Qualitative fieldwork in medical contexts: Confessions of a neophyte researcher

Phoebe Sanders1, Ross Wadey1, Melissa Day2, and Stacy Winter1

1School of Sport, Health & Applied Science, St Mary’s University, Twickenham, UK 2Department of Sport & Exercise Sciences, University of Chichester, Chichester, UK

Phoebe Sanders (corresponding author): phoebe.sanders@stmarys.ac.uk

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Immersive fieldwork can facilitate an understanding of the richness, complexity, and multifaceted relationships within medical environments, and is increasingly being used to explore sensitive topics within healthcare. However, few published studies have made use of immersive methods within hospitals or clinics, and there is a lack of guidance for those seeking to conduct immersive research within medical spaces. In this confessional tale, the first author, a neophyte qualitative researcher with no medical training, reflects upon her experiences during the first five months integrating into an amputee rehabilitation clinic prior to a period of immersive fieldwork. Drawing on 195 hours of observation and the author’s reflexive journal (totalling more than 20,000 words), alongside discussions with the supervisory team, four main challenges are discussed: finding a role, navigating waiting spaces, encountering the unfamiliar, and ethics in the boardroom and in the field. Specific recommendations for novice researchers entering medical environments include: preparing to encounter those who do not share their beliefs, identifying a safe environment in which they can share their emotions, and engaging in reflective practice to explore the impact their (in)experience and willingness to embrace opportunities for learning may have within their own research context.

Key words: confessional tale, qualitative fieldwork, healthcare research, neophyte, amputee rehabilitation

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For many years, there has been debate around what are, and are not, appropriate methods for research within healthcare domains. Medical research has traditionally been dominated by a positivist paradigm that views knowledge as observable, empirical, quantifiable and verifiable (e.g., Pope & Mays 1995; Watts 2011). Whilst this paradigm has helped to predict and explain behaviour, it has done little to extend our understanding of people’s lived experiences of healthcare. In recent years, recommendations have been made to embrace qualitative research and alternative paradigms (e.g., Greenhalgh 2016) in which knowledge is viewed as multiple, situated, and socially and historically bounded (e.g., interpretivism). As such, hermeneutical and dialectical methodologies have been recommended in which the role of the researcher changes from objective observer to participant (Whaley & Krane 2011; Sparkes & Smith 2014). Researchers engaging with such participatory practices may utilise immersive fieldwork (e.g., prolonged participation in natural settings) to understand the world from the participants’ point of view and facilitate a more in-depth understanding of the richness, complexity, and multifaceted relationships within natural environments (for examples of such work, see Caddick et al. 2015a; Caddick et al. 2015b; Cavallerio et al. 2016).

Few published studies have made use of immersive methods within hospitals or clinics (for exceptions, see Chenhall 2008; Peters et al. 2001a; Peters et al. 2001b; Wind 2008) and there is a lack of guidance for researchers seeking to conduct such research within medical spaces. As a doctoral student embarking upon a program of research underpinned by ontological relativism and epistemological constructivism, I, the first author, was particularly discomfited by the lack of accounts of other neophyte researchers to whom I could relate and learn from. Stories of researcher experiences are few within the realm of healthcare, where the primary means of communicating qualitative research findings is the realist tale, characterised by absence of the researcher and the use of closely edited quotations from participants (Sparkes 2002). As Bryman (2015) highlights, “what we read in reports of research are often highly sanitised accounts of how the research was produced, without a sense of the sometimes difficult problems the researcher(s) had to overcome.” (p13). In line with this statement, Waddington and Smith (2014) proposed that such accounts present a partial picture of research, focusing on how research *ought* to be done, rather than how it is *actually* done, and leaving the ‘messiness’ of research unrecognised.

In contrast, confessional tales (Van Maanen 1979) are increasingly being used to explore the research process as experienced by the author (e.g., Peters et al. 2001a; Watts 2008; Watts 2011; Wind 2008). The confessional tale adopts a highly personalised style to elucidate the author’s own point of view, making him or her highly visible within the text and taking readers behind the scenes of the research (Sparkes 2002). Consequently, they expose the ‘interpretive’ nature of fieldwork (Stevens 1993) and may help to reduce the shock to those new to conducting such projects by shedding light on some of the dilemmas, tensions, and surprises of the research process (Sparkes 2002). However, there is a lack of such reports from neophyte researchers within medical research contexts.

The aim of this paper is to use the genre of the confessional tale to highlight the challenges encountered by a novice researcher entering a medical environment for the first time. Specifically, I (the first author) use my own voice to explore and reflect upon my first five months integrating into a hospital prior to a period of immersive fieldwork. As Bryman (2015) described, confessional tales tend to be explicit about the research questions that drove the investigation. In line with this approach, our confessional tale begins with an outline of the research context and research questions. In addition, the following reflective questions were developed specific to the confessional tale: a) What were the challenges faced as a novice researcher in the hospital environment and b) How might other novice researchers anticipate and address these challenges proactively?

# The research context

The research to which this confessional tale relates arose through a partnership between the first author’s university and a UK-based amputee rehabilitation centre operated by the National Health Service (NHS). The question that drove this research was: what are the psychological and social experiences of patients throughout the first year following loss of a lower limb? To answer this question, the research aimed to build an understanding of the dynamic nature of amputees’ experiences, and how these are constituted and constructed, over the first 12 months post-surgery. The setting was a multidisciplinary amputee rehabilitation centre, comprising a medical clinic, inpatient ward, amputee gym, and prosthetic workshop. Patients attending the centre have undergone amputation due to a variety of causes including vascular condition, trauma, infection, disease, or congenital defects. Patients usually attend the centre full-time for several weeks post-surgery to learn to use a prosthetic limb, and continue to attend periodically for ongoing health checks and prosthetic reviews.

There were four members of the supervisory team, each of whom provided expertise in sport psychology and qualitative research methods or amputee rehabilitation. The study used an immersive approach, which included the use of observation and interviews (formal and informal) with staff and patients within the amputee centre, for up to 15 months. This confessional tale explores the challenges that I encountered during the initial months that I spent within the hospital environment. Since I had no prior experience of conducting immersive research or spending an extended period of time within a hospital, my supervisors and I agreed that I should build my understanding of the environment prior to data collection. Consequently, for a five-month period I engaged in a combination of observation, interaction with staff and patients, and worked as a contracted volunteer for up to two days per week within the hospital.

In this confessional tale I discuss four main challenges: finding a role, navigating waiting spaces, encountering the unfamiliar, and ethics in the boardroom and in the field. Throughout the paper, I draw on two ways of reflecting: first, the reflexive journal that I kept during these initial months, detailing my daily experiences, thoughts, emotions, and reactions to what I was witnessing. Between April and September 2016, I spent 195 hours in the hospital, and my journal totalled more than 20,000 words. Second, this confessional tale draws on discussions with my supervisory team, with whom I met weekly to discuss and reflect upon my experiences.

These reflections were not intended to be written up for publication; rather they were deemed as good practice to learn about the experiences of being in a medical environment prior to data collection. However, upon reviewing my reflections at the end of this time period, it became clear that the issues raised and lessons learned could be of benefit to other researchers and, therefore, worth sharing. This confessional tale, and the reflective practice underpinning it, did not meet the definition of ‘research’ set out by the NHS and Health Research Authority. Therefore, neither body would consider this work for ethical review. Yet, our institutional ethics committee did consider this as research. Therefore, retrospective ethical approval was sought and granted.

# Finding a role

On my first day in the hospital, I felt out of place and burdensome to the staff. I was based within the amputee therapy unit, primarily in the rehabilitation gym and medical clinic, and it quickly became clear that each member of staff was working at capacity, with very little time to orientate me into this world. I entered the hospital expecting to feel displaced and uncomfortable, however, I had not comprehended how difficult that would be in an environment where everybody was occupied with the day-to-day challenges of supporting patients. The NHS provides state-funded healthcare to over one million patients every 36 hours (NHS Confederation, 2016). However, a recent report indicates the organisation is expected to deliver a 10-15% real-terms cost reduction by 2021, with staffing efficiencies central to the cost-saving strategy (Carter 2016). As an observer on the ground, I felt everybody else was racing around with too many tasks and too little time, whereas I had very few tasks and more than enough time.

In one sense, I faced similar socialisation challenges to any employee entering an organisation for the first time. Socialisation literature shows many new recruits experience reality shock and ‘upending’ experiences (e.g., embarrassment or failure) during the entry process (Jones 2005; Seymour & Sandiford 2005; Scott & Myers 2005). Peters, McAllister, and Rubinstein (2001a), in their ethnographic study of a cancer clinic, acknowledged how overwhelming it can be for a newcomer learning about the diverse staff in a hospital. I did not know anybody other than my supervisor, who was often engaged in work in other parts of the hospital, and I did not understand the unique emotional, social and behavioural norms, practices, and conventions inherent to medical environments. In my journal, I noted:

Being in this environment exhausts me. It’s so awkward just hanging around without really having a function or anything particular to be doing, and I worry that I’m getting in the way. There are always so many new people to meet, but I don’t know when and where to approach people (or not). I feel so shy; today I missed the opportunity to sit in on the two clinic appointments simply because I was too nervous to speak to the doctor about whether or not I was able to observe.

Whereas other individuals within the hospital seemed to have clearly defined roles (e.g., physiotherapist, nurse, patient), I struggled to situate myself within this new environment. I was neither a patient nor a medical professional. I felt stranded in a new place with no clear purpose, as even my voluntary role did not confer specific duties or accountabilities. In my journal, I described my role as that of ‘a professional stalker, hanging around at someone else’s workplace with no role or purpose’. Others have described the discomfort associated with ‘doing nothing’ during periods of observation (e.g., Peters et al., 2001a, 2001b), and I felt this acutely during the initial weeks, and I longed to be able to contribute. Instead, I found myself looking for excuses to get away from the ‘action’: using toilets on the other side of the hospital, offering to sit out of appointments where there were several staff members and limited space, or simply hiding behind my laptop at the desk in the gym.

My experiences are not exceptional and other researchers immersing themselves within fieldwork environments have also described their struggle with the lack of a defined role. Researchers engaging in ethnography have described the dichotomy between the researcher as an outsider, who is not a member of the culture under study, or an insider, who has been a member of that culture (Krane & Baird 2005). Each position may confer both limitations and advantages: where the outsider may struggle to gain acceptance and become familiar with the research setting, the insider may hold misleading preconceptions about the environment and people in it (Holt & Sparkes 2001). Wind (2008) proposed the term ‘negotiated interactive observation’ to define fieldwork in hospital settings, on the basis that becoming a ‘true’ participant (a patient or member of medical staff) is not an option to most researchers. Instead, researchers must negotiate a distinct role in which they may observe and interact with their participants. As I became more familiar with the hospital environment, I was able to identify shared ground with both the staff (e.g., a love of sport and scientific educational background) and with the patients (e.g., a lack of medical training and long periods with little to occupy me). Indeed, during interactions when common ground allowed me to move closer towards insider status with the patients, I felt I simultaneously distanced myself from the staff, and vice versa.

Looking to the extant literature for guidance, I noted the ways in which other researchers had responded to the challenge of finding a role within their field environments. In a healthcare context, Peters (Peters et al. 2001a) maintained a volunteering role throughout the research, which Watts (2008) also identified as allowing for a flexible, responsive approach to fieldwork. Researchers who found themselves to be outsiders in other domains have also spoken of the challenge of finding a role, for example, within the emergency services (Scott & Myers 2005), a national sports governing body (Wagstaff et al. 2012), or a sports team (Howe 2001). I entered the hospital believing that a voluntary role would supply me with some specific duties within the centre, however, it quickly became clear I would need to proactively identify tasks I could undertake. So, if I heard members of staff discussing outstanding administrative tasks (filing, auditing, creating spreadsheets, etc.), I offered to do them. By volunteering for specific jobs, I took the burden of delegation off the staff, who had been hesitant to pass on menial tasks to me, and began to build relationships by demonstrating my willingness to pitch in. I wrote in my journal:

I feel as though I made some real headway with [staff member] this morning. Previously, whilst I had said I wanted to be useful, there hadn’t been any obvious ways in which I could be. So whilst she was always polite and helpful, I don’t think she could see any way in which I could be of benefit to her. Whereas now, I have identified two tangible ways in which I can contribute, and sensed almost an instantaneous softening. Previously she was polite, but by the time I left today she also seemed warm.

These initial responsibilities snowballed as other members of staff delegated similar tasks to me, and so I found my role. To the clinical staff, such tasks were an unwelcome distraction from their other responsibilities. To me, a newcomer lacking medical training, they felt like a lifeline that allowed me make a contribution with the skills I do have. These jobs gave me a place to be and something to do, which was reassuring. By seeking out tasks for which I was qualified, and those which nobody else wanted, I created a role that allowed me to build relationships and make a contribution to the day-to-day activities within the centre, yet also maintained the boundaries between myself, and the staff and patients. Even the small act of being thanked for something I had done felt like a breath of fresh air after so many days of feeling like more of a hindrance than a help. This is something I encourage other neophyte researchers to give thought to prior to entry into the field: what are your strengths and how might they be applied in your research context?

Combining the roles of researcher and volunteer may, however, present additional complications within the field. Conflict can arise when balancing participant and observer tasks (Morse & Field 1995). For example, my volunteer role sometimes took me away from the patients and placed me in areas in which observation opportunities were limited; not much happens in the filing cupboard! I made staff aware when I began collecting data so they understood why I was no longer volunteering for all the outstanding administrative tasks, however, my input was still requested from time to time. Since I planned to collect data over a 15-month period, I decided the benefits of offering staff this support (improved relationships and integration within the team), outweighed the potential costs in terms of lost data collection time, particularly since I was often able to complete these tasks at times when the patients had returned to the ward or their homes.

# Navigating waiting spaces

Whilst awaiting NHS ethical approval, I became incredibly frustrated at being immersed within my fieldwork setting for 16 hours each week yet unable to collect data. Other doctoral students in my department struggled to recruit participants to their studies, yet I was surrounded by possible participants who I could not even attempt to recruit. For a time, I lost some of my initial enthusiasm for the project, as I noted in my journal:

On my walk to the hospital this morning, I felt as though I wanted to turn around and get back on the train. I feel so futile and demotivated; I watch all the other PhD students getting on with their first studies, and I feel as though I am banging my own head against the same brick, in the same wall, over and over again. I know that every PhD is different, but it is so frustrating feeling as though I am not achieving anything.

I discussed my lack of motivation with a colleague who had recently completed her own PhD utilizing qualitative inquiry. She suggested I spend some time reflecting on my frustration with the research process. Connolly and Reilly (2007) highlighted the importance of such reflexivity within the research process to create a safe ‘unloading zone’ (p. 534) for the emotions that emerge. As I reflected and debriefed my experiences, I began to think beyond my frustration to consider the value of these waiting spaces. It dawned on me that I was not the only person waiting; at any one time, there were also several patients waiting, whether taking a break between bouts of walking in the gym, awaiting an appointment with their prosthetist or the doctor, or having a drink. Having previously been too nervous to approach patients during these times, as I was concerned about disturbing them, I began tentatively to start conversations. The vast majority of these approaches were met with a positive response from patients:

Today I saw one patient sitting in her chair, drinking a cup of tea, looking around her with not much to do. . . . After a while, I thought I should go and speak to her. I took my coffee over and said, ‘Why don’t we have a coffee morning chat?’ She gave me a huge smile and said that would be lovely. We chatted for at least an hour about all sorts of things . . . It was a truly fascinating conversation, and I walked away feeling so pleased. She and I had both enjoyed ourselves . . . and I had learned so much.

By viewing my situation through a researcher’s lens, I realised that, far from being wasted, my time is an important means of allowing me to connect with those who may become my participants, and to understand where I can collect data. I am also possibly the only non-patient in the centre who has the time to sit and have a conversation and to get to know the patients as a person, not just as an amputee.

As described by Mannay and Morgan (2015), waiting spaces are never empty or without use, but a salient aspect of the research process that gives greater knowledge of the environment and my future participants. Indeed, it was during this period of integration that one of the occupational therapists suggested I spend a day in a wheelchair, telling me: ‘You can’t possibly understand the experience if you don’t try it for yourself’. I was concerned the patients would not like it, perhaps thinking I was parodying them or being disrespectful (see Leo & Goodwin, 2016). My fears were unfounded, as the patients took great delight in my old-fashioned, heavy, yellow wheelchair (and my inability to get through doorways without scraping my knuckles). However, I still find it uncomfortable writing about this experience, perhaps through concern that I might be perceived as presuming to ‘know’ or understand something about the experience of being in a wheelchair. Although many of the amputee patients I encountered will learn to walk with a prosthesis, the wheelchair will still be part of their daily lives. I may have glimpsed something of what it is like to navigate a hospital for a day, but nothing of negotiating one’s life as a wheelchair user. As I noted at the end of that day:

Overall, the day actually got better. . . . But this was very much dependent on my ability to get around. If I had been trapped in a house or microenvironment (living in one room), as some patients are when they are discharged, that would have been a very different story. I suppose I also knew I was going to be able to get out of the wheelchair at 3pm, so it was more of a challenge and less of a sentence.

During the time I was in the wheelchair, I noticed that my routine shifted very quickly to match that of the patients. Rather than walking around the gym or sitting behind the desk, as I would usually do, I parked my chair alongside theirs, thereby joining one of their own waiting spaces. Paying attention to such spaces has given me a greater insight into the rhythms of the environment: the rehabilitation process, the daily timetable, the roles of the staff members, and when best to approach people. For example, a patient is more likely to be open to chatting when taking a rest between bouts of walking than when waiting for an appointment with a doctor, nurse, or prosthetist. Patients undergoing full-time rehabilitation do not have scheduled appointments, but slot in whenever the appropriate member of staff is free, and it is difficult to have an informal conversation with someone who is worried they might miss their chance.

I also believe these waiting spaces and the reflective time they have afforded me, have made a critical contribution to my ability to look beyond the daily functioning of the centre to the norms, narratives, conventions, and unique experiences of those within it. As I noted in my journal:

When I am feeling as though all this time in the hospital is futile, I remind myself of how nervous and out of place I felt initially, just because of a lack of familiarity. Had I felt this way when conducting the research, I would have had very few psychological resources left with which to focus on anything else.

I was also aware of the risk that, with increasing familiarity, I might neglect the conscientious observation of seemingly mundane social interactions, norms, conversations, and events inherent to immersive fieldwork (Krane & Baird 2005). However, the constant stream of new, and sometimes uncomfortable, experiences seemed to prevent me developing too great a sense of familiarity.

# Encountering the unfamiliar

Given my lack of medical experience, my time at the hospital was, and continues to be, filled with new experiences, some of which I found jarring. In particular, I struggled to cope with some of the things I saw whilst observing appointments in the medical clinic. I noted after my first day at the hospital:

This morning I came into contact with a stump for the first time at close quarters. I will admit; this did make me feel faint initially. For a moment, I was concerned that I might start blacking out. In fact, the doctor then moved between the patient and me for a few seconds, which gave me a moment to compose myself.

The unfamiliar sights and smells were a constant reminder that I was outside of my own environment. In a footnote to her reflections on conducting ethnographic fieldwork in a Danish hospital, Wind (2008) remarked that, whereas she did not notice the various odours of the clinic during her career as a nurse, she became acutely aware of them as an anthropologist. Lacking Wind’s nursing experience, my senses were constantly assaulted by smells that I could not, and sometimes did not want to, identify. For example, after attending an appointment in the clinic, a physiotherapist asked whether I could smell gangrene. I had indeed smelled something unusual and unpleasant during the appointment, but was unable to identify it. Once I knew it was gangrene, I found it very difficult to spend time with that patient without constantly checking whether or not I could smell anything. In this instance I wondered whether my initial naivety had a protective effect that excused me from the need to manage my reactions to this patient. Once I knew that smell was decomposing flesh, and subsequently started to imagine what it might look like, I found myself experiencing a sense of revulsion that I did not want to reveal to the patient.

Where the impact of odours was often mitigated or delayed by my inability to identify them, the visual impact of the unfamiliar was instantaneous. I found my initial exposure to wounds incredibly difficult, often feeling faint and nauseous whilst observing appointments. Wind (2008) described how feeling faint whilst watching a medical procedure validated and reassured her in her transition from nurse to researcher. I felt ashamed that I was unable to cope with what I saw, believing I should maintain my composure in the same way that I saw other staff do. Other staff seemed to look at wounds with curiosity and compassion, and would physically lean forwards into them. I longed to be able to do the same, when in reality I sometimes struggled even to stay in the room:

I had to walk out [of an appointment] because I was feeling faint. It was just really tough. In addition to extensive injuries, which I could hardly bear to look at, the patient was in pain and extremely anxious. She seemed almost childlike, and I found it incredibly difficult to witness. It was as though I was trespassing on a private and frightening experience, and I felt completely overwhelmed by the patient’s distress.

I entered the hospital sharing a widely-held belief that emotion labour (the regulation of emotional display to meet with organisationally-based expectations; Hochschild, 1983), was an important part of health care professionals’ role (e.g., Mann, 2005). I had read research suggesting that managing one’s emotions has great significance for patients, and may provide reassurance for those experiencing pain, fear, and anxiety (Mann 2005; Phillips 1996). However, my early experiences within the hospital provided a stark illustration of the difference between knowing and doing. The appointments I observed were the patients’ first contact with the centre, and many of them seemed overwhelmed and nervous. As the staff maintained a calm and caring professional demeanour, I was afraid I would reveal myself as not capable of performing the requisite emotion work (Hochschild, 1979), and therefore not capable of conducting this research. For the same reason, I was reluctant to ask other staff members how they coped. Instead, I managed my emotions by avoidance, literally averting my eyes from the source of my discomfort. In the same way the images seemed to be context-bound, and did not haunt me outside the clinic, my discomfort would usually dissipate once the cause was out of sight.

This pattern began to change after a few weeks, when a member of staff asked whether I was finding the appointments any easier to witness. To me, this implied such reactions are to be expected, and that perhaps nobody had commented on my discomfort because this was part of a predictable, yet implicit, socialisation process. The same day, another member of staff told me a story of bringing her young son into work with her, and her surprise at how upset he became on seeing the patients in wheelchairs. She continued that the staff tends to forget what it is like to be new to this environment, and how distressing that can be. This social support and normalisation of my own reactions reassured me; it did not mean I should not be there, just that I was not *accustomed to* being there. Once I realised my fears of judgement were based on my own assumptions, and not on the beliefs of those around me, I became more confident in sharing my feelings rather than suppressing them.

I have also wondered at what impact my discomfort might have on the research process. Whilst a researcher’s own emotions and sensations may be an important source of information, unmanaged distress or discomfort could have a negative impact on the data collection process, leading the researcher to avoid certain situations, contexts, or people who trigger uncomfortable emotions. Having been afforded the opportunity to spend several months integrating into my research field without the pressure of collecting data, my initial shock and discomfort have abated. However, the strength of my reactions could also help me to understand what the patients experience; for many, their amputation will be their first encounter with this procedure. Connolly and Reilly (2007) suggested that discussions of trauma can create an atmosphere of intimacy between the individual and the researcher. Might the same intimacy be created through my witnessing of the patients’ wounds, a hyper-visible mark of their trauma? Watts (2008) argued that without a shared emotional space that offers the possibility of trust, a shared narrative space may be difficult to establish. By witnessing what the patient was experiencing, I may have taken steps towards creating this shared space and establishing myself as part of the plot within the field setting (Wind 2008).

Understanding that my initial reactions were ‘normal’ also gave me the confidence to gradually expose myself to the sights I had found so distressing. As I spent more time at the hospital, and developed an understanding of amputation, healing, and rehabilitation, my conceptualisations of what I saw began to shift:

As I watched the team going through the physical assessment exercises with the patient, I realised that the stump still moved in the same way that his ‘normal’ leg moved. . . . it made me realise that until that point I hadn't been seeing the stump as a leg, I'd been seeing it as ‘A Stump’. Once I could re-categorise the stump in my brain as just a bit of a leg that still moved and felt like a leg, it didn't seem so disconcerting any more.

The more time I spent in the hospital, the better I understood how a residual limb and a wound that is healing may be symbolic of hope and recovery, rather than something frightening. That said, I still regularly encountered the unfamiliar and the shocking. However, I understood the importance of maintaining an awareness of my responses rather than trying to block them out, and in sharing my thoughts and feelings to learn about how others manage their own reactions.

Sharing these experiences with my academic supervisors also provided me with an important emotional outlet and normalisation of my negative emotions by others unfamiliar with what I witnessed. In a similar vein, Connolly and Reilly (2007) described the role of supervisory conversations between the two authors in allowing Connolly, who was immersed in the field, to ‘blend the emotional insider experience back to a cognitive outsider role so that I can reflect on the data, conduct the analysis, and resume my role as a researcher’ (p. 534). The writing of this confessional tale is both part and product of the process of stepping from emotional insider to cognitive outsider, helping me to better understand my experiences throughout the initial stages of my research. These early encounters and my strong emotional reactions also gave me an opportunity to develop these coping strategies in advance of data collection, and allowed me to put theory into practice: rather than lengthy ruminations on the theory of emotional labour, my reflexive journal became punctuated with more practical instructions, such as: ‘EAT YOUR BREAKFAST!’

# Ethics: In the boardroom and in the field

The process of securing approval from the NHS Research Ethics Committee (REC) required submission of numerous documents detailing every aspect of the research process, before appearing in front of a panel to defend my proposal. I was struck by how poorly suited this process seemed to my research paradigm: REC’s tend towards a regulatory model of ethics based on positivist traditions, and may lack expertise in judging qualitative designs (Sparkes & Smith 2014). When I came to defend my application, I realised the committee saw many of the safeguards I proposed to protect my participants’ rights, as a problematic lack of control. For example, I proposed to re-affirm participant consent at each point of contact, believing that informed consent should be a continuous process of communication between investigator and participant (Resnik 2009). To the REC, however, this introduced an undesirable element of confusion. Similarly, in respect of my participants’ autonomy, I proposed to give them the option of which research activities to participate in and when, such that they could opt out of certain activities without compromising participation in the rest of the study. However, this approach was at odds with the tightly controlled clinical trials traditionally utilised within medical contexts, and I felt the onus was on me to convince the REC that I could respect my participants’ autonomy without compromising the quality of the research.

Tracy (2010) argued that qualitative researchers must design ways to respond and act within, rather than being ‘worked over by’ (Cheek 2007, p. 1058), an environment that favours quantitative studies. As an early-career qualitative researcher, I found it difficult in the face of challenge to articulate why I was taking my chosen approach. On my first day in the hospital, a consultant asked me what ‘validated measure’ I would be using to collect data. I tried to explain I would be exploring the participants’ unique experiences, focusing on the richness of description rather than the ability to generalise (Hagger & Chatzisarantis 2011). However, the trouble I had contextualising this within any broader paradigm showed I was lacking a strong grasp of the ontological and epistemological beliefs underpinning my approach. Therefore, the doctor’s questions were fully justified. This prompted me to go back to the literature and to my supervisory team to interrogate and affirm the underpinning foundations and assumptions of my research, which will make an important contribution to the quality and meaningful coherence of my research (Tracy 2010). In light of these experiences, I would encourage other researchers to engage in a similar debate, perhaps with a supervisor or critical friend, prior to entering the field. Had I been better prepared, I may have been able to help the doctor to understand my point of view and explain my own role as the primary instrument of the research (Peters et al. 2001a), rather than responding defensively and struggling to explain my rationale.

As Sparkes and Smith (2014) observe, REC’s may also lack an understanding of ethics as an emergent process. Although the approval process demanded in-depth analysis of how I would manage any anticipated risks to my participants or myself, it did not prepare me for the reality of the ethical tensions encountered day-to-day. An initial dilemma presented itself to me on my very first day in the hospital, during an appointment with a new patient. At the beginning of the appointment, each member of staff introduced themselves to the patient. As each person gave his or her name and role, I realised I did not know what to say. I worried that if I labeled myself as a student or volunteer, patients would see me as an unnecessary extra observer at a time when they were already under scrutiny from several medical professionals. Label myself as a psychologist, and the patient would likely assume I was a clinical practitioner. When I tried referring to myself as a psychology researcher, patients often pretended to grimace or flinch as though I was a stereotypical ‘shrink’. Eventually, I settled on referring to myself simply as a researcher. I felt that helped imbue my presence with a sense of legitimacy, as though I was there to do something useful, without creating expectations in the patients, thus allowing me to remain a passive observer during these appointments.

However, I quickly discovered the lines between researcher and staff member could be easily blurred, no matter how I introduced myself. Within a few weeks, patients were asking me questions about processes and procedures at the clinic, such as what would happen during a home visit, or whether he or she would be allowed to take the prosthesis home for the weekend. As my knowledge of the rehabilitation process, which now typically exceeded that of incoming patients, increased, so did my ability to offer an answer to their questions. Peters makes a similar observation (Peters et al. 2001a), noting that patients and their families often sought medical reassurance that she could not give as a volunteer and researcher. For Peters, the risk was that she would begin to act in accordance with her other role as a genetic counselor, thereby undermining her role as a researcher. Personally, I balanced a desire to provide information and reassurance with the knowledge that, in this environment, I was not qualified to do so.

Gouldner (1960) described a norm of reciprocity, which demands that we should help those who help us in order to create stable affiliation. In this instance, helping to provide patients with the answers they sought would represent an act of reciprocity for their letting me into their world, helping me to create the relationships needed to gain entry. Connolly and Reilly (2007) described a similar dilemma posed by the first author’s ethic of care during her interactions with participants: ‘Is this the role of an academic researcher? No. Is this within the bounds of qualitative inquiry, as we tend to understand it? Likely not. Is this the right and human thing to do in this circumstance? Absolutely.’ (p. 530). Whilst Connolly was able to provide the participant in question with informational resources, which I could not, I found alternative means of satisfying my desire to help. For example, I could explain to the patient that, whilst I was not able to answer their question, I could direct them towards someone who could, or approach him or her on the patient’s behalf. In my role as a volunteer, I could also perform small tasks such as fetching water, taking notes for the occupational therapist on a home visit, or providing a friendly ear to ease the boredom and loneliness of life in hospital, away from friends and family.

I usually feel honoured if a participant takes me into their confidence, seeing it as evidence of rapport and trust (e.g., Smith et al. 2015). However, patients sometimes shared confidences that presented me with such a dilemma that I almost wished I could un-know what I had been told. On one occasion, a patient asked me to fetch her reading glasses and wheel her outside for some air. When I picked up her glasses case, a number of cigarettes fell out. She exclaimed that I was not supposed to see those, and asked me not to tell anybody. The previous day I had been present during this patient’s appointment with the consultant, during which she told him she no longer smoked; she had a lung condition that might be aggravated by smoking, which also delays surgical healing post-amputation (Anderson et al. 2012). I was conflicted; respect the patient’s autonomy by complying with her wishes, or undermine her trust by telling a member of staff. As I debated with myself, I realised that if I told a member of staff about the patient’s request, I would be establishing myself in a position of superiority purely on the basis of our respective levels of health. I am no more medically qualified than the patient, so by making a health-related decision on her behalf, I would, at best, be overstepping my boundaries as a volunteer and researcher, and, at worst, discriminating on the basis of disability.

The British Psychological Society provides a useful set of ethical guidelines for researchers, which emphasise the importance of being sensitive to the dynamics of perceived authority over participants, and recognising their rights of privacy and self-determination. However, even these guidelines leave room for interpretation, recommending that researchers make ‘reasoned judgments’ and strike a ‘reasoned balance’ (The British Psychological Society 2014) between protecting participants and recognising their agency. In this instance, I complied with the patient’s request, and it later transpired that other members of staff were aware that she was still smoking, but accepted it as her decision. Such tensions are far more nuanced than anything I had come to expect through any ethical approval process, which focus on black-and-white issues such as poor practice, which can be managed in line with relevant policies and procedures. I have yet to encounter such a straightforward question of ethics, or to have sufficient time to consult a policy. Fieldwork requires a researcher to make decisions on his or her feet, responding to the ever-changing environment with openness, sensitivity, creativity, and insight (Tamminen & Crocker 2013). However thorough I believed my preparation to be, I could not have anticipated all the tensions, conflicts, and dilemmas that I would encounter. This is something all novice researchers and their supervisors should expect, and think in advance about how to identify and manage such dilemmas. Many of my supervisory conversations have focused on such issues, and have been invaluable in enabling me to learn from each experience. In addition, reflecting on my experiences after the fact (reflection-on-action) via my reflexive journal has improved my ability to reflect on situations that are ongoing (reflection-in-action; Schön 1983), often whilst walking between areas of the hospital, and to consider the implications of my actions.

# Conclusion

The aim of this confessional tail was to provide an honest account of my entry into a medical environment as an early-career qualitative researcher. In sharing my own experiences, I hope to offer a novel perspective as yet unaddressed by extant literature: that of a neophyte qualitative researcher with no prior experience of immersive methods. In preparing to embark upon this project, I found the lack of reports from other early-career researchers disconcerting. Whilst the findings of this confessional tale bear many similarities to those of more established researchers, their accounts failed to resonate with my fears about my lack of experience, knowledge, and credibility upon embarking on this project. My hope is that I have offered an accessible account that acknowledges the self-doubt that may accompany, and at times undermine, the research efforts of other newcomers. In concluding, I summarise the key lessons that I have learned, which may serve as food for thought for other early-career healthcare researchers entering into a period of fieldwork.

First, whilst the process of securing ethical approval for the project was frustrating, defending my research against the critique of those more experienced in positivist paradigms forced me to revisit my understanding of my underpinning philosophy. To those researchers whose proposals will not be subjected to such external scrutiny, I recommend engaging in a similar process through self-interrogation and debate with a supervisor or critical friend, to ensure that you are able to respond and act within an environment that favours quantitative approaches (Tracy 2010). Whilst I hope the increasing recognition of qualitative healthcare evidence will bring with it broader REC expertise across a range of paradigms and more appropriate questioning, for the time being, I advise other neophyte researchers to be prepared to defend yourself to those who do not share your beliefs. Hagger and Chatzisarantis (2011) provide a particularly useful overview of the criticisms often leveled at qualitative researchers by those operating from more positivist, quantitative paradigms. Be aware that this debate is likely to follow you into the research field.

Second, I encourage other neophyte researchers to be open with those around them, and to keep a reflexive journal. During the early days, I struggled with my perceived inability to find a role and my lack of knowledge of the behavioural and emotional rules at the hospital. I felt privileged to have been given access to this exclusive world, and ashamed at the feelings of shock, revulsion, and nausea that I experienced. Initially, I tried to cope with this alone, barely acknowledging my reactions even within my own reflexive journal. It took time to realise that by adopting these avoidant coping strategies, I created a cycle whereby the same experience simply repeated itself. Once I began to speak to other members of staff and my supervisors about the challenges I faced, and to honestly explore my experiences through my reflexive journal, my responses were quickly normalised. I came to understand that my negative reactions occurred not because I was incapable, but because I was a newcomer. Yet, I do not deny the importance of emotional management in healthcare contexts, particularly during interactions with patients (see Mann 2005). Indeed, it may be useful for researchers entering a medical environment to spend time learning about and practicing emotional labour within such contexts (Gray 2009; Hayward & Tuckey 2011). However, I also suggest researchers identify a safe environment in which they can openly share their emotions without fear of recrimination, be that in a journal or with trusted others.

I feared that asking questions would reveal an unacceptable lack of knowledge, however, asking questions of both staff and patients has proved to be an effective way of building relationships. I learned that my fear of revealing my inexperience was based on my own preconceptions, and not on the expectations of those around me, who understood that I do not have experience in this area and were happy to share their knowledge. On this basis, I believe the fieldworker does not require an extensive theoretical knowledge of the environment they enter, but a willingness to be open about that inexperience and embrace opportunities for learning. In my case, the tensions I experienced may, in part, have reflected my attempts to integrate with both staff and patient populations. Douglas and Carless (2010) describe seeking ways to place themselves both physically and emotionally alongside participants, and whilst my lack of medical expertise may place me alongside the patients, I feared it would create a barrier between myself and the staff. For me, the solution lay in my enthusiasm to learn, and encourage others to explore the impact their (in)experience, and their willingness to embrace that inexperience, may have within their own research context.

In concluding, I draw attention to a recurring theme throughout this paper: the importance of reflective practice. Wind’s (2008) concept of negotiated interactive observation ‘forces’ (p.87) researchers to reflect upon and openly discuss how we negotiate our way in the field, something to which I did not give enough thought prior to entering the hospital. As noted by Culver, Gilbert, and Trudel (2003), adopting a constructivist epistemology entails recognition of the complex and changing nature of rapport and trust with our participants, requiring a reflexive stance throughout the research process. In reflecting on such issues, I improve my capacity to recognise and negotiate the ethical complexities of day-to-day immersion in the field, respecting the rights of both my participants and the REC-approved protocols to which I must adhere.

I admit: there are times when I do not want to sit down and reflect. Reflection can feel time-consuming, tedious, and emotionally challenging: I do not always want to re-live a difficult experience by writing about it afterwards. It was not until another doctoral student described how reflective practice had benefited her throughout her fieldwork that I began to be more open, honest, and thorough in my reflections. Although the quality of my practice still varies, I am now able to recognise the benefits of engaging in reflection. Writing this confessional tale has, in itself, been an illuminating element of this process, as I try to give voice to my experiences and emotions and tell a coherent story of my entry into the research field. I am no ‘expert’ in qualitative research; I cannot leave readers with a skeleton key to unlock the secrets of medical fieldwork. I can, however, do what that colleague did for me, and offer up my own experience as a novice researcher who has started to learn.

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