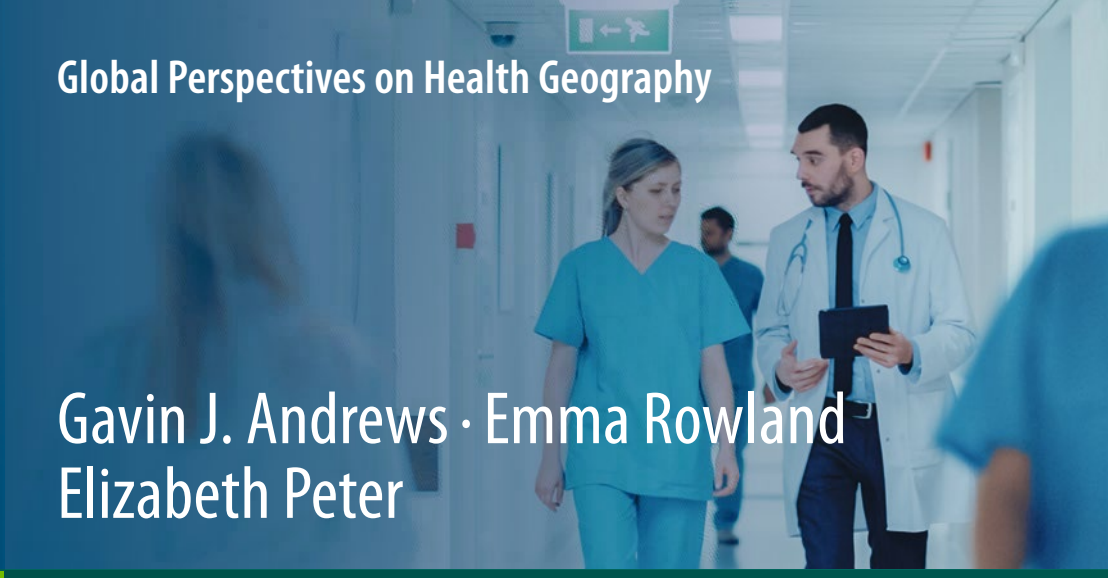
Global Perspectives on Health Geography



Gavin J. Andrews · Emma Rowland
Elizabeth Peter

Place and Professional Practice

The Geographies in Healthcare Work

Springer

Global Perspectives on Health Geography

Series editor

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Foreword

There is much to commend in this book. The first is bringing the discipline of geography, geographical topics and professional practice together. Covering a wide expanse of terrain, topics, issues and approaches, the team is well equipped to take forward an innovative agenda. Gavin Andrews—a health geographer who studies health care practice, Emma Rowland—a new scholar and nurse researcher with a PhD in human geography, and Elizabeth Peter—an established nurse ethicist with a career interest in ethics and place, all tackle geography and professional practice in different ways. By coincidence, I have had the pleasure of 'bumping' into each scholar in different venues, Gavin Andrews in the United Kingdom (UK), Elizabeth at the University of Toronto and Emma working in the same faculty as myself. We have discussed our intersecting interests in spatial dynamics of history, comparative geography of nursing workforce and emotional ecosystems of practice.

Space and place—the two core geographical concepts are of increasing importance in professional practice. At the time of writing, COVID-19 brings geography into stark reality with concepts such as social distancing, sheltering in place, transmission routes, care homes and the notion of 'community' as a setting all coming to the fore, not only as professional considerations but also in everyday public conversations. However, more generally, in the last thirty years, practice has been extended to a greater range of community places (such as homes, schools, the street) and has occurred in established settings (such as hospitals) that are ever-changing in their form and function. Moreover, technology has changed the spatialities and interactions between professionals and clients, particularly as remote care becomes more common via the telephone, internet and robotics.

Nurses talk often refers to the 'proximity' between themselves and their clients—their availability in space and time, and pressures on them. We talk of 'presence' and how, as physical and felt, it is important in therapeutic relationships and outcomes—where patients and clients come from, what routes they have taken to bring them to their current situations and how this shapes expectations, experiences and access to care. No where is this now more potent than geographical variations in the social determinants of care. Talk about 'therapeutic environments', both community and hospital-based, and what clients need to have 'in place' to maximise

their experiences and outcomes is germane to how we organise care. As health professionals, we might not always think of all these things as geographical, but they clearly are.

But thinking geographically about care also helps us quite explicitly see how a geographical imagination and approach can be integrated into both research and practice. No previous publication has done this so far. Specifically, two of the middle chapters describe an applied qualitative geographical study in detail as an exemplar, and the final two chapters explicitly engage with well-known concepts and debates in practice and research, Skill Acquisition and Person-Centred Care, but add a new spin. There is also a new emergent vocabulary built into the methods and theoretical insights discussed in the book—'carescapes' and 'mobilities of care'. These chapters will be useful, not only to health professional researchers/academics thinking about geographical issues and frameworks but also to leaders in both management and professional practice and innovation. Students and clinical nurses will find much to relish and reflect upon in the reading. This book demonstrates that geography has arrived and can reframe and open new 'spaces' for analysis and the conduct of care.

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Ann Marie Rafferty

Preface and Overview

This book is focused on geographical research on, and the geographical facets and dimensions to, health care work; on a broad range of work contexts, workplaces and work practices. It is perhaps the first book to consider these things explicitly and in-depth. *Conceptually,* the book conveys how space and place and related geographical ideas matter to clinical practice from the historical beginnings of care and medicine to the present day. *Theoretically,* it outlines the contributions of various traditions that have informed these understandings, ranging from classical 'in house' professional theories on the nature of clinical environments to ecology, spatial science, political economy, humanism, social constructionism and various post-structuralist and posthumanist theory. *Positionally,* the book showcases how a critical perspective can be usefully deployed at the very heart of medicine and health care research, exposing the many geographies in their (re)production. *Empirically,* it covers work across a range of job types (including physician, nurse, and multiple technical and therapeutic roles across multiple specialties). Finally, *informatively*, the book draws not only on the research of geographers but also on the research of those in other fields who have, over the years, conducted their own spatial/geographical studies, including in health services research, design and architecture, and the academic wings of various clinical specialities (most notably nursing research). Hence, it looks at the intimate geographies in practice (e.g. Andrews and Evans 2008) rather than macro-scale human resources, labour and workforce issues (e.g. Connell and Walton-Roberts 2016).

In terms of readership, we intend the book to be of interest to teachers and students; those leading or taking courses/modules focused on work and/or health care in human geography and other social science degree programs, and those leading or taking courses/modules in nursing and other health professional programs. Whilst, through the book, teachers might find fresh ways to convey the nature of health care work, students will find fresh perspectives that assist their understandings. We also intend the book to be of interest to researchers—indeed, to (post)graduate students and professional researchers, helping extend the scope of their research engagements with health care and health care work.

In terms of its academic position and rationale, the book comes at as distinct moment in time. As will become clear in the book, over a number of decades, both medical geography and the more recently emerging geography of health have displayed varied 'associations' with the topic of professional health care work. In medical geography, often using quantitative methods and with a conceptual emphasis on space, scholars have mapped important contexts to health care work (such as the distributive features of health and disease and the spatial accessibility and utilization of services), and even specific decisions made by workers (such as on where to work and where to refer clients); classic texts in this area include Joseph and Phillips (1984) and Meade and Earickson (2000). In the 'post-medical' geography of health, using qualitative methods and with a conceptual emphasis on place, scholars have focused largely 'downstream' from health care work on the consumption of health services (i.e. what one might think of as the net 'effect' of work), or otherwise have focused outside system interactions on experiences of illness and wellness (i.e. at times what might be the net 'neglect' of health care work) (Parr 2002, 2004). Meanwhile, most recently, changing things up considerably and filling the gaps left by above research, an increasing number of studies by geographers and by nurse scholars have begun to illustrate far more directly how health care roles and practices are shaped by space and place, and hence in research terms, how they might be understood through a geographical lens (see Andrews 2006, 2016; Andrews and Evans 2008). Engaging with and beyond this emerging literature, this book presents the first single comprehensive analysis that illustrates the vast breadth of geographical realities in health care work.

In terms of further justifying the book, it might be argued that all social science perspectives are relevant in approaching health care work because they reflect 'on-the-ground' practice realities that are important to understand. Sociology has proved insightful to professional practice because health care does not exist in a vacuum, and the social nature of it and its contexts are critical. Social psychology has proved insightful to professional practice because health care workers, their clients and the public ruminate and opinionate upon and make decisions on health matters. Economics has proved relevant to professional practice because workers increasingly take responsibility for, or are themselves, scarce resources (and so on). By the same token geography is insightful because, as suggested, all practice and purviews play out over space and place that determine their character (Andrews and Evans 2008). Indeed, showcasing the many on-the-ground geographical realities of clinical roles and practices, this book illustrates why geography is as important as any other discipline.

With regard to structure, Part I of the book is introductory and contextual. Chapter 1 examines how geographical ideas have been central to various types of practice, thinking and acting over many centuries and in many places. This includes labour divisions and forms of caring in prehistoric times, in the earliest origins of ancient Chinese and Indian (traditional) medicine, in the health ideas of ancient Greek writers, in medicine in the age of European exploration, in the nineteenth century origins of public health practice, in the work of Florence Nightingale and in mid-twentieth century nursing theory. The chapter explores how these historical strands have

reached fruition in the current era with contemporary practice and research concepts such as ‘work environments’, ‘clinical environments’, ‘environmental health’, ‘life-words’ and broader movements such as environmentalism. Chapter 1 hence sets the scene for the ones that follow it, which are focused more on contemporary geographical thinking and ideas. Moving on, Chap. 2 reviews the contemporary geographical study of health care work. Initially, it examines key ‘on-the-ground’ transformations in health and health care which are fundamentally geographical in their making, form and consequences—hence, transformations which have demanded a geographical research perspective be taken as well-aligned vantage point with which to report and understand them and their impacts. These include increasing spatial diffusion of health professionals and roles; the transition of health care settings; the role of technologies in overcoming spatial limitations; the increasing emphasis on community and the social model of health; the embeddedness of geographical scales and concepts in policy and administration, and the globalization of work roles and responsibilities. It then moves on to examine how a number of academic developments—including in medical/health geography and other social and health sciences—have at the same time coalesced to provide an additional set of sectorial motivations and opportunities for geographical scholarship on health care work. Finally, it describes the main theoretical traditions and approaches which have constituted ‘geographies of health care work’ as a multidisciplinary academic enterprise and field—including spatial science, political economy, social constructionism/humanistic and most recently non-representational—providing examples of recent empirical research which has been framed by each.

Part II of the book is exemplary, Chaps. 3–5 being empirical case studies based on two of the authors’ original empirical work, that showcase contemporary geographies in professional practice. Chapter 3, the first of these, presents data derived from ethnographic observation of four hospital wards and interviews with individuals working in them (together they representing multiple work roles/categories). The aim is to articulate the character and function of ‘emotional geographies’ in hospital-based/ward work. Specific themes include geographies of emotional detachment, contested emotion, emotional attachment, emotional containment and communicating emotions. Chapter 4, the second of the case studies, presents data derived from ethnographic observations of ambulance work and interviews with ambulance crew, the aim being to describe the nature and impact of particular spaces on this form of work including ambulance stations, mobile workspaces, public spaces and private spaces. Similar emotional categories to Chap. 3 are explored. Moreover, across many of these spaces, a number of experiences are mapped, including frustrations, stresses, coping strategies, gendered dimensions and bodily agency (body categorization, practices, transformations, routines and rituals). Indeed, this chapter showcases issues related to professional health care work across non-traditional community spaces. Chapter 5, the final case study, presents an analysis of published policy, institutional, legal and media statements relating a case where a nurse was found to be extremely ‘dangerous’. The idea is to think about how trust in ethical nursing work, and the places of nursing work, is represented. Attention is paid to the involvement of different scales in work and its regulation

and its representation (international, national, city and setting), and how each is used/implicated.

Part III of the book is more visionary. The final two chapters showcase the potential for a more integrated geographical contribution to professional practice. How geography might be elevated beyond its current role as a 'useful' research lens and perspective by giving the discipline a more central voice in mainstream health professional debates. To this end, Chap. 6 showcases how geography might play a fuller and more embedded role in understandings of 'person-centred care' (PCC). After reviewing traditional research areas on PCC, it describes how PCC might be understood as a 'more-than–human' spatial production. Specifically, it describes how a posthumanist theoretical orientation might rethink some concepts central in PCC (identity and meaning, emotions, difference and oppression, agency and communication). Then, using a recently developed three-part posthumanist typology, it considers how PCC might emerge and express within material social assemblages; be enacted and performed affectively by vital bodies and vibrant objects; and be conducted in immediate, pre-personal, more-than-representational spacetimes. Chapter 7 showcases how geography might play a fuller and more embedded role in understandings and debates on 'skills'. Specifically, after briefly reviewing traditional approaches to studying and understanding skill in health professional research, it takes principles of non-representational theory, and proposes some ways forward for future research through a deeper ontological understanding of skill and its processual, spatial emergence—summarised by us in the term 'skilling space'. Finally, at the end of this last chapter a nod is given to the broader research agenda as we move forward with geographical perspectives.

Hamilton, ON, Canada — Gavin J. Andrews
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Part I
Introductions

Chapter 1
The Geographical Origins of Geographical Thinking on Health Care Work

Gavin J. Andrews, Emma Rowland, and Elizabeth Peter

Abstract This chapter explores how geographical ideas have been central to thinking and acting in caring practice over many centuries in many places. This includes in forms of caring in prehistoric times; in the earliest origins of ancient Chinese and Indian medicine; in the health ideas of ancient Greek writers; in medicine in the age of European exploration; in the nineteenth century origins of public health practice; in the work of Florence Nightingale, and in mid-twentieth century nursing theory. The chapter then explores how these historical strands have reached fruition in the current era with contemporary practice and in research concepts such as 'work environment', 'clinical environment', 'environmental health', 'lifeworlds' and in broader movements such as environmentalism. The chapter sets the scene historically for the ones that follow it in the book.

Introduction

This opening chapter is unique in that it looks back in time in order to establish some foundations and precedent for the book, considering the origins of geographical thinking on health care work and practice. Telling this history is challenging because different versions of it exist. As Valencius (2000) notes, there is certainly no one universally accepted story of geographical thinking in this area. Current scholars with different backgrounds—be they geographers, historians, medical historians or physicians—have written quite different accounts that emphasize the work of particular ancestors that tend to support their own disciplinary allegiances and priorities. Nevertheless, we think we can do a more wide-ranging job than others have done. Structured chronologically, the chapter moves quickly between diverse time periods conveying how, prior to contemporary scholarship, geographical thinking was undertaken predominantly by clinicians with a view to improving the health states of the individuals and populations under their particular spheres of responsibility and improving the nature of their practice directly. Hence there are two take home messages. First, that the origins of geographical thinking on health care work and practice have reflected their particular geographical contexts and situations.

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Second, and perhaps most fundamentally, because these people were some of the earliest thinkers and actors of any on health care, they and their geographical ideas have been central to developments and priorities in the overall sector over many centuries, as we shall see from the very earliest forms of interpersonal care and medicine, to later tropical and social medicine, through to more recent eras and the idea of 'practice environments'.

The Prehistorical Origins of Place-Based Care in Archaic Human and Modern Human Populations (450,000 BC+)

We start the story from the very beginnings of humankind, not typical in academic reviews. Recent anthropological research has identified forms of what would now be categorized as care in the earliest archaic human populations. Forms of care that were very much a product and reaction to the environments that these populations had to live and survive in (Spikins et al. 2018a, b). Laying the basis for care was the development of compassion in populations. In terms of definitions, psycho-anthropological research tells us that to show compassion is to show sympathy and concern for various forms of suffering that others might experience, this resulting in forms of tolerance and sensitivity, both of which lay the foundation for kind and supportive acts. Indeed, as Spikins et al. (2010) note, compassion is feeling emotion for another individual's emotion. It is free from immediate obligation, often being spontaneous and not thought out, yet as an 'idea' might be incorporated into rational thoughts and planning (Spikins 2015; Spikins et al. 2010).

Covering a broad swathe of prehistoric history, Spikins et al. (2010) note four stages or thresholds of compassion existing in archaic humans and modern humans (Homo Sapiens). Each differs from thresholds of compassion observable in more primitive primate groups (such as chimps and other great apes), which, although capable of displaying concern and some forms of care, usually only extend this to young and/or for limited periods: (1) fleeting responses to distress (6.2 million years ago); (2) regulated emotion and rational thought (1.8 million years ago); (3) deep seated commitment to welfare of others, including long term planning (300,000–50,000 BC); (4) moral obligation, including the development of abstract concepts—such as shown in symbolic material objects and art about the duty to care (100,000 BC). As Spikins (2017) explains, however, it was Neanderthal populations (archaics of 450,000–40,000 BC) that displayed most progress in terms of compassion, evidence suggesting that family and social groups would look after vulnerable members for as long as was required, often for their full lives (evidence existing, for example, of feeding, sharing food and water, and protection). These kinds of concerns and acts, far from being wasted energy, constituted the basis for collaboration and species development, and certainly challenge the popular stereotype of Neanderthals being mindless thugs engaged purely in a game of survival of the fittest (Spikins 2017). As Spikins suggests, there is a practical 'logic' to com-

passion and its utility, it being passed on through natural selection. The most successful individuals and groups would display greater degrees of compassion (hence displaying one's emotional credentials attracted a mate). Through compassion, then, what eventually developed is complex emotional minds in early humans. These in turn allowed even greater degrees of trust, networking, role definition and perseverance in technical skills to emerge, and overall more rapid social development (Spikins 2017).

What was critical to species development in Neanderthals was the specific environments they were attempting to survive and prosper in, the activities they had to undertake for this to happen, and the specific instances where compassionate acts were most useful and necessary. As Spikins et al. (2018a, b) explain, Neanderthals lived in the cool temperate zone climates of what is now Europe and Northern Africa, which were prone to great seasonal temperature variations and periods of glaciation. They existed here because of the abundance of large mammals—megafauna—which were their primary source of food. However, hunting these mammals involved quick movement over terrain and close range killing, both of which frequently resulted in injuries (evidence of injury resulting from inter-group/human aggression and conflict being less clear (Spikins et al. 2018b)). Research suggests that in order to be more successful Neanderthals gradually became more knowledgeable in approaches to injury management. Indeed, the archeological record shows that their 'primary care' included applying stints to breaks, cleaning and covering wounds, administering water for fever management, and eventually administering types of acids as early painkillers and antiseptics. Meanwhile, 'after care' for the sick included providing shelter, protection and food sharing. This often lasted weeks or however long it took for injuries to healing and infections to clear (Spikins et al. 2018a, b). Indeed, research describes how most older Neanderthal skeletons show at least one injury, suggesting that such care was common and effective (Spikins et al. 2018b). Meanwhile, research argues that labour reallocation was also undertaken for mutual benefit; injured or recovering group members being given less physical tasks such as childcare, tool or clothing manufacturing, cooking or fire tending (Spikins et al. 2018a, b). What is not known though is how primary or after care might have been allocated between group members, although it is logical to assume—given distributed behaviors and roles known to exist in numerous other primate groups—that certain group members might have been more expert and involved in caring than others (Spikins et al. 2018a, b). If so, this would constitute the very earliest form of specialization in care.

In sum, in terms of overall contribution, in Neanderthal populations caring for injured members of a group constituted a form of 'risk pooling'. Knowing that if injured you would be cared for, allowed individuals to take greater risks whilst hunting and subsequently to achieve greater success for the benefit of the group (Spikins et al. 2018a, b). Moreover, as part of this, caring practices showed a basic understanding of the risks of non-care and a basic understanding, if not of disease pathology and physiology, at least of the consequences of disease pathology and physiology (Spikins et al. 2018b). The extent to which caring in Neanderthal populations constitutes conscious geographical 'thinking' on health care practice is of