Jeannine Moreau, RN, MN, PhD candidate  
Faculty of Nursing and Midwifery  
University of Sydney, Australia  
Email: jmoreau@uvic.ca

**ABSTRACT** for Annual Liverpool Symposium on Current Developments in Ethnographic Research

**Discursive cultural ethnography: a trialectic of space/knowledge/power**

“If one is interested in doing historical work that has political meaning, utility and effectiveness, then this is possible only if one has some kind of involvement with the struggles taking place in the area of question” (Foucault, 1988b, p. 64).

Foucault’s words reflect my choice of discursive cultural ethnographic methods that offer “ethnographic representation as a site of unequal discursive power” (Bucholtz, 2001, p. 166). Discursive cultural ethnographic methods offer a way to “avoid the fallacy of reducing social realities to text and discourse...[and provide] understanding [of] the social/discursive” (Blommaert et al. 2001, p.9). These methods provide more than a “reading” of one kind of text that is an immediate yet partial view of a discourse (Fairclough, 2001). Analysis across written, read, spoken and performed texts from reviewed literature, organisational documents and the field site explicates sites of discursive skirmish to reveal mechanisms of power, fluid and changing not static and fixed; where there is power there is resistance (Foucault, 1990).

I use a matrix to make sense of entangled discourses and examine power relations within/between texts influenced by non-discursive social, economic and political environments. Foucault’s (1999) space/knowledge/power trialectic organises how such dispersed yet interrelated discourses constitute that of which they “speak” and have effect as complex exchanges of ideas and practices. My intent is not to offer solutions but to show the powerful political workings of discourse to inform policy and care practices; and to influence more effective care outcomes that account for a variety of discourses besides a biomedical discourse of care. I look at the “felicitous ambiguity” (Fairclough, 2001, p. 23) of what individuals do and say in tension with contingent/discursively informed social conventions manifest as entangled discourses of functional decline, risk, safety, patient-centered care, economics, hope, ageing, ageism, nursing, and so forth.

The ethnographic field site, an orthopedic surgical unit, offers involvement in the area of question, older adults’ hospital care following repair of hip fracture due to a fall. The struggle
concerns how it is hospitalised older adults often get worse not better. I contend inequities in this site of struggle stem from the power of a biomedical discourse of functional decline presented as truth claims that efface social realities relayed by personal stories. In this paper I will examine power relations and tensions between privileged care provider expertise, truth claims, and patient subjugated knowledge in the space of medical practice, the hospital.

I offer the story of Ethel, 80 years old, who says she knows the importance of mobilising following surgery but complains how hard it is, resists getting up saying it is too difficult, how getting old is not for sissies, how tough it is to get going. She says she has fibromyalgia and smoked years ago. However, despite this her oxygen saturation level is almost 100% after walking a few steps 1st day post-operative. By 2nd day post-operative, she should be walking with her walker about her room. At 9:05AM the nurse commands Ethel “we are going to walk with your walker to the door”. Ethel frowns saying “I can’t go that far”. The nurse moves her along at the elbow saying “we will get to the door”, offers encouragement “you can do this” then praises “you did it!” Later, the nurse tells me “I am not fluffy. I am straight with my words. She can do it.” Ethel, who lived independently and walked a couple kilometers a day, says broken hips are for old people. Now she “feels down knowing life will never be the same” asking how will she ever manage on her own again despite the physiotherapist telling her there is no reason she cannot “be where she was before”. Ethel’s hospital stay was 18 days (13 on the rehabilitation unit) in contrast to the clinical pathway of a five day stay. Ethel saw herself as worse not better, the nurse saw her as able to be better but choosing to be worse and according to the system, worse still, her stay took three times longer than expected.


