness or a health-care process. The focus on culture (or subculture) is framed within discrete community or phenomenon and context. The investigation is also carried out with participants that have specific background about the topic or area being studied.

FE offers a different approach to deductive observational studies popularly used in health care, that is, case series and cohort studies, which according to Higginbottom et al. (2013) failed to capture a holistic perspective of the subculture under scrutiny. Meanwhile, FE also known in epidemiological studies

as rapid appraisals, micro (Spradley, 1980) or mini ethnographies (Leininger, 1985), is expected to have useful applications in health-care practice as its inductive method will produce an in-depth understanding of a specific phenomenon within distinct client or professional cultures or subcultures (Roper & Shapira, 2000). Moreover, its distinctive feature being problem-focused and context-specific (Morse, 1987) makes it a good alternative, if not equivalent to deductive approaches with descriptive outcomes.

Traditional uses of ethnography in health care have been widely focused on small-scale communities that were thought to share culturally specific beliefs and practices (Atkinson & Pugsley, 2005; Long, 2008; Savage, 2000). With the changes in political and social landscape brought about by the dramatic shifts in technological developments and uses, ethnographies shifted from communities to “home,” that is, corporate organization, subgroups or consumer brackets, specific patients, and so on. As Savage (2000) further argued:

Phenomena such as new information technologies, new national and local identities, and the development of theoretical perspectives that rejects assumption about social coherence have challenged the traditional view that “culture” is a matter of shared beliefs and practices. Instead, a recognition is given to the differences existing within social groups . . . (p. 1400)

Indeed, two major changes have taken place not only in terms of focus or need for specific knowledge on specific population but also in terms of the methodology used to produce this knowledge.

The first is about changes in the need for age-specific knowledge. Because of the success of many epidemiologic or population-based deductive investigations, disease occurrence and distribution have been mostly determined in terms of its group-specific effects and impacts, that is, in age, sex, race, or ethnicity, as well as specific behavior patterns and lifestyles of groups or population. However, our customary regard toward elderly and our sociological biases on older people precluded expression of their “voice” in those studies. This resulted in major exclusions of the older population in investigations, even on topics concerning them, or actually affecting their sector (Herrera et al., 2010). Likewise, major ethical dilemmas have been raised by research involving older people, not only considering the risks and benefits but about more pragmatic concerns of not studying them. In fact, studying this age-group may pose practical and ethical issues, but not including them in studies affects the generalizability of the findings and may pose negative impact on the population later (Bayer & Tadd, 2000; Cruz-Jentoft & Gutiérrez, 2010; Dent & Clemons, 2005).

The second is the demand that older populations have created owing to their highly specific needs and their numbers increasing exponentially. The pressure that the aging phenomenon is posing on health care and other service sectors is overwhelming, as societies and/or policies are shifting to more sustainable and age-friendly configurations (Herrera et al., 2010). Thus, the clamor and demand to enroll them in studies

will benefit their sector, even in risky trials or those not traditionally accessible to their group.

Besides ethical concerns about their age or their state of health, another concern in studies with older people is the issue on participant observation traditionally used in ethnographies (Savage, 2000). The concern about informed consent heightened by the lack of “power” seen in older people’s groups is a major topic of debate by ERCs and practitioners. For the users of ethnography, carefully negotiating, renegotiating, and reconfirming with participants through an ongoing consent process will work in favor for both the meeting of ethical requirements and integrity of the research process itself.

A New Take on FE Research on Older People

Strategies for increasing older people’s participation in studies according to Herrera et al. (2010) must consist of programmatic and study design changes. This is to ensure that while the seniors’ inclusion in relevant studies is being addressed, their needs are also being met and their rights protected throughout the course of the research. There is indeed a need for a systematic examination of how we study and engage older people in research and in health-care delivery to be relevant and effective to their needs.

This is precisely the advantage of FE for it can generate on one hand, the understanding on and about a specific population group within a so-called subculture. On another, FE can provide the researchers a strategic position to make sense of the invisible aspects of health care (Atkinson & Pugsley, 2005) and gain insights that may be highly relevant in refining clinical practice, education, and research (Pope, 2005). Given the enormous changes that have taken place in research with the ERC standards in place, FE can be used to allow researchers and health-care professionals to make sense, explore, and change the many assumptions and stereotypes that impact on old people and themselves as health-care providers.

To understand the experience of older people and to extrapolate on their cultural makeup as consumers of health is only one half of the whole equation. The other half is in the bigger cultural makeup of the health-care delivery system that is managed and shaped by the providers, largely by the health-care professional groups. FEs can generate holistic understanding through the interplay between “emic” (insider’s or individual view) and “etic” (larger collective or societal picture) perspectives in an individual-cultural dialectic as posited by Draper (2015). In other words, individual understanding and/or actions are shaped by the collective culture. In the same way, that individual understanding contributes to the formation of a collective culture. The “rich point” elucidated by Agar (2006) earlier is also the very point where change can take place and where negotiation and renegotiation of understanding can happen. The collective understanding about older people consuming health and the health-care delivery system that caters to older population groups will be impacted eventually by the utilization of a methodology that will allow for critical consciousness and cultural sensitivity. In effect, a much bigger

impact (transferability) is expected to unfold, and this versatility in FE use will allow the methodology to expand and evolve to meet new insights and changing circumstances in health care (Wolcott, 2016).

Conclusion

Understanding old age, dying and death as a natural process in life may lead to a higher appreciation of what health care is and how health-care practice should be. Health professionals need to open up to learning and practicing their valuable profession around how nature has created things in harmony. To restrain health care in terms of its power over people and society means to put more premium on balancing science and humanism to minimize the detachment of the practice from the real world and to prevent the disintegration of the patient’s sense of self-determination. To learn how to die must be a natural process for people as it is in being born, in growing, and of learning how to live or survive. Much of the ethical debate will follow later to set the boundaries on how and up to where nature can take place, but the core of the issue remains that health-care practice must uphold nature and the integral human conditions that make up life even in old age illness, dying, and death.

Meanwhile, the need for studying cultures as understood to be dynamic, multifaceted, and evolving as people interact within a specific context cannot be overemphasized in industries like health care or in other sectors where consumer behavior and preferences are major considerations. The need for a nuanced understanding of a population or even subculture that will allow for comparison or even explanation of their uniquely situated conditions is paramount to meeting their needs as a group and in protecting their interests as a sector.

FE is therefore highly relevant especially as we shift from its traditional use to more contemporary application in current societies. More specifically, that a bigger transition is taking place in terms of our understanding of culture that paved the way for evolving an approach within the umbrella of this genre to tackle the so-called highly differentiated division of labor and highly fragmented culture (Knoblauch, 2005).

Finally, including older people as research subjects may pose overwhelming ethical concern but not without a possible solution or remedy. Older people’s involvement in ethnographic studies about health and illness will impact future care for dying and death processes. More specifically, an interesting change is expected to unfold, as this methodology finds itself more useful not only in providing better context-specific or grounded knowledge than other grand theories. It also has the potential later to relate to macro discourses such as generational issues as we are facing a wider, perhaps the widest gaps between generations of “baby boomers” and “millennials,” both if not together, are consuming health and coexisting within one health-care system.

Acknowledgments

We would like to thank Prof. Claudia Lai (honorary professor, School of Nursing) and Dr. David Kurt Herrold (assistant professor,

Department of Applied Social Science) of The Hong Kong Polytechnic University, who provided critical inputs in the development of the article, and Prof. Mae Florence Nierras for proof reading/editing work.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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