Tacit Knowledge of Caring and Embodied Selfhood

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Abstract

The tacit knowledge paradigm is gaining recognition as an important source of knowledge that informs clinical decision-making. However, it is limited by an exclusive focus on knowledge acquired through clinical practice, and a consequent neglect of the primordial and socio-cultural significance of embodied selfhood, precisely what provides the foundational structure of tacit knowledge of caring and facilitates its manifestation. Drawing on findings from a qualitative study of forty-three dementia care practitioners in Ontario, Canada that utilized research-based drama and focus group methodology, we argue that embodied selfhood is fundamental to tacit knowledge of caring. Results are analyzed drawing upon the theoretical precepts of embodied selfhood that are rooted in Merleau-Ponty's (1962) reconceptualization of perception and Bourdieu's (1977, 1990) notion of *habitus*. We conclude with a call for further exploration of the body as a site of the production of tacit knowledge.

Keywords

Tacit knowledge; caring; embodied selfhood; person-centred; dementia care

Introduction

Tacit knowing is gaining recognition as an important source of knowledge that informs clinical decision-making (Malterud 1995, Malterud 2001, Rycroft-Malone *et al.* 2004). The tacit knowledge paradigm privileges clinical experience in the gradual bodily assimilation of skill/knowledge, and the subsequent capacity of the body to perform (Benner and Tanner 1987, Malterud 1995, Malterud 2001, Meerabeau 1992, Shaughnessy *et al.* 1998, Purkis and Bjornsdottir 2006, Thompson 2003). Yet the emphasis on clinical experience overlooks the primordial and socio-cultural significance of embodied selfhood (Kontos 2004b, Kontos 2006a), precisely what we argue provides the foundational structure of tacit knowledge of caring and facilitates its manifestation. The primordial/existential body that provides the

basis for temporal and physical manner of being-in-the-world, and bodily dispositions that are shaped by socio-cultural-specific conditions of primary socialization are integral to selfhood (Kontos 2004b, Kontos 2006a), and, by extension, are fundamental to tacit knowledge of caring.

This paper argues for an expansion of the tacit knowledge paradigm to include embodied selfhood as a source of caring practices. The theoretical precepts of embodied selfhood rooted in Merleau-Ponty's (1962) reconceptualization of perception and Bourdieu's notion of *habitus* (1977, 1990) provide the theoretical framework for the articulation of the body as a site for the production of tacit knowledge of caring. Findings are drawn from a qualitative study of forty-three Canadian dementia care practitioners. The findings suggest that social and cultural habits, movements, and other physical cues disclose significant information about the individuality of care recipients, which brings their personhood into focus for practitioners. In addition, practitioners use their *own* bodily dispositions to make meaningful connections with their care recipients in the course of providing dementia care. We conclude with a call for further exploration of the relationship between embodied selfhood and tacit knowledge in the context of caring.

Rethinking Tacit Knowledge

Tacit Knowledge

Explorations of tacit knowledge in nursing (Benner 1984, Meerabeau 1992, Purkis and Bjornsdottir 2006, Thompson 2003, Welsh and Lyons 2001) and in medicine (Malterud 1995, Malterud 2001, Gordon 1988, Shaughnessy *et al.* 1998) have highlighted the importance of tacit knowledge for clinical decision-making. Physician Malterud (1995) suggests that 'tacit clinical rationality', also referred to as 'medical craftsmanship' and 'intuitive knowing', constitutes the core knowledge of clinical epistemology.

Much of the literature on tacit knowledge in clinical practice is premised on Polanyi's (1966, 1969) and Benner's (1984) conceptualization of embodied knowledge that is acquired through experience. Knowledge is said to be tacit when it cannot be explicitly articulated (Polanyi 1966) and when the body knows what to do without deliberation or forethought (Benner 1984). Benner and Tanner (1987) describe the role of tacit knowing in the performance of instrumental skills, such as inserting an intravenous catheter. The experienced nurse, they note, develops a tacit connection between her fingers and the catheter, and experiences an 'embodied takeover of a skill' wherein she probes with the catheter tip as if it were an extension of her fingers (Benner and Tanner 1987: 26). The importance of tacit knowledge for expertise has been identified in the practice of anesthetists (Pope *et al.* 2003), where it has been demonstrated that knowledge of cannulating a vein, for example, is not imparted explicitly through texts but rather tacitly through clinical apprenticeship. This is consistent with Carlsson *et al.* (2002) who argue that caring does not develop through theoretical learning, but instead is assimilated as bodily knowing that becomes an extension of the learner. Carroll (1988) identified the importance of nurses' tacit knowledge in predicting the risk of patients developing a pressure sore, when systematic procedures for prediction alone often failed. Tacit knowledge has also been identified as key to the clinical assessment of cognitive capacity of brain-injured patients (White 2006), to the

psychiatric assessment of clients with complex mental health problems (Welsh and Lyons 2001), and to the multidisciplinary assessment of progress and discharge planning in patients receiving neurorehabilitation (Greenhalgh *et al.* 2008).

Such examples contribute to the establishment of the legitimacy of tacit knowledge and the creation of a new epistemic potential for understanding competence, expertise, and caring in clinical practice. However, since tacit knowing has been strictly conceptualized in terms of 'situational understanding' (Gordon 1988: 272) that derives from extensive encounters with concrete situations of clinical practice, we contend that the primordial and socio-cultural significance of the body has inadvertently been neglected. Our explication of such significance takes its theoretical bearing from Merleau-Ponty's reconceptualization of perception (1962, 1968), and Bourdieu's concept of *habitus* (1977, 1990). Merleau-Ponty's and Bourdieu's theoretical perspectives on the body have been elaborated in Kontos' (2004b, 2005b, 2006a) conceptualization of selfhood in Alzheimer's disease which is said to persist despite severe cognitive impairment because it is sustained at a pre-reflective level. Here we wish to extend her argument to suggest that knowledge of caring similarly inheres in the pre-reflective level, and that caring is tacitly known to the body and thus to selfhood itself.

Merleau-Ponty's Reconceptualization of Perception¹

Central to Merleau-Ponty's philosophy is a radical reconceptualization of perception as *embodied* consciousness. In his major work, *Phenomenology of Perception* (1962), he argues that embodied consciousness is a fundamental level of existence that does not involve *cognitive* consciousness. For Merleau-Ponty, embodied consciousness is the body's pre-reflective directedness towards the lived world; the body actively and intentionally takes up elemental significance. He cites the following example of the pre-reflective nature of the coordination of visual, tactile and motor aspects of our body:

If I am sitting at my table and I want to reach the telephone, the movement of my hand towards it, the straightening of the upper part of the body, the tautening of the leg muscles are super-imposed on each other. I desire a certain result and the relevant tasks are spontaneously distributed amongst the appropriate segments (1962: 149).

He argues that no aspect of this existential knowledge of coordination is reflective or discursive (i.e. learnt). Hence, in their first attempts at reaching for an object, children look not at their hand but at the object, the implication being that the body is known to us through its functionality without co-ordination ever having to be learnt (Merleau-Ponty 1964b: 149). In this sense the pre-reflective body is itself intentional in that it is directed towards the world without the need for reflective understanding of the manner in which it is directed (1964b: 213, 233). Intentionality '... takes for granted all the latent knowledge of itself that ... [our] body possesses' (1964b: 233). This tacit knowledge is a field of possible movements, a kind of inner map of movements the body 'knows' how to perform without having to reflect upon such movements (1964b: 144). Merleau-Ponty's reconceptualization

¹Here we draw upon Kontos' previous explications of Merleau-Ponty's philosophical program that focus on his redefinition of perception as a *pre-reflective* intercourse with the world (Kontos 2006b, Kontos 2004b, Kontos 2006a).

of perception further suggests we share a corporeal existence with other beings and thus, to some extent, we immediately have a level of shared knowledge of sensory experience that is tacit.

Habitus: Bourdieu's Socio-Historical Conception of the Body²

In contrast to Merleau-Ponty's preoccupation with the elemental capacity of the body, Bourdieu investigates the social genesis of competence, know-how, skill and disposition. His approach to understanding the embodiment of social structures illuminates our analysis of the interrelationship between socio-cultural bodily dispositions, tacit knowing, and caring practices.

Bourdieu uses the concept of habitus to describe the practical logic of social and cultural practices and the regulation of human behaviour (Bourdieu 1990: 26, 91). Habitus, or socialized inclinations associated with membership in a particular cultural group, instills in individuals dispositions and generative schemes for being and perceiving. Dispositions are embodied and materialize as postures, gestures, and movements (Bourdieu 1977: 93–94, Bourdieu 1990: 69). These dispositions are the product of a *modus operandi* of which the individual has no conscious mastery (Bourdieu 1977: 72–73, 79–80).

Here, as Wacquant has noted (1992: 20), Bourdieu is clearly drawing on Merleau-Ponty's idea of the body as the source of practical intentionality and of inter-subjective meaning grounded in a pre-objective level of the body. The body is treated as a 'generative, creative capacity to understand' – as a kind of corporeal awareness – as a practical reason, existing primarily in corporeal ways. Bourdieu's theory of the logic of practice (1977, 1990) explicates a source of tacit knowledge, that, as we shall argue, gives practitioners sympathetic embodied connection to their care recipients.

Embodied Selfhood

Kontos argues that selfhood consists primarily in our intrinsic corporeality of being-in-the-world in that selfhood is a synthesis of primordial and social being (2004b, 2006a). It is a synthesis wherein one's socio-cultural manner of being constantly utilizes the primordial hold of our body in relation to the world (Kontos 2006b). Thus self-expression discloses a cultural particularity that is shaped by socialization, but is dependent upon the primordial unity of the body for its actual expression (Kontos 2004b). Though embodied dispositions are shaped by culture-specific conditions of primary socialization, there is a foundational structure inherent in bodies which facilitates the initial 'internalisation of externality' (Bourdieu 1990: 55), as well as all subsequent manifestations of socio-cultural bodily self-expression.

In drawing upon Merleau-Ponty's and Bourdieu's theoretical insights to conceptualize selfhood, Kontos effectively shifts the discourse on selfhood in Alzheimer's disease towards a recognition of the significance of our embodiment. This offers an alternative vision to the presumed loss of selfhood in Alzheimer's disease, by disentangling selfhood from the

²See Kontos (2006b, 2004b, 2006a) for a more elaborate explication of Bourdieu's concept of habitus.

cognitive categories upon which it is presumed to depend (Kontos 2004b, Kontos 2006a, Kontos 2003).

Approaching tacit knowledge with a concept of self as embodied is a perspective that stresses the active and the acted upon nature of the body both of which are of paramount importance for understanding tacit knowledge. Embodied selfhood is what makes tacit knowledge possible both in terms of providing its foundational structure and facilitating its manifestation.

Methods

Focus Groups and Research-Based Drama

Six focus groups were conducted in three academic health care facilities located in an urban region of Ontario, Canada.³ Study facilities provide a range of services from acute inpatient care to long-term care and rehabilitation, and specialize in the care of persons with dementia of the Alzheimer's type. Alzheimer's disease is a degenerative, irreversible disorder of the brain characterized by a complex combination of neurological and psychiatric symptoms (Cotrell and Schulz 1993). The most prominent symptoms are cognitive deficits (memory loss; decline in language, reasoning, judgment) and behavioural and affective disturbances (Volicer and Hurley 2003). Due to cognitive deficits it becomes increasingly more difficult to perform simple tasks of daily living such as toileting, bathing, dressing, and eating (Cohen *et al.* 1984). The most frequent and persistent behavioural disturbance is agitation, usually characterized by verbal and/or physical aggression, restlessness, and abnormal vocalizations (Cohen-Mansfield 1996). The treatment and management of challenging behaviours has traditionally been mandated by institutional policies of control and containment (i.e. combinations of environmental, mechanical, or pharmacological restraint) (Andrews 2006). The philosophy underpinning more humane approaches to persons with dementia is referred to as person-centred care (Brooker 2003, Kitwood 1997), which focuses on the environmental and social causes of challenging behaviours (Cohen-Mansfield and Mintzer 2005) and utilizes non-pharmacological behavioural therapy as the gold standard approach to their suppression or elimination (Douglas *et al.* 2004). Interventions that are responsive to the individual needs, wishes, and values of care recipients (Emerson 1998) require accurate, personalized interpretation of behaviour which, in turn, is enabled by practitioners' physical, emotional, and existential closeness with care recipients (Kitwood 1997, Ford and McCormack 2000). For the purposes of our study, choosing facilities that specialize in the person-centered approach to care of persons with Alzheimer's disease was critical given our interest in exploring the implications of embodied selfhood for person-centred dementia care.

The focus group method was chosen for its facilitation of exploratory research in areas in which little is known (Morgan and Krueger 1998). Focus groups promote the articulation of ideas and experiences as well as highlight cultural values or group norms making the method particularly well suited to the study of experiences and perceptions of staff (Kitzinger 1995). It is argued that focus groups differ from interviews in that they facilitate a less hierarchical

³The methods employed in this study are described elsewhere (Kontos and Naglie 2007a, Kontos and Naglie 2007b).

research process as the researcher does not fully control the proceedings and regulate the conversation (Wilkinson 1998). Focus group participants tend to have more freedom to explore issues they perceive as important. This tendency is particularly pronounced where focus group researchers study pre-existing or naturally occurring social groups such as work colleagues because participants are able to relate each other's comments to incidents in their shared daily lives (Kitzinger 1995).

In our study, focus groups began with a live performance of a research-based drama, *Expressions of Personhood in Alzheimer's*, which was developed in partnership with a theatre school and creative drama centre for older adults. A growing number of health researchers are turning to theatrical performance as an innovative approach to knowledge translation, thereby making research more accessible and relevant in health care settings (Gray *et al.* 2000, Kontos and Naglie 2006, Mieniczakowski 1999, Sandelowski *et al.* 2006, Colantonio *et al.* 2008). Dramatic performance is particularly effective as a method for disseminating qualitative research because it privileges phenomenology, and thus has the advantage of drawing the observer into a particular social and cultural world with all its textures, sounds, gestures, and movements (Kontos and Naglie 2006).

Expressions of Personhood in Alzheimer's consisted of five vignettes featuring bodily expressions of selfhood by severely cognitively impaired residents of an Alzheimer support unit. Vignettes were based on ethnographic observations of an Alzheimer support unit (Kontos 2004b). The following is one of the vignettes. On the eighth day of the Jewish holiday of Hanukkah, a party is organized for the residents of the Alzheimer support unit. Following the celebratory lighting of the Menorah (a ceremonial candelabrum), the staff begin to return the residents to the unit, when a female resident resists. She clutches the personal support worker's arm and shakes her head vehemently indicating that she does not want to go. The personal support worker is temporarily distracted by another resident. The woman struggles to make a path for herself through the crowd, manually pushing her wheelchair to the table where the Menorah stands in glorious full flame. She carefully unfolds a napkin on which she had earlier been served a jelly donut, and places it with utmost care atop her head to cover her hair as is required at the time of prayer under Jewish law. As is typically done when lighting candles upon the beginning of the Jewish Sabbath, she then holds her palms up to the Menorah, embracing the warmth of the candles, and after making three sweeping motions with her hands she covers her eyes with her hands and she privately prays to herself as tears stream through her fingers. She removes the napkin that covered her head and when staff return for her, she does not resist. Her hands are gently clasped in her lap, and her face is peaceful as she leaves the room.

Ethnographic findings were translated into dramatic vignettes to provide focus group participants with a more direct pathway to how selfhood is manifested in gesture and action, and in face-to-face interactions, than could be achieved through conventional dissemination practices (e.g. academic discourse) (Kontos and Naglie 2006). Dramatic performance is increasingly being used as means to help practitioners and medical trainees reflect on the care they provide and increase their understanding of patient care issues (Kontos and Naglie 2006, Kontos and Naglie 2007b, Rossiter *et al.* 2008).

The focus groups were each approximately ninety minutes in duration; a thirty-minute live performance of *Expressions of Personhood in Alzheimer's* followed by a sixty-minute discussion. Each focus group discussion was facilitated by the first author (PK) and audiotaped and observed by a research assistant. To ensure confidentiality throughout the research process, participants were instructed to keep in confidence all information shared during the discussions, and publications anonymized facilities and identified participants solely by profession.

A prepared, open-ended interview guide was used by the facilitator to explore with the focus group participants their reactions to the live performance, including their understandings of self-expressions through bodily habits and gestures, and their interpretation of the interactions between practitioners and their care recipients depicted in the staged vignettes. Participants compared and contrasted the vignettes with their own experiences thereby facilitating exploration of the breadth and importance of non-verbal self-expression by persons with severe cognitive impairment, and the ways in which the recognition and support of such self-expression might improve person-centred dementia care.

Participants

A purposive sampling strategy (Denzin 2000) was used to select participants who fulfilled the following criteria for eligibility: 1) personal support worker, nurse, occupational therapist, physical therapist, or recreational therapist; 2) experience in providing direct care (e.g. bathing, dressing, feeding, rehabilitation) to residents diagnosed with dementia; and 3) perceived by managers, clinical nurse specialists, advanced practice leaders, and/or appropriate Department Heads as practicing in accordance with a person-centred approach to care. It was presumed that including nurses and allied professionals would bring a diversity of clinical experience that would broaden and enrich the focus group discussions. Also, the focus of nursing and allied health professionals on the body as the primary site of care work gives them the opportunity to observe residents' bodily habits, gestures and actions. This would be crucial to our exploration of the meaning and significance of self-expression through the body in the context of dementia care. Finally, those practitioners who adopt a person-centred approach to their dementia practice would recognize that behaviour is not always symptomatic of dementia but could be an expression of an unmet need. Such recognition would be indispensable for a discussion about self-expression in Alzheimer's disease.

Administrators from each facility identified eligible participants and requested permission for release of contact information. All agreed to be contacted by the researcher and provided informed consent to participate in a discussion about personhood, Alzheimer's disease and dementia care practice. Ethics approval was obtained from the ethics review board of each study facility.

In each of the three facilities, two focus groups each consisting of 6–8 practitioners were conducted. Forty-three female practitioners participated; 16 nurses, 10 occupational therapists, 8 physiotherapists, 7 recreational therapists, and 2 personal support workers. Fewer personal support workers were recruited because two facilities do not staff this category of practitioner. Participants were recruited from long-term care (67%), behavioural

management (26%), and geriatric rehabilitation (7%) units that varied in size (10-bed to 79-bed units) and client/staff ratio (3:1 to 7:1).

Analysis

Electronic verbatim transcripts were professionally prepared for each focus group discussion, verified against the original audiotapes (PK), and analyzed using thematic analysis techniques (PK, GN) (Denzin and Lincoln 1998). Descriptive coding was first conducted wherein segments of text were assigned a code reflecting the original statement. These codes then served as the basis for category formation. Categories with similar content were summarized and ultimately these categories were further refined and formulated into fewer analytical categories through an inductive, iterative process of going back and forth between the data, the literature on tacit knowledge, and the conceptual framework of embodied selfhood. An audit trail (Richards 2005) was used to maintain records and encourage reflexivity including reflections on data collection, explanations of codes, concepts and analytic models related to tacit knowledge, and the conceptual framework of embodied selfhood that shaped the study. While the original study pertained to accounts of practices of dementia care solicited following exposure to a research-based drama about embodied selfhood in Alzheimer's disease, analysis of practitioners' accounts of tacit knowing revealed a strong affinity with the pre-reflective sources of embodied selfhood. Thus, embodied selfhood was further conceptualized as a significant source of tacit knowledge of caring.

The data are organized by the thematic categories of 'bodily experience,' 'power of gesture,' and 'socio-cultural habits of the body.' These categories capture how caring is tacitly known to the body emanating from the pre-reflective sources of embodied selfhood. Findings⁴

Bodily Experience

Merleau-Ponty's reconceptualization of perception suggests that there is a powerful nexus between bodies connecting individuals over time and space. He notes,

... my body is made of the same flesh as the world ... and moreover ... this flesh of my body is shared by the world, the world *reflects* it, encroaches upon it and it encroaches upon the world ... (1968: 248, original emphasis).

Hamington cautions that Merleau-Ponty is not suggesting a perfect colonization of the experiences of another person (Hamington 2004: 53) because as Merleau-Ponty argues, for the other person 'these situations are lived through, [but] for me they are displayed' (1962: 356). Merleau-Ponty further notes that 'certainly I do not live their life; they are definitively absent from me and I from them. But that distance becomes a strange proximity ... since the perceptible is precisely that which can haunt more than one body without budging from its place' (1964a: 15). The importance of shared bodily experiences for bridging the distance between oneself and another, and eliciting a caring response is exemplified by the following statements of the focus group participants:

⁴Some of the findings presented here have been published elsewhere (Kontos and Naglie 2007a, Kontos and Naglie 2007b).

In the winter I feel the residents' cold when I take them out of the bath. So I wrap them in a towel quick and rub their back and arms just as I do myself because I know how it feel [sic] to be wet and cold. [Personal Support Worker]

I had just finished my shift and I was on my way out when I saw Mrs. B standing in the dining room with feces on the floor. She was crying out for a nurse to help. I could have just left seeing that my shift was finished and all, but I couldn't bear to let her wait another minute to be cleaned up. I mean I could feel her embarrassment and discomfort when I looked at her standing there. So I took her to her room right away and I changed her clothes thinking all along, 'I bet that feels much better.' [Nurse]

I have to crush pills for some residents who can't swallow them whole. But for many it's really difficult to get them to take it. I mean, I know how bitter it can taste when you crush a pill and just mix it with juice. So I try to find out what the resident likes that I can mix the crushed pills with. I noticed that one resident loves jam with her toast so I got the idea to mix the crushed pills with a teaspoon of jam for her. It makes a huge difference. She doesn't notice the pills at all (emphasis in original expression). [Nurse]

The practitioners' comments resonate with what Merleau-Ponty refers to as the common bond of embodied experience (1968: 143). Hamington (2004) illustrates this shared corporeal existence by referring to our response when a person is cut by a knife; we need not reflect whether pain was felt since our own aggregate bodily experiences inform us that pain comes with such an experience. Hamington argues 'there is an internal 'logic' to caring habits. They make sense for others because they would make sense for me and my body given similar circumstances' (2004: 56). Thus the shared experience of being wet and cold, embarrassed or uncomfortable, and the recalled bitterness of crushed medication facilitates a connection that informs practitioners' sympathetic approach to caring.

The body possesses, according to Merleau-Ponty, a coordinating power in relation to itself, what he refers to as the primary perceptual level that is prior to any explicit act of intellection on our part (Merleau-Ponty 1962). The following accounts reveal that practitioners' bodily movements are dependent not upon cognition but rather upon what Merleau-Ponty refers to as motor intentionality (1962: 110, 137–138):

Their feet are so dry and cracked and that. They get their nails clipped but that can't feel good because their nails are so thick and hard. And that's no pedicure you know! Where's the comfort and relaxation? So I would put their feet to soak in a basin of warm water with some nice smelling soap to soften their feet. And these people, whenever I can put their feet to soak in some warm—'Oh I've never had that! It feels so good!' Then I take it out after a few minutes, you dry it gently, and put some lotion and rub their feet like a massage and they feel terrific! [Personal Support Worker]

I remember one night I was working the night shift, and this lady there complaining that she's always climbing out of bed, she's restless, sometimes she's crying out, and I went in to investigate what was going on and I spoke with her, and I noticed

that she was half covered. And I noticed that her skin was very, very dry, scaling. And I started applying moisturizer all over. I used like a warm cloth just to give her like a bed bath, like, and I started applying moisturizer. And after I did that she slept right through the night. When I left at seven o'clock in the morning at the end of my shift she was still sleeping. So maybe because of her dry skin she was itchy, and she couldn't express herself. Maybe that helped. [Personal Support Worker]

The pre-reflective nature of the coordination of visual, tactile, and motor aspects of our body (Merleau-Ponty 1962: 105–106) is evident by the fact that the practitioners are not reflecting on how to perform their actions. They do not describe in any detail the 'how' regarding their movements and gestures because the body is naturally invested with what Merleau-Ponty refers to as perceptual significance. By this he refers to a corporeal knowledge that manifests itself only when bodily effort is made and cannot be articulated in detachment from that effort. The pre-reflective moving body is in and of itself intentional by virtue of being naturally invested with a certain perceptual significance, a bodily know-how or practical sense. Kontos argues that this primordial level provides the foundational structure for selfhood (2004b, 2004a, 2005a, 2006a). Here, we extend Kontos' argument to suggest that just as selfhood is tantamount to the existential expressiveness of the body, caring emanates from and is supported by the existential expressiveness of embodied selfhood.

The Power of Gesture

Merleau-Ponty's corporeal intentionality underscores the expressive dimensions of the gestural body, which are fundamental to communication in human interaction (Merleau-Ponty 1962). As Kisiel (1974: 205) so aptly suggests, there is a 'generative grammar' that finds its locus in bodily behaviour: the expression of the face, the play of the eyes, the movement of other parts of the body and the tone of voice. This 'generative grammar' is apparent in the following incidents where meaning is conveyed in the absence of speech:

I was working with Mrs. D on her walking and she was resisting the physio. I was trying to explain to her how important it was to get her legs moving but I wasn't getting anywhere with her. As I took a moment to myself to figure out what I could do to connect with her it suddenly became THE moment we actually connected. Our eyes met and she smiled. I immediately smiled too and several moments passed like that of us just smiling at each other. We then proceeded with the physio. It was like she needed me to show her that I was there for her and I did.
[Physiotherapist]

One of our residents who I'm thinking of is extremely agitated, often she'll wander into the main room there and sit next to another resident who likes to sleep on the sofa. But this time the agitated resident started to cry and hit her head repeatedly with her hand. Her agitation woke up the other resident who then got upset pointing to the woman saying something like, 'she is sick.' I explained to her that she probably missed her family, and I put my hand on the resident's hand and kept it there as her cries quieted. The other resident fell back asleep as I sat there holding the woman's hand. [Nurse]

In the silent exchange of expressive gesture, the physiotherapist and nurse are able to communicate with the residents and to make a meaningful connection. The significance of their connection derives not from semantic content but rather from the meaning their bodies directly convey (Kontos 2006a). This is consistent with Merleau-Ponty's argument (1964b: 7) that communication dwells in corporeality or, more specifically, the body's capability of gesture. Thus it is our claim that just as selfhood persists in and through the body's power of natural expression (Kontos 2004b, Kontos 2006a), caring too emanates from the body's ability to tacitly apprehend and convey meaning.

Socio-Cultural Habits of the Body

We saw with Merleau-Ponty that the body naturally lends itself to movement and gesture because of the primordial body that functions as a generality giving to embodied consciousness its form rather than its content. However, our data disclose a certain style or content to bodily movements and gestures, the source of which cannot be attributed to what Merleau-Ponty describes as the primordial body, but is instead reflective of Bourdieu's socio-cultural domain of habitus.

The data demonstrate that social and cultural habits, movements, and other physical cues disclose significant information that brings personhood into focus for practitioners. Many participants recounted instances where care recipients' previous vocation instilled in them bodily dispositions to move and act in particular ways. For example, a nurse spoke of a care recipient of hers who was previously a farmer:

In the middle of the night, 3:00am, he gets up and goes in the middle of the hallway, and he's doing like this [demonstrating the motions of planting] because he is thinking that he is still a farmer and has to wake up early to plant the rice, or whatever.

When asked about her response to his behaviour, the nurse replied, 'so long as he isn't harming anyone I think it is important to support and encourage this because he is expressing himself in the way that he knows'. Another nurse similarly reflected on how one's previous vocation can be expressed through the body:

One of our residents was a policeman so he's always pacing up and down the hallway peering into bedrooms and sometimes it even looks as though he's holding a flashlight although he isn't really. He's making sure there isn't any suspicious behaviour on the unit.

These examples demonstrate the durability of the effects of socialization through cumulative exposure to certain socialization associated with particular vocations.

Knowledge of the life history of care recipients enables practitioners to accurately interpret and respond to their behaviours. The importance of having some knowledge of the life history of another person for caring has been previously recognized (Mayeroff 1971, Hamington 2004). Hamington suggests that 'as the details and specific context of people become increasingly known ... they become persons with names, faces, bodies, and other aspects to which sympathetic identification gives us a connection' (2004: 42). Knowledge of life history not only renders the care recipients' socio-cultural bodily dispositions

recognizable to the practitioner, but facilitates practitioners' creative incitement of the care recipients' practical capacity to grasp and engage in therapeutic activity, as indicated by a physical therapist:

There are a lot of war veterans who live here and I'll never forget this one resident who I worked with. I had a hell of a time getting him to stand up from his wheelchair so we could work on his walking ... He refused. One day I was thinking about who this man was, and what his life experiences were, and started singing the national anthem. Well you wouldn't believe it but he stood up from his wheelchair and saluted me! So from then on we began our physio sessions with the national anthem.

Following Bourdieu's logic, the mastery the resident demonstrates in this example emerges from the intersection between his habitus and objective structures that originally produced the dispositions of his habitus. As a result of the internalization of these structures, the resident is able to meaningfully connect with and react to the solicitations of his environment in a coherent and systematic manner. The taken-for-granted, pre-reflective nature of his behaviour flows from what Bourdieu describes as the embodiment of cultural and social conventions that harmonizes behaviour and guarantees appropriateness and constancy without any conscious reference to a norm, and without explicit coordination (Bourdieu 1990).

Such recognition is further evident in the following account of a recreational therapist who describes the importance of hats for residents of a veteran's facility:

Hats. I find that hats, because I do a lot of outings, you know, it's like, 'oh, we got to wear a hat.' They're used to wearing a hat to go out, and then we enter a building, off comes the hat, you know. And I used to do a lot of Legion trips. If anyone wore a hat to go into a Legion, they had to buy everybody a round of beer. So you see, once they're coming in, oops, there goes the hat, you know. So, some of those things that they've grown up with or have done their whole life stay with them.

Following the logic of habitus, the persistence of the residents' respect of removing one's hat upon entering a Legion owes its regularity and predictability to the objective structures that produced the dispositions of the residents, and which facilitate the appropriate response to social convention (Bourdieu 1990: 59). However, the coherent intelligibility to the residents' management of social convention is evident not only where there is consistency to social practice, but also when conditions deviate or contradict the customary code. The following account of a resident's strong reaction to others who failed to adhere to proper etiquette is exemplary:

I'm thinking of someone who when he was more mobile, he used to hit a lot of people in the dining-room, and it was because they were wearing their hats at the table, but you don't wear a hat when you're sitting at the dining table. He would go in there and knock their hats off their heads. [Recreational Therapist]

A similar disjunction between habitus and objective conditions is described by a nurse who discovered that the source of a resident's resistance to morning care was his desire for privacy:

I have a gentleman who always was resistive when I tried to remove his pants during care. He would keep pulling them back up or just push my hands away. So I took some time to speak to the wife to figure out what was happening and she says he always was a very private man, always closing the bathroom door and covering himself when he would bathe. So I came up with the idea to attach Velcro to the towels we use so I could get his pants off without him being exposed. So we use that around him, you know, during care, and because you have him covered, he's less resistive, and it's much easier and less time consuming to get his care done.

The reaction of the residents in each of the above two examples – knocking off hats from the heads of those who failed to respect the convention of removing their hats at the dining table, and resisting morning care - can be interpreted as a negative sanction because the situation deviated from what they had internalized as appropriate behaviour. As Bourdieu argues, '*habitus* tends to favour experiences likely to reinforce it ... to protect itself from crises and critical challenges by providing itself with a milieu to which it is as pre-adapted as possible' (1990: 61, original emphasis).

Practitioners not only recognize and respond to socially acquired habits of the body as expressed by their care recipients, but practitioners themselves use their own socio-cultural bodily dispositions to initiate a connection with their care recipients and to structure care. The following incidents are illustrative of this:

I was dispensing the meds one morning and a resident was crying out 'MAMA, MAMA!' She was weeping as she repeated this over and over. She was upsetting some of the other residents who were yelling 'SHUT UP' and 'GO HOME!' So I moved my medication cart over to where she was sitting and hummed a lullaby. There's something so soothing about a lullaby. And it worked like a charm! [Nurse]

Mrs. S. is a real performer and loves attention. When I see her in the hallway I say 'Well hello gorgeous!' and start singing some Broadway hit and she throws her hands high in the air and starts doing this thing with her hips and then explodes in laughter. I always give her her moment in the stars. [Nurse]

There's another gentleman ... he'll often stand by the door of the dining room blocking the residents from going in and out. But, you know, talking to him will not help, ... What I found, and I just found this out by accident, I just put my hand out like this [motioning the gesture of putting one's elbow out for another to take hold of], kind of like when an older couple walk together arm-in-arm, and he took it. [Occupational therapist]

Here, habitus clearly facilitates the creative construction of opportunity by the practitioners, which, in turn, exercises the pertinent incitement of the residents' practical capacity to grasp and engage in the opportunity (Kontos 2004b, Kontos 2006a). The practitioners' caring gestures are illustrative of Bourdieu's argument that just as grammar provides the

organizational structure for speech without determining the actual expression of the speech, the structures of habitus can generate ‘an infinite number of practices’ (Bourdieu 1990: 55).

Kontos argues that ‘as dispositions are embodied and materialised in practice, so is selfhood embodied and manifests in socio-culturally specific ways of being-in-the-world’ (2004b: 842). Our data provide important validation of this claim. The practitioners recognize the mastery that the residents have of various social practices, the coherence and socio-cultural specificity of which is attributable to their selfhood being embodied and expressed in a habitual state, tendency and inclination to act in a particular way (Kontos 2004b, Kontos 2006a). Caring largely emanates from practitioners’ recognition of the selfhood of their care recipients as it is manifest in the embodiment of culture-specific conditions of their socialization. However, the practitioners’ own vocal and gesticular expressions further corroborate Kontos’ argument that the socio-cultural aspects of corporeality endow selfhood with the capacity for improvisation and spontaneity (Kontos 2004b, Kontos 2006a). As Kontos argues (2004b: 845), embodied selfhood is not mechanically constraining of action but rather permits ‘an element of inventiveness and creativity, albeit within the limits of its structures, which are the embodied sedimentations of the social structures which produced it’. Practitioners’ use of their own socio-cultural bodily dispositions in interactions with residents renders visible how their embodied selfhood is central to their tacit knowledge of caring which is expressed as an improvised engagement with their care recipients.

Conclusion

Our analysis of study participants’ accounts of their interactions with persons with dementia broadens and enriches the discourse on tacit knowledge. In its exclusive focus on experience acquired in clinical practice, current research on tacit knowledge falls short of capturing the full potentiality of the body as an active, communicative agent, imbued with its own intentionality and purposefulness (Kontos 2003, Kontos 2004a, Kontos 2004b). Conceptualizing practitioners’ tacit knowing as acquired exclusively in the context of their clinical practice is to miss that caring is tacitly known to the body because of the pre-reflective sources of selfhood.

This is not to suggest that tacit knowledge can always be drawn upon for caring. Organizational context and culture are factors that influence practitioners’ ability to provide quality care (McCormack *et al.* 1999, McCormack *et al.* 2002, McCormack 2006). Klein (2003) argues that organizational policies that restrict individual decision making, and the excessive use of procedures that reduce reliance upon the perception of subtle cues and nuances impede the incorporation of tacit knowledge in medical practice. Understanding how practice organizations themselves invite or reject, complement or inhibit practitioners’ use of tacit knowledge, and the implications this has for person-centred care is an important direction for future inquiry. This raises the important question of the applicability of our reformulation of tacit knowledge to contexts such as care giving relationships which are not person-centred. Given the existential and socio-cultural structure of tacit knowledge, we must presume that it is not extinguished in the context of such relationships. However, non-person-centred care is underpinned by the deeply embedded cultural assumption that with advanced dementia there is a corresponding loss of selfhood (Kontos 2005, Kontos and

Naglie 2007a), an assumption that militates against the activation of tacit knowledge. Kontos and Naglie (2007a) have argued that it is the imagination that transcends assumptions about the diminishing humanness of persons with Alzheimer's disease. Thus further research might explore the relationship between tacit knowledge and the imagination.⁵

The applicability of our reformulation of tacit knowledge to other groups and contexts is an important direction for inquiry. For example, exploring the relationship between embodied selfhood and tacit knowledge in the context of caring for persons with conditions of both cognitive and physical impairment (e.g. stroke, Parkinson's disease) might indicate other ways that embodied selfhood is expressed and, as a result, expand the notion of tacit knowledge of caring in clinical practice. However, if there is truth to Merleau-Ponty's and Bourdieu's claims about the body, and by extension embodied selfhood, as we believe there is, our reformulation of tacit knowledge should not be specific to sympathetic caring in clinical environments, nor to caring for the sick. Extending the above noted exploration to social contexts such as the home, office, and schools would further expand the notion of tacit knowledge of caring.

Because study participants did not discuss certain types of behaviour manifested by their care recipients, such as extreme violence, we were unable to explore the possible role that tacit knowledge plays in such circumstances. It might be that 'social desirability bias' (Stone *et al.* 2000) led participants to refrain from discussing negative examples of caregiving interactions from their practice. Thus another important direction for future inquiry is the experience of practitioners who encounter violence and other extreme forms of behaviour in their interactions with care recipients, and the ways in which tacit knowledge might inform their approach to care in such interactions. We are not suggesting that with Merleau-Ponty and Bourdieu we have found a substitute for cognitive knowing or that embodied selfhood as a source of tacit knowing should alone inform clinical practice.

We are however suggesting that given that tacit knowledge is integral to sympathetic care, it is indispensable to the creation of what McCormack (2006) refers to as 'evidence-based person-centred cultures of practice'. A notion of caring knowledge that takes seriously the primordial and the socio-cultural body is not presumed to encapsulate all aspects of what Polanyi (1966) refers to as 'knowing how'. Our exploration of the communicative capacity of the body to facilitate sympathetic care is intended to provide new insight and direction for future investigation of the body as a site for the production of tacit knowledge.

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⁵Kontos and Naglie (2007a) have argued that the imagination plays an important role in facilitating sympathetic connection. They argue that when the imagination is informed by *both* expressions of the primordial and socio-cultural body, practitioners can more fully empathize and contextualize their caring efforts.

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