Part III
NEW SOCIALITIES AND SUBJECTIVITIES IN CARE
Muslim migrants in Montreal and perinatal care

Challenging moralities and local norms

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Stemming from multisited research on Muslim migrants in Montreal and perinatal care, this paper centres on the local and transnational socialities in regards to perinatal knowledge as well as how these socialities and knowledge-sharing practices become actors in the local clinical encounter. We address these two themes within a pluralistic setting, where health services (whether community or tertiary) seek to adjust to local demographic changes (31% of Montrealers are born outside of Canada (Statistics Canada, 2007)). For more than a decade, Muslim countries have been among the leading home countries of Montreal's migrants, making Islam (mostly Sunnite) the second religion in Quebec, after Catholicism.

Families of all backgrounds share perinatal knowledge that is passed on from one generation to the next (Cresson and Mebtoul, 2010). Yet, this knowledge changes over time and place (Hjelm et al., 2009; Grewal et al., 2008; Boyacioglu and Türkmen, 2008; Yount, 2007). How it is met within clinical encounters with Muslim migrants gives rise to a number of questions, particularly in regards to gender roles, family dynamics, and decision-making processes related to healthcare issues (Ny et al., 2007, 2008; Pels, 2000; Fortin and Le Gall, 2012; Fortin, 2013b).

In this contribution, we discuss socialities in the context of migration, with special attention to the changing role of fathers and how these socialities are involved in the clinical encounter. We see that expert knowledge

1 The pluridisciplinary research team that led this study funded by the Canadian Research Health Institutes (2007–2012) was composed of S. Fortin, J. Le Gall, G. Bibeau (anthropologists); A. Payot, F. Audibert (clinicians); F. Carnevale and A. Gagnon (nurses); and many research assistants: M. Bélanger and S. Maynard (successively team coordinators); R. SiAllouch, M. Rietmann, C. Thériault, and É. Fréchette Audy; as well as G. Désilet, L. Benhadjoudja, A. Adouane, A. Détole, and J. Letarte.

2 Montreal's historical migrant diversity gives rise to a dynamic plural locality. This cosmopolitan metropolis welcomes from 40,000 to 50,000 migrants per year from more than a hundred different countries (Gouvernement du Québec, 2013).
is rarely questioned, and examine how perceived gender relationships and inequalities shape clinical discourses and practices, despite (or due to) a greater involvement of the father in the perinatal sphere. In examining the varied habitus of the caregiver/patient interaction, we make sense of the values, norms, and practices that emerge and how they shape subjectivities.3 We conclude by situating these socialities and subjectivities within a broader context and noting how the contrasting different logics help us understand our future socialities.

Methodology

The main goal of the study was to analyse the encounter between Muslim families and healthcare providers (HCPs), paying particular attention to the negotiation of knowledge, norms, and values as well as familial and professional practices. Observations were carried out in Montreal, in the obstetrics and neonatal wards of two university tertiary paediatric hospitals, one university general hospital, as well as during perinatal activities in several front-line community healthcare establishments (prenatal group meetings, breastfeeding clinics, programmes for low-income pregnant women, postnatal visits at home).4 Over a two-year period, we repeatedly attended unit meetings, observed daily practices of the obstetrical and neonatal wards, shadowed community nurses on their home visits (all mothers in Quebec are seen at home a few days following childbirth), and attended perinatal activities.

Findings were also collected from semi-structured interviews with 54 HCPs (15 hospital physicians, 12 hospital and 20 community nurses and 7 other professionals (psychologist, nutritionist, social worker) in the community or hospital setting), and 95 Muslim mothers recruited in these

3 There are multiple definitions of subjectivity. It is a rich and complex notion that embraces ‘continuity and diversity of personhood’ while taking into account the different processes that participate in its making (Biehl et al., 2007, p. 1). For anthropologists, subjectivities are ‘landscapes of explosions’, ‘noise’, and ‘disconnects and dissociations’ mixed with ‘reason’ and ‘rationalizations’, all of which have sociopolitical dimensions (Fisher, 2007, p. 424). For our part, we understand it to be the delicate relationship between the construct and the perception, an approach that combines in the same instant experience and background; structure, agency and interaction; the individual; and his/her path in relation to political, economic, and historical conditions in which this course occurs.

4 Our study was approved by the ethics review board of all participating institutions.
institutions, of which 20 became case studies.\textsuperscript{5} We met repeatedly with the latter (a mean of five encounters per case) during pregnancy and in the first months of motherhood, as well as with their spouse and any other household figure (friend or family member) present in the home, or in the community activity space or hospital clinic at the time of our study. The interviews with the HCPs were all conducted in French (Quebec being a French-speaking province in all public affairs). The interviews with the mothers were conducted in French or in English and secondarily in Arabic or another language (with a translator), upon the mother’s choice.

The majority of the women interviewed were from North Africa (63%), mainly Morocco and Algeria, which are among the top countries of origin of the recent immigrant population in Quebec, the others being mostly from South Asia/Indian subcontinent (15%) and the Middle East (14%). Most of these mothers (80%) had been in Montreal for less than five years (and in fact, 55% had been in Montreal less than two years). Many of these women (50%) and their spouses (67%) had a university degree and spoke French on a daily basis (68%). They nevertheless encountered numerous difficulties entering the mainstream workforce. The majority affirmed being ‘practicing believers’ (of Islam).

As for the HCP, most (76%, 41/54) were non-migrants (Canadian born of French descent) while the others came from an array of localities (European, Middle Eastern, North African, Asian, or Caribbean). While the vast majority were of Catholic faith (83%, 45/54), only a few (29%, 13/45) affirmed being ‘practicing or moderate practitioners’ of their religion. With the exception of one HCP, those of Muslim, Jewish, or Buddhist faith were all ‘practicing or moderate practitioners’.

Local and transnational socialities in regards to perinatal knowledge

The perinatal period, particularly for primiparous women, can be quite a ‘test’ in the context of migration. Some of the daily challenges include accessing and understanding the local healthcare system, sharing knowledge, and gaining regular everyday support. The care of other children is an
additional challenge for multiparous women who, in their places of origin, often benefitted from significant support at this stage of life.

In Montreal, 90 out of 95 mothers interviewed lived in ‘nuclear’ families. While more than half of the mothers encountered (52%) had at least one family member in Montreal (often siblings close or far), the support provided by extended family at the time of birth was found to be limited (only 33% had experienced this). Beyond the family, local friendships (often of the same ethnic background) or neighbours nearby are also a source of support and knowledge (for 71% of mothers interviewed) with regard to the care of the newborn in the broader respect of available public services (information or accompaniment), providing useful accessories for the perinatal period or emotional and material support (cooking, dishes), etc. One woman told us:

They come over, they talk to me on the phone all the time. And yes, they try to make me laugh. [...] Because they know, they have experience. They don't stop calling. They come [...] and bring Algerian dishes. I don't know these people [Algerian women she encountered at the park or whose kids know each other]. There was even one woman who brought me everything I needed—the baby bath, [...] clothes, things, many things. (Samia, Algeria, multiparous, in Montreal for less than two years)

While support from the extended family in Montreal is scarce, many mothers seek advice from family members living in the country of origin, especially from the mother (recently or about to become grandmother). Virtual support (via telephone, Internet), on a quasi-daily basis, will be given in response to requests for advice on pregnancy and mothering, and knowledge about food, nutrition, and care of the newborn. During periods of ‘lying in’, however, a third of the women (all from the Maghreb) benefitted from the presence of a mother or stepmother who travelled from the homeland to support them. As described by a new ‘grandmother’ from Morocco: ‘I cooked, did laundry, washed the dishes, I took care of the newborn. [...] I slept with her for three days in the hospital.’ The women interviewed unambiguously demonstrated the importance of this virtual sociality during pivotal moments of the perinatal period. Important decisions that

6 For the other four (of Indian, Pakistani, or Afghan origin), they lived within a more extended grouping of the husband's family (in-laws and/or siblings of the husband).
7 In the home localities, the involvement of the family follows a typically vertical structure of support, with the mother (or stepmother) helping the daughter (or daughter-in-law), and more rarely a horizontal pattern (intragenerational support).
can affect a pregnancy (at risk), the intention (or not) to do a screening test (such as amniocentesis), the possibility of an abortion in the case of a negative diagnosis or prognosis or anything that falls within neonatology (and the many decisions surrounding different treatments or withdrawal from treatment)—in short, all these situations give rise to a search for advice in response to complex issues for which the family or the mother of the respondent is widely sought. In a similar fashion, if the mother or mother-in-law is visiting Montreal (notably for the ‘lying-in’ period (les relevailles)), she will take an active part in the decision-making that affects the couple. Spiritual guides might also be solicited to help with decision-making during these ‘pivotal’ moments. As such, the relationship with religion is often inseparable from the decisions that will impact perinatal life and death. In effect, it becomes an integral part of sociality, whether it be local or transnational. At the same time, the quest for less-invested knowledge is commonly channelled through the Internet and accessible literature. As Maisah, from Pakistan states:

One thing we noticed in Pakistan is that the information only comes from parental or close peers who have gone through the experience. Here, I guess it’s more like, you know, website, books and everything. [...] So I was just like buying books and we were just reading and that’s, so we kind of got it from both ways. (Maisah, Pakistan, multiparous, in Montreal for less than two years)

Women also choose what knowledge is best:

You know common sense, at the end common sense. Yeah I listen to my mother but I listen to the doctor too and I read a lot. So if you read a lot, and because they gave me a lot things to read, I was always searching on the Net for definitions of what to do, what not to do. So I was ready, if my mother gives me advice, I will like just know by common sense that this is right. (Zeina, Lebanon, mutliparous, in Montreal for less than two years)

Family dynamics and gender roles in the making

Mothers are likely to remember the quality of support present in the locality of origin compared to life in the context of migration:

The difference is that here [in Montreal], several times I’ve thought, I’ve wondered: Is it a good decision to have a baby? Who will help me? Who
will take care of me? In Morocco, I didn’t worry about that, I didn’t ask myself these questions because I had my family by my side. [For my first pregnancy in Morocco] they helped me enormously, everyone, my sisters, my mother. They took care of me, they prepared the food. Up until the third month after the birth, I was still at my mother’s. (Nora, Morocco, multiparous, in Montreal for two years)

Although family presence is often longed for, some women point to the advantages of living at an extended family distance:

Maybe, I guess it’s nice to have your family around, you know, and your friends as well [in the homeland]. But here, maybe I was more relaxed because it was more quiet for me. Like, I wake up whenever I want with my baby and I sleep whenever I want, you know. Each place has its advantages and disadvantages. Back in Saudi Arabia, everyone wants to see the baby and everyone wants to come to visit and it will be very busy for us. But at the same time, I will have more help. But here I think, he’s a very quiet baby. You know? He just wakes up, feeds, has his diaper changed, and sleeps. And now I’m not working. I’ll start working in July. My baby will go to the day care at the same time. So, yeah, it’s comfortable and it’s quiet. Like we love to be in a quiet place, you know, yeah. (Sara, Saudi Arabia, multiparous, in Montreal for less than two years)

In the same way, a Turkish mother (primiparous, in Montreal for five years) shares with us her mixed feelings in regards to her in-laws. Since the birth of her daughter, her in-laws have been living with her, helping out. She considers all this help too much and expresses the desire to see them live more at a distance. Two weeks after childbirth, she has yet to change a diaper. At the same time she says she feels guilty after having such thoughts, knowing that the in-laws will miss their granddaughter once they are back in Turkey in a few months’ time. But could they help out more with the house chores and less with the baby? As a mother, she appears to feel left aside and to fear the baby’s bonding with her mother-in-law. Abir similarly recalled her ‘lying-in’ period in Lebanon, telling us that she felt like the message was ‘the baby is no longer yours’ (Abir, primiparous, in Montreal for one year).

In other words, the ‘nuclearization’ of the perinatal period is not only a sombre process. Some women experience a reconfiguration of roles and responsibilities, an easing of social expectations associated with the birth of a child, or even greater autonomy.
Yes, at my place, my mother came over [from Algeria]. There were too many visitors. It was a bit tiring, especially for my mother—she took care of the baby and of the visitors. You don’t have any private time with your husband. […] That’s why I liked it here. We enjoyed the arrival of the baby with [our] family. Father and children, that’s all. (Hezora, Algeria, multiparous, in Montreal for two years)

Zeina, a Lebanese mother (primiparous, in Montreal for less than two years), also mentioned how her pregnancy away from home and the independence she developed throughout her maternity helped her to become autonomous. Had she been in Lebanon, she said, she would have been cared for by her family (her mother and mother-in-law, in particular) and she would not have learned to care for her child.

Migration (and the perinatal period) also favours change in the couple and family dynamics: the new father becomes an actor in the foreground. A large percentage (67%) of the mothers mentioned the increased participation of the husband, who accompanied them to and interpreted at medical appointments, neonatal care, or during delivery, as well as assisting in everyday household and family tasks (Fortin and Le Gall, 2012). Whether running errands, preparing meals, or taking care of older children, fathers occupy a new ground within the family:

After the birth, he was very sincerely involved. Very present—well, he didn’t really have any other choice. Who will help me? He didn’t have a choice. […] There is no one here with me, there is just him, so he is obligated. And especially for men at home, it’s not easy for them to get involved, they are spoiled, they do nothing. No, they do nothing, it’s just the woman. […] I’m talking about home, tradition is like that. For the men, it’s just work outside the home. But here they are forced to [help] […], it’s the culture. But [in my home country] we don’t need them, really. There is the mother, the sisters, there is all of that so [husbands] don’t do anything. It’s just a psychological support or you know, moral support. Otherwise, for the house, [we are well] surrounded: you have your mother, you have your sister, your friends. (Nadine, Morocco, primiparous, in Montreal for five years)

Migration can indeed result in an increase of paternal involvement due to the diminished family network and the greater availability of men (limited social network, lack of work). See also Le Gall and Cassan (2010) on this topic.
As a Mauritanian husband (multiparous spouse in Montreal for five years) put it:

Well, of course, it’s very different from home and obviously if it would have happened there, I would have been less involved because there are plenty of things that—it’s ok, it will be done by the mother [of my spouse], the cooking, things like that. Here, well, I represent a little bit of everything. So it is a good experience and, as we said, it takes a lot of patience, a lot—but we must be ready.

The husbands’ contribution will fade, however, with the arrival of a family member from the place of origin. The mother-in-law (or mother) often eclipses the father in the care of the newborn in terms of presence at the hospital. In the context of restrictive neonatal visits for example, it is not uncommon for fathers to transfer their visiting rights to a visiting family member.

Yet, for many fathers, accessing the obstetric ward is a novelty. In their home country this is often not possible, as the perinatal world is most often a woman’s space. As Raghad’s husband, Rashid, recalls in this exchange:

Rashid: Yes, the difference is with the husband. The husband, they will not like his being involved in the pregnancy, like [the way it is] here. Here I’m involved, I feel I am involved a lot. In Libya I can’t [do the same]. Well, I can’t say ‘no, I can’t’, but like, there is a custom, like how to deal with your wife—just call her mom or her sister or ask her to come and help her. And especially in the case room, or the delivery room, so maybe her mom or her sister will go with her inside.

Interviewer: The husband usually doesn’t go?

Rashid: No, no, in Libya, no. And here like it’s, it’s good for me or for husbands to see how the wife gets tired from the delivery and the pregnancy. [...] So this is the good thing that gives the husband [knowledge] on how his wife gets tired and what pregnancy means exactly. (Rashid, Libya [husband of Raghad, primiparous], in Montreal for two years)

And from Tanisha’s point of view:

My husband, he was all the time with me. I think he did everything. He was a substitute for my family because I was worried that maybe I
would miss my mom during the delivery. So he was very, very good with me, emotionally, and he helped me in everything. Actually, he was with me in the, in the room where they’re making the surgery, the C-section. Everything was good with him. (Tanisha, Syria, primiparous, in Montreal for less than two years)

In short, the here and the elsewhere meet virtually in the migratory context to offer emotional, informative, and moral support. Perinatal support may take the form of a mother or a mother-in-law visiting Montreal. If this is not to be, the husband often assumes a new role and demonstrates a level of participation often very different from his role in the place of origin. He takes an active part in various tasks in the household and is a more sustained presence in the healthcare institutions of Montreal.

How these socialities and knowledge-sharing practices become actors in the local clinical encounter

Knowledge and support

The large majority of the women interviewed consider HCPs to be (the most) significant source of information. Knowledge put forward by medical professionals, in the community as well as in the hospital setting, pose little or no problem with families accepting and adhering to this advice. This knowledge is perceived as a ‘value-added’ aspect of the local society. Biomedical knowledge is already esteemed key knowledge in the locality of origin although the conditions of public supply of medicine are often strongly criticized. The ‘aura’ surrounding biomedicine in North America plays favourably in the reception of different knowledge.

Expert knowledge is no less heterogeneous and sometimes even contradictory, depending on the practice settings (intra- and inter-institutional, hospital, and community care), the training environment (and time thereof), and the social paths. The clinical encounter is coloured just as is the negotiation of knowledge between experts and nonbelievers based on the healthcare settings. For example, nurses who visit new mothers in the context of an at-home, universal, postnatal care programme confirm that they gently modify their practice to manage each situation on case-by-case basis and adjust as necessary. To the extent that knowledge (and practices) do not harm the health of the mother or the baby and do not seem ‘imposed’ on them, the perspectives of the mothers and the extended
family are valued. In discussing the risks associated with early pregnancy, a (community, non-migrant) nurse will say: “They are told by their mother: “I did it myself, you are able to do it too.”

Overall, nurses are coping well with the various practices brought from the locality of origin, whether it be specific body treatments such as using clay, olive oil, or coconut oil on the baby’s skin (for hydration), the shaving the newborn’s hair (as an offering, or symbol of cleanliness), or how to swaddle the baby (to prevent bowleggedness). When a practice is perceived as problematic (by the HCP) such as excessively covering the baby (so that he falls asleep while being breastfed, doesn’t drink enough, or sweats to the point of becoming lethargic), or giving the baby instant formula rather than breastfeeding, the nurse intercedes. They say that the ‘security’ of the baby is the key to this negotiation and insofar as it is not called into question, the sharing of knowledge is possible.

In addition, community nurses—given the nature of the care anchored in the locality have a near daily interaction with this population—recognize the valuable contribution of members of the extended family and the general importance of support in the migratory context. The nurses assert that they develop strategies of inclusion in their work with the mothers:

The family can pose a problem at this level [excessive swaddling, early incorporation of infant formula], but for other things, the family is very supportive, like when the mother or mother-in-law is present, it is she who prepares meals for the woman. She will help her, giving the baby baths, give the woman massages so it is very helpful in this regard. It is concerning nursing advice that we sometimes have problems. (Community nurse, immigrant)

**Otherness, evolving socialities, and challenging moralities**

The clinical encounter or the patient/provider interaction is nonetheless a moment of negotiation, and may even be a clash, though less so in regards to medical knowledge (even when transnational medical advice is taken into account), but rather in the relational domain and in the decision-making process around birth, perinatal health, and death. Religious and cultural ‘otherness’, diversity of values, as well as evolving socialities (extended family members, gender relations, parental dynamics, and spiritual leaders) and social practices come into play, challenging moralities and local norms.
Religion

Hospital HCPs consider religion a problem or a barrier when families are making medical decisions that do not follow staff recommendations, particularly in end-of-life situations (that is, whether to terminate pregnancy because of major foetus anomalies or to limit medical assistance when newborns are severely impaired). The hospital practitioners also question the ‘weight’ of religion as it seems to limit the mother’s autonomy, an important value within the healthcare system. Physicians speak of an invisible interlocutor during the clinical encounter. In their view, Muslim mothers rely most often on God when having to make important decisions. For example, religion may support the decision not to abort, to continue care, to refuse the use of contraceptives or different screening tests, including amniocentesis (despite the risk of trisomy 21, or Down syndrome). Doctors declare that Muslim women consider this decision as belonging to God, a position often endorsed by religious leaders who are consulted in this regard. In some cases, religious leaders even become interlocutors in the clinical encounter, although exterior to the family, which is judged problematic by some doctors.

Otherwise, our data demonstrates how ‘religious faith’ can sometimes become an issue in the patient–provider relationship, particularly when religious or cultural markers are interpreted as signs of gender inequality. It is perceived that this ‘religious faith’—in this case Muslim—is subordinate to gender relations (real or imagined) in the local society. Our study highlights how gender inequality (real or perceived)—so often associated with mothers who wear the veil, or with the couple’s dynamics (if the woman is silent and the husband is the principal interlocutor)—is troublesome for many HCPs. In this regard, it is worth mentioning the influence of several factors (notably the migratory journey and religious affiliation) on the sensitivity of the staff to these questions (Le Gall and Xenocostas, 2011; Fortin, 2013a).

The father and gender inequalities

As mentioned earlier, the role of the father often evolves in the migratory context. Paradoxically, the behaviour of these fathers does not necessarily

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9 Our work in other areas of the hospital with different populations brings us to the same conclusion: Deferring to God in the decision-making process is a shared practice among more ‘orthodox’ believers, whether Christian, Jewish, or Muslim (Fortin, 2013a, 2013b).
correspond to the conception of the paternal role put forward by local social policies and health facilities, leading to frustration among fathers and HCPs alike (Le Gall et al., 2009; Ny et al., 2008). For some professionals, the father's role is perceived positively: they speak of ‘support’ and ‘involvement’, even if this involvement is gender differentiated (gendered tasks), saying things such as ‘He takes to heart the whole family.’ For others, often in the hospital setting, this role is discerned rather negatively and associated with gender inequalities (real or perceived): ‘lack of involvement’ in care and limited to positions of ‘provision’ or ‘control’. These fathers are considered ‘interventionist’, ‘claimants’ who negotiate for the couple and ‘speak for’ their wives.

These gender dynamics become a real point of tension, a relational ‘node’ between the nurses, doctors (particularly women), and fathers. This tension extends to the mothers who consequently defend the involvement of their husbands in the household. As one HCP stated:

I think what strikes me the most, what bothers me the most, is the role of the woman in that religion. The little power women have over their own decisions. That is the perception we have. From the very beginning, the first contact, they are always accompanied by their spouse. Often she doesn’t respond to questions but rather her husband responds for her. If there are ever any decisions to make, it will be the husband and the imam. Maybe for us it troubles us to see that she does not control decisions that affect her. In effect, she has no autonomy for her person or pregnancy. So that’s what confronts us the most in interacting with the Muslim population. I’m generalizing. They are not all like that, but there is a large percentage of Muslims like that and it really challenges us, it challenges our feminism, in our liberation to care for ourselves as women, it really gets us going. So we always try—it’s stronger than us—I am convinced I am not alone in doing that [...], to impose a more direct communication with the woman. She is our patient, not the husband, not the imam, she is. (Obstetrician, non-immigrant)

From a different perspective, the male physicians say they see this dynamic at work, but that it doesn't affect them in the same way (idem for male nurses). For example, unlike the female staff, they associate more readily the interventionism of the father with a willingness to act as a ‘linguistic mediator’, or as a sort of ‘buffer’, and to relay information hoping to ease the situation for the wife rather than seeing it as a form of control over her. Overall, however, one impression dominates: the perception that the mother
is not at the heart of decisions concerning herself or the child. Termination of pregnancy, birthing methods, and ending care for the newborn are rarely perceived by clinicians as decisions made or shared with the mother.

One mother, Radia (Algeria, multiparous, in Montreal for one year), to whom was announced a very grim prognosis for the baby she was carrying, chose, against the advice of the healthcare team, to continue the pregnancy. The entire team, in particular her obstetrician, was convinced that the mother did not show up for her medical appointment to abort the pregnancy under pressure from her husband. However, when we met Radia, she shared with us how she had wanted—against the will of her husband, but in agreement with her imam—to complete the pregnancy even if it should result in the death of the newborn. The husband had been upset by the choice of his wife, but accepted her quest for peace and her willingness to offer her (stillborn) child a burial following Muslim rites.

The perceptions of HCPs are, however, not fixed. An obstetrician admitted that what she first perceived as a lack of autonomy on the part of the mothers and as a lack of initiative (communication and decisions were mostly the domain of the husband) was later reinterpreted as a particular couple’s dynamic at a specific stage in the trajectory of the couple and their migration, the husband having been an intermediary for the mother during hospitalization. Even if many of the women HCPs (non-migrants) involved with Radia’s case were convinced of her submission to gender or religious domination, the neonatal physician (a migrant and a practicing Christian) read Radia’s choices very differently:

I find it difficult to live here in Quebec where late-term abortions are performed. [...] The child will die at birth so why not let him be born. We can give him love, palliative care, and he will die. [...] I feel like it is killing someone. [...] In Radia’s case, I was relieved. I felt close to her and her family. [...] I shared their choice to go ahead with the pregnancy and cherished as they did, the importance of life. (Neonatal physician, migrant)

The extended family

The influence of the extended family (or of a member of the ‘community’) in the decision-making process is sometimes seen as positive, and other times as obstructing medical ‘common sense’. Two examples illustrate this point:

During treatment discontinuation in neonatology, a grandfather was helping the medical staff. Using verses from the Koran, he was explaining
to the parents that God, through the physicians, was somehow asking to take back the child. This discursive strategy made it possible to stop treatment whereas the prohibition to end a life is often at the heart of a disagreement between Muslim parents and care teams. (Observation notes, neonatal ward)

In another context, while the mother agreed (on medical advice) to a withdrawal of care, the father insisted on its continuation. Despite a grim and hopeless prognosis (the newborn was suffering from cerebral bleeding), the husband’s family did not accept the discontinuation of care proposed by the team and exerted moral pressure on the father to make sure he did not retract from his position. Recognizing the treatment impasse, we asked an independent practitioner who engaged in discussions over several days, discussions inclusive of the parties involved. After this discussion period (some might say that it was too long to do so while the child was suffering, others will see this as the amount of time necessary to accept the end of a life…) we decided to end the treatment. (Observation notes, neonatal ward)

Conclusion

Our study documents social change in the making. Through the perinatal period, migrant women long for family and yet appreciate distance. Knowledge follows the family’s path but is not the only means of gaining information. Many women choose what suits them best, whether that means following the advice of the family, religious leaders, or HCPs. As well, husband and wife relations evolve in the context of migration. Men feel concerned either by obligation (no other relative can support the expectant or new mother) or because they are invited to share an otherwise female domain. These different paths influence the clinical encounter where personal experiences, social milieu, community practices, and institutional cultures come into play. Moralities and norms evolve as knowledge is shared at different paces. Subjectivities are co-created, exposing a complex dialogue between individual experiences, wider social relations, and organizational issues. The healthcare paths of migrant Muslim women and their partners, the place of the extended family, or that of a spiritual guide seems for some to be awkward or unjust, and for others an important support. The dynamics specific to healthcare settings are not foreign to these divergent rationalities.
In community health services, diversity is expressed in everyday relationships, as the participating centres are located in the most plural, multi-ethnic settings in Montreal. Care delivery in the community is also based on proximity, as mothers encounter care on several occasions (through perinatal activities and at-home visits) in intimate settings. The sharing of knowledge is often the basis of the encounter between caregiver and patient; it is the result of subjectivities that fuel the relationship on a daily basis. Diversity is learned, discovered, negotiated. In contrast with the hospital context, though, community HCPs are less confronted with issues related to life and death where religious beliefs can come into conflict.

For the hospital, the often-critical interventions place the caregiver and the patient in very different positions where individual values can collide. The very organization of care, the multiplication of experts, the ever-present use of technological support—many elements are involved in the clinical encounter, not to mention the uncertainty of diagnosis and prognosis, and the relational uncertainty generated by this otherness (Fortin, 2013a). The clinical culture is also different: negotiation is a part of the learning process. In so doing, with a few exceptions, noncompliance with biomedical instructions (or suggested therapeutic guidance) is often explained by otherness, by different relational dynamics between couples, and by a connection to the collective and to religious belief that in turn become important actors in the clinical space. This noncompliance viewed through otherness hides an encounter of different rationalities (of different norms and values) constructed in very different habitus. The discontinuation of treatment, and its relation to life and death, doesn’t have the same meaning for everyone. And if biomedicine sees treatment as a possible avenue because of a given diagnosis or prognosis, it may still be very different for the user, the mother, and the father.

Like Kaufman et al. (2006, 2011), we can relocate these gaps at the heart of differing subjectivities and temporalities, the one(s) from the clinical milieu and the one(s) from the patients and families. There are gaps based in the way we think about care, the values enshrined at the hearth of medical rationality, the weight of diagnosis and prognosis, and therefore what happens in the present. These concepts of future and present held by clinicians may be quite different for families. For the latter, biomedicine, with its often very wide therapeutic range and unprecedented technological support, fuels a hope that, along with one or the other conceptions of life, ‘quality of life’, and death, gives rise to the rationalities that may oppose those that have become standards in the clinical space. The ways of expressing these
rationalities will in their turn match forms that reflect social, cultural, ethnic, and religious diversity present in any cosmopolitan environment.

Recognizing the gap or tensions between these rationales (Hacking, 1992), between community and tertiary hospital settings, between clinicians and families, is already recognizing that different rationalities coexist and that we gain by thinking of them as plural. Furthermore, thinking with religious diversity, in this context as well as social and cultural diversity—of the caregivers as well as of the cared for—is to think these rationalities as embedded not only in this patient/caregiver relation but in wider social rapports that cross any given society.

The ‘religious fact’ is defined differently according to the interlocutors and their personal orientation. The caregivers who are also ‘believers’, all faiths regrouped, are in general more receptive to the decisions of religious parents: the families’ rationales resonate. For others, namely the caregivers of the local majority group, acknowledging religiously motivated decisions can sometimes (or often) be problematic and contribute to the shaping of otherness. In Quebec, this relation to religious belief cannot be fully understood outside of its recent history, notably the stranglehold that the Catholic Church had on (French-Canadian) society until the 1960s and the ‘quiet Revolution’ (Meintel and Fortin, 2002). The same is true concerning gender relations that particularly affect professionals from here and abroad. In so doing, the evolution of gender relations and relations to religion in the local society becomes the backdrop that we must grasp in order to better appreciate the importance these relations have in a caregiver–patient relationship.

Finally, the migratory path, the family structure, the forms of sociality, and their activation are all contexts that influence the clinical encounter, where norms and values crystallize and subjectivities get fuel. The different ways of relating to the ‘religious fact’ are constructed through time (colonial past, contemporary social structures), space (local, transnational), and, of course, depend on different religious currents and dogmas. To be interested in the clinical space allows us to better understand an ever-changing society, with all of the tensions that underline its vitality, a process ‘in the making’ instead of a context where everything is given and ordered (which in turn often reflects tighter borders between these different logics). Ultimately, following Zaman (2005) and Van der Geest and Finkler (2004), we reiterate the interest of thinking of the social space of the clinic as a ‘capital of the mainland’.
References


