

Reflexivity

A challenge for the researcher as practitioner?

Anne Arber PhD, MSc, RGN
Duke of Kent Building
University of Surrey
Guildford
Surrey GU2 7TE

a.arber@surrey.ac.uk

Abstract

In this article I focus on what it means have a dual identity as a practitioner and a researcher within an ethnographic research study in the context of a hospice. I discuss moments when I experienced the tension between the roles of researcher and practitioner during fieldwork. I discuss some of the difficulties of managing the boundary between closeness and distance in terms of the observer and participant roles adopted. I explore the challenges for the researcher with a dual identity and how methods of reflexive accounting enhance the credibility of such a study. Thus I document the lived experience of my fieldwork; my thoughts and feelings when the insider and outsider identities collide; and how the identity crisis that resulted was resolved.

Keywords: ethnography, hospice, reflexivity, access, fieldwork, observation,

Introduction

In this article I discuss the implications of being a researcher and a practitioner when carrying out an ethnographic research study within a hospice in the UK. I discuss the rationale behind my methodological decisions with reference to the practitioner/researcher boundary and how a degree of reflexivity is necessary when making methodological decisions. Reflexivity is the capacity to reflect upon one's actions and values during the research, when producing data and writing accounts and to view the beliefs we hold in the same way that we view the beliefs of others (Seale 1998, Gouldner 1972). Reflexivity is a characteristic of the ethnographic imagination and establishes the researchers' integrity, which is part of good ethnographic practice (Brewer 1994). I discuss what it means to be a researcher and a practitioner and how this dual nature was represented in my research and what it means for the data collected. I discuss how I experienced the feeling of being an 'insider', a practitioner as well as experiencing that of feeling an 'outsider'. I reflect on how such insider and outsider moments were revealed to me. I discuss the feelings, emotions and tensions that can occur in the researcher when s/he attempts to keep to a marginal positioning on the boundary between the practitioner and researcher identities and how this tension was resolved with reference to the lived experience of my research.

My study was conducted within the medical speciality of palliative care with a focus on how the palliative care team orientates to the concept of 'total pain'. The study was set up as a comparative study in three settings: hospice, hospital and community palliative care settings (Arber 2004). I am interested in the hospice and palliative care concept of 'total pain' (Clark 1999). Cicely Saunders, the founder of the modern hospice movement, sought to 'humanise' the dying process through the concept of 'total pain', the gestaltian notion that the social, emotional, spiritual and physical each entwined contributing to the 'total pain' experience (Saunders 1996). I was interested in how practitioners in palliative care orientate to this concept and how they talked about patients in pain. In this article I am going to discuss the fieldwork carried out within the hospice and community setting. In designing my research I was concerned with a number of issues, one of which was the sensitivity of the setting, where patients are generally extremely ill and dying. So when planning my research I wished to gather data with minimum disruption to work routines within the hospice. I was also concerned about avoiding the danger that my presence would interrupt the work of the staff and that my presence as an observer would cause

any undue distress to staff/patients. I was aware that many hospice staff would know about the concept of 'total pain'. For example they may have read about it and talked about it during their education and practice. So I wished to avoid a situation where I was exposed to the rhetoric of palliative care rather than the practices, which occur in this setting. My research design therefore included audio recording of palliative care team meetings and fieldwork concerned with observing staff during ward rounds and shadowing staff when visiting patients in their home. The concerns and constraints identified above are what I perceived to be important in designing my research. I sought to combine subjective and objective methods of data collection by combining observation with the audio-recording of naturally occurring data.

Framing the study: a naturalistic approach

I framed the study within the naturalistic paradigm of an ethnographic study. My intention was to spend time in the research field observing as much as I could of the action in relation to the problem of pain. The naturalistic approach to research includes attending to what informants tell you and beginning to understand what things mean to them (Gubrium & Holstein 1997). One of the difficulties of the naturalistic approach is that of maintaining 'distance', for example by getting up close to the action one might overlook the more interesting aspects of what is going on (Gubrium & Holstein 1997). Terms such as 'bracketing' and 'suspending' have been coined to alert the researcher to the issues of distance and the aim of objectivity when a researcher is studying one's own tribe for example (Pollner 1987). The issue of distance is important. As a nurse I am familiar with the medical world, its specialised language and culture and I feel at home in this world. This familiarity, I reasoned, might blind me to certain aspects of the setting that I took for granted. Thus I felt I needed to get as close as I could to the action but to balance this by stepping back so that an eye is cast on how everyday realities are experienced (Gubrium & Holstein 1997). It is suggested that to learn participants meanings, we need to not only be reflexive about our own meanings but to attempt to 'flow' with the experiences in the world that is studied (Charmaz 2004). Therefore I made a decision to audio record naturally occurring data such as nursing handovers and palliative care team meetings as well as shadowing and observing staff. Following Silverman (2001:159) data which is naturally occurring exist independently of the researcher's intervention, so to some extent this data has a degree of objectivity in that it is not 'researcher provoked' data. I felt that this

combined approach to data collection would enable a balance between closeness and distance, incorporating a degree of subjectivity by participating and observing in the field (making field notes), balanced by collecting naturally occurring data that was audio recorded. This combined approach may shed light on the tacit and implicit that may not be easily shared as they are taken-for-granted (Charmaz 2004).

Making contact, gaining access and acceptability

As an experienced practitioner in the field of cancer care I had a network of existing contacts on which to draw to enable me to gain access to a hospice setting. However, I still felt concerned about whether I would gain access. Back (2002) describes the 'real sense of trepidation' when it comes to beginning your research' and worrying about contacting people. For example Lawton (2000) an anthropologist found initial access to a hospice setting difficult. However, once she gained the trust of the hospice professionals in the day care unit she was granted free access within the hospice and successfully completed her research taking on the role of a volunteer. Hospice staff understandably feel protective toward their patients as they are usually very ill or have very advanced disease. While I was negotiating access to the hospice setting with senior practitioners I was also submitting the study to a local ethics committee and approval was granted for the study.

My first point of contact was with a local hospice. However the hospice was going through major organisational change and my key contact (a senior nurse) had left the hospice suddenly. I made a decision not to pursue entry to this hospice. From this experience I decided that when I approached another hospice I would make early contact with the medical director as well as senior nursing staff. I approached a second hospice. The senior nurse at this hospice was very interested in my research and she acted as my sponsor and I was given direct access to the Medical Director. Gatekeepers have the power to grant or block access within a setting and they have expectations about the ethnographer's identity and intentions. In this setting I felt that the gatekeepers were keen to sponsor research and to perhaps encourage good relations with the university where I worked. It is important as to ascertain whether the host community sees the researcher as an expert and thus someone to be welcomed or a critic and very unwelcome (Hammersley and Atkinson 1995). At this stage I believe I was being positioned toward the expert status rather than the critic as I had built up a

good relationship with the senior nurse. However, I did feel uneasy about being positioned as some kind of expert and I will come back to this later.

I was invited in to the hospice to meet with the Medical Director and he showed me around the hospice and introduced me to many of the staff. When we went into the community team office I realised I knew one of the community nurses as she had attended one of the courses I teach on. She greeted me in a friendly manner and the Medical Director said, 'She speaks well of you. This is payback time'. I realised that this link may help my acceptability with other staff.

Lawton (2000) describes how once she had developed good rapport with day care staff it was then easy to set up her second project within the hospice as the hospice staff had heard positive reports about her fieldwork. I had two concerns about going into the palliative care settings to carry out research. Firstly, if I was to be attributed with an identity as some kind of expert I didn't think I could bring it off. Of course I am familiar with aspects of hospice and palliative care but my own nursing experience is with patients with cancer. I have not worked in a specialised palliative care culture or hospice. I therefore consider myself an outsider within this context. Secondly, it may be thought that I was in some sense overly inquisitive and/or attempting to evaluate the work going on in such settings. To combat the potential for these concerns surfacing I worked to appear relaxed and agreeable. My goal was to enable all levels of staff to feel comfortable when I was around. I decided to carry off the research role by working at a demeanour of approachability, and to push the help I needed from them to accomplish my research. Coffey & Atkinson (1996) say that one cannot control how others perceive your participation. I agree with this but I believe you can manage it. My impression management was an outward demeanour of being friendly, to watch and listen, greet people, and to use good eye contact. I decided not to ask too many questions, as this in itself might be perceived as threatening to some people. This self-management did shape the data and meant that I would avoid asking too many questions unless invited to do so. I worked at my non-verbal behaviour and attempted to look engaged, animated, alert and interested in everything that was going on. This enabled me to have a degree of acceptability in such a setting I believe.

I wondered what social category the group would assign to me. I decided when explaining my research that I would emphasise the fact that I was a part-time research student combining my research toward a PhD while working as a lecturer. I felt that if I was perceived as an expert this would not help me as I

was not an expert in hospice work. Of course I did not want to be positioned as a critic. This would mean that people were defensive with me or might avoid me. I monitored this by paying particular attention to how I was greeted and non-verbal behaviour towards me. The social worker for example left a note for me with my name and the title she gave me was, 'research nurse'. The hospice medical director described me as 'a very, very experienced nurse tutor' when he introduced me to the community team. The nurses were concerned about who I was rather than what I wanted. For example the team leaders quickly found out about where I lived, that I had children and that they went to local schools. This identification helped to reduce feelings of social distance. I felt that the team leaders were going to help me and were not going to put obstacles in my way. In this context my social and family circumstances matched my hosts and this enabled me to present myself in a non-threatening way with the nurses. The ethnographer should create different self-presentations for different settings according to Walsh (2004). Being a mother and a nurse might help with some people but I also had to pass as a credible researcher someone who knows what they are doing when it comes to research. This identifies the dynamic nature of presenting oneself, which I found required constant work and monitoring of oneself and others' reactions.

I found that one of the most tiring aspects of being an ethnographer was finding a balance between the different roles one has to play. I believe that being constantly alert to how one is being positioned by the practitioners in the field as well as positioning oneself to get the best out of the situation as emotionally tiring. For example I always arrived at the hospice a little early so that I could get mentally prepared and psyched up for whatever would be required of me to access data. Indeed Li (2002) explores the distressing situation when her fieldwork was almost scuppered by a hostile member of the nursing staff. At this time Li experienced the emotional reaction of 'loathing and the desire to withdraw' described by Lofland & Lofland (1984). She managed to stay in the field and complete her fieldwork by getting good support within her research and supervisory network. Fortunately for her she found a sympathetic sponsor within the hospice team despite the resistance of one of the nurses. Many writers agree that in all stages of the ethnographic enterprise social relationships remain key (Coffey 1999, Walsh 2004, Hammersley and Atkinson 1995). I found that keeping on good terms with people, avoiding looking strained or irritable requires a degree of thought and emotion management similar I suspect to acting or going onstage (Goffman 1959). However, although social relationships need

to be smoothed and negotiated as access to data often depends on these relationships, rich data can also be acquired through being reflective when encountering resistance. Persistence can pay off even in hostile territory if one has the time to be patient and to get good support during the process (Lawton 2000, Li 2002).

Observer as participant

I prepared to take on the role of observer as participant within the hospice setting. This role achieves the balance in favour of observation over participation (Junker 1960). According to Junker most overt ethnography takes up a position between the observer as participant and participant as observer roles. Most writers agree that the marginal positioning is the best place to be (Junker 1960, Hammersley & Atkinson 1995). However this can be difficult and can cause some emotional strain in keeping this positioning. For example Frank (2004) says it can be difficult to keep your balance on a boundary in that we can fall back in to ourselves or forward into the other. This experience of falling in to the 'other' was experienced by Rager (200) who describes how she cried together with her respondents during her research involving women with breast cancer. Thus within a relationship one needs an acceptable level of distance and difference so that there is a space between two people to enable dialogue, according to Frank. Lofland & Lofland (1984) produce a typology of different sources of emotional stress caused by fieldwork namely, deception and fear of disclosure, loathing and the desire to withdraw, sympathy and the impulse to help, marginality and the 'temptation to convert'. For my own work the later two points are important. In the next section I will discuss the 'temptation to convert' to the complete participant sometimes referred to as, 'going native' and the pull back to being an observer. I will discuss this tension in relation to a visit with one of the community palliative care nurses.

'Temptation to convert'

I visited a patient with one of the community palliative care nurses. This was going to be a difficult visit as it had been presented problematically by the patient's district nurse (DN). The patient's husband was reported to have touched the district nurse inappropriately and Rachel the community palliative care nurse was quite anxious about this. This is what I recorded in my research journal:

1 What is all the fuss about? The patient's husband has had a stroke and sometimes
2 this sort of behaviour can occur. Why is Rachel so edgy about the visit? Perhaps it
3 is because she is in the late stages of pregnancy. She is glad I am accompanying
4 her on this visit. Perhaps I should be worried, there may be a 'scene' in the house
5 and perhaps Rachel may become upset.

14th November 2000 Extract from research journal

6 We visited Eileen today she looked slight, quiet, frail and worried I thought. I
7 wondered what exactly had gone on with the district nurse? Eileen's daughter was
8 with her and she was very welcoming and friendly. There was no sign of the
9 husband. As we entered the house I felt very alert and I surveyed the room and
10 Rachel settled herself in an armchair near Eileen. Then I found somewhere to sit
11 facing the door so I could see anyone entering the room and to my left there was
12 access to the kitchen. I was making a mental note of all the exits from the room
13 and I found myself rehearsing what to do should the husband appear and do
14 something that upset Rachel and the family. Rachel started her assessment and I
15 felt very alert and watchful. Rachel asked 'where is your husband?' and Eileen said
16 he was upstairs as 'he gets up quite late'. I wondered if he had been told to stay
17 upstairs until we had gone. After about one hour, I could hear the patient's husband
18 moving about upstairs. I thought 'oh no he is going to come downstairs now just
19 as we are about to leave'. I couldn't wait to get out of the house. But I kept what
20 I hoped was a 'cool demeanour'.

21st November 2000 Extract from research journal

When we visited the patient I suddenly found myself in a situation where I might have to take some action as I thought there might be a 'scene' in the house (line 4). I also was aware that Rachel was pleased I was accompanying her on the visit, perhaps then I had a part to play (line 3,4). I found I was worrying about physical and spacial safety by making note of all the exits and entrances from the room (line 12). I was rehearsing how to do emotional labour managing my own emotions (line 10) to prepare to save face for the family and for Rachel should an incident occur (Hochschild 1983, Goffman 1959). I was therefore completely involved in this situation thinking as a practitioner would; planning where to sit to get a good view of the room (line 11); making mental notes (line 12) and rehearsing in my mind what to do (line 13). I enjoyed the feeling of complete involvement and the fact that I had a part to play. I suppose I felt useful. Gerrish (2003) a researcher and also a trained nurse describes how she felt vulnerable when she visited a young woman with terminal breast cancer with the district nurse. She felt the district nurse was using her as a colleague, someone who could listen to the district nurses concerns and a sense of reciprocity developed. Unlike Gerrish I did not feel vulnerable but I did experience the sense of reciprocity with Rachel. Rather than being an observer, I was completely involved in this situation and I like Rachel was worried about this situation (line 18) despite my initial feeling of 'What is all the fuss about?' (line 1).

Having written down what happened in my research diary I forgot about this incident until it was discussed at the palliative care team meeting a few days later. When this visit was discussed in the team meeting I was asked a direct question about the visit:

- 1 Nurse R: But when I was asking about the husband, I wanted to know how he was two
 - 2 years ago, before the stroke, you know, because and they were very hesitant about coming
 - 3 forward with that weren't they?
 - 4 AA: Mm. Mm
 - 5 Nurse R: We didn't get, what I expected them to say was oh he was a lovely man. He was
 - 6 a lovely dad and it is such a shame. We didn't get any of that. She just looked down. So,
 - 7 you know, I'm not sure and apparently he's got a CPN as well and he goes to Smith wing
 - 8 to day-care because when he went to a normal day care he kept fondling everybody, he
 - 9 was, they put him in Smith Wing
 - 10 (Laughter)
- Audio-recording of palliative care team meeting*

Rachel sought my opinion about the visit at line 3, 'they were very hesitant about coming forward with that weren't they?' I could not frame a reply that I thought would be satisfactory, in effect I went blank. This was uncomfortable for me and I felt tense. I got over the incident by encouraging Rachel to continue to tell the story herself by my response Mm Mm (line 4). I felt I was letting Rachel down by not being able to construct a reply that would sound articulate and meet the expectation of the team. Rachel uses 'we' twice at lines 5 and 6. I believe that in this talk Rachel is positioning me as a member of the team, a colleague through her use of 'we didn't get' (line 5) and again 'we didn't get any of that' (line 6). Together 'we' observed and experienced what is reported by Rachel and furthermore this was discussed between us in the car on the way back to the hospice. However by not being able to reply in a satisfactory manner I felt similar to that described by actors as 'corpsing'. I was completely frozen and unable to respond in an appropriate manner. I now understood 'the fear of disclosure' identified by Lofland & Lofland (1984). I was not playing my part as an insider properly I was not able to offer a fluent reply and this was being displayed in the meeting I thought.

As the talk went on it became more humorous and in the next excerpt of data there is laughter at my reported reaction to the incident, which relieved the tension I was feeling:

1 Nurse R: He's does most of the time when he goes. I mean apparently he doesn't like it. He
2 kicks up a bit of a stink about it but most of the time he goes. So I think probably your safest
3 to ring. Make sure he's gone. He was upstairs when we were there (laughing). Anne had a
4 quick getaway in the kitchen didn't you? She worked it all out. We were all right. So it was
5 okay. But it was a bit very intimidating for carers and of course for her.

Audio-recording of palliative care team meeting

The story was told with some humour and there was laughter about the situation and my reported reaction to this situation, 'She worked it all out. We were all right' (line 4). In this utterance I am being presented as someone who 'worked it out' so Rachel is presenting me as competent in the situation even though I felt I could not respond as a practitioner. I also had not been able to tell Rachel that I was worried about her safety and the 'quick getaway in the kitchen' (line 4) was a strategy for me to be mobile and allow me to intervene if needed. This incident in the team meeting made clear to me the tension of being in a marginal place balancing involvement with detachment and I think this is what caused the feeling of discomfort (Adler & Adler 1994). I did not think I could maintain objectivity if I started to take on a status as a type of insider. A researcher who cannot stand back from the knowledge they have acquired may face analytic problems (Coffey 1999). I had not planned on being part of the action but clearly in this situation it was difficult to control. Participant observation is referred to as an 'oscillating situation' (Kirk & Miller 1986:7). The oscillating uncertainty on this occasion was around, which identity was going to be given, or withheld and the fact that I had to react in an appropriate manner. The tension that this situation engendered in me was similar to the identity crisis discussed by Jarvie (1969). He says it is not possible to be both a stranger and a friend and the identity crisis that may arise precipitates an integrity crisis and one role overrides the other to resolve the crisis. Thus for me the researcher role overrides the practitioner role at this meeting. My discomfort was relieved by Rachel's use of humour and I felt she 'got me off the hook'.

Ethnography is often conducted by members of a culture or related cultures rather than by complete strangers and these cultures are not homogenous (Coffey 1999). So according to Coffey one can interrogate what is a stranger or a member, or an outsider or an insider. She continues that a self is crafted through personal relationships and interactions between the researcher and those that are researched. Thus the issue of identity is not fixed but malleable. My role and identity was therefore defined and re-defined by myself and by others and this is what can cause discomforting feelings when expectations about identity

are not shared at any given moment. Similarly Stanworth (2004) describes how her status as a researcher was transformed into confidante, confessor, comforter and judge when researching the sources of meaning of people who are dying. This malleability and fluidity of identities given and taken is perhaps characteristic of all relationships. However such identities and roles can also constrain. I did feel uncomfortable when observing distressed patients and relatives. For example one day the doctor had some sad news for the relatives of a very sick patient. The relatives broke down crying. I felt in a dilemma 'what should I do should I try and offer some comfort to the relatives as a nurse would do?' I was aware that there was no nurse present. The tension between being a researcher and a nurse was arising again but on this occasion I kept the researcher boundary in place even though I felt very uncomfortable about this. I used my fieldwork journal to reflect on this experience. I note in my research journal 'one of the most distressing aspects of observing distress is not being able to have an active role in relation to this'. By this I mean that a nurse would have a part to play in consoling and comforting the relatives but a researcher can only witness the distress and write about it. For the researcher to become a nurse on this occasion I felt may cause some embarrassment for the team. Conversely it may have not been a problem for the team at all but a judgement I had made and a boundary I had put in place.

Strategies for enabling reflexivity

One of the ways of enabling reflexivity is in keeping a fieldwork journal. Keeping journals as distinct from fieldnotes enables one to keep track of theoretical perspectives and assumptions as well as keeping track of emotional reactions (Gilbert 2001). According to Lofland (1971:234) keeping a journal is not only for recording the setting but 'for 'recording' the observer as well'. Most researchers and writers agree with this and keeping a journal may enable understanding through self-reflection and avoid a tendency to self-absorption (Kleinman & Copp 1993, Rosaldo 1989). Thus closeness and distance is not only about experiences and reflection on the field but also about how one feels and the emotions that may be engendered. Recording of personal opinions, emotional responses and responses to being an observer according to Lofland (1971) enable the observer to keep track of such events, which may be useful later when looking for leads during analysis. This is a particular issue for those studying members of a group to which they have membership or professional affiliation (Edwards 2002). There may be particular problem for clinicians such

as therapists and nurses as they have to negotiate a research relationship rather than a therapeutic relationship. Furthermore the therapist or nurse may feel a tension between the role of nurse or therapist and researcher, as highlighted earlier (Arber 2004, Gilbert 2001).

I carefully completed a fieldwork journal every time I went in to the research setting. I also planned to give a conference paper on my fieldwork experience (Arber 2001). At this conference another researcher talked about his experience of ethnographic fieldwork describing how he felt scared to go into the acute psychiatric ward due to the threatening behaviour of a couple of patients (Quirk 2001). He expressed the same feeling that I had about getting myself psyched up to go into the research situation, but unlike Quirk I did not have a feeling of being scared but more a feeling of apprehension. I was not having regular supervision meetings during my period of fieldwork in the hospice therefore the feeling of isolation that could arise was balanced by belonging to a social network of PhD students with time spent socialising and discussing research informally (Wincup 2001). Other strategies have been suggested for dealing with the emotions engendered by research include counselling, peer debriefing/review, 'creating space' and relaxation techniques (Edwards 2002, Rager 2005). In fact Rager recommends that preparation for social science researchers to include information on appropriate self-care strategies to avoid 'compassion stress'.

Credibility and reliability

The types of 'self' that is presented within research may enable claims about authenticity such as 'being there' and to enable the reader to judge the validity of the whole enterprise by being transparent about the 'goings on' in the field (The 2002, Seale 1999). Credibility and reliability can be improved by firstly identifying the particular status position taken by the researcher, as this sheds light on what can and cannot be observed. For example Li (2002) was unable to observe 'critical moments' as staff indicated her presence in the patient's room was not welcome. Therefore some of the data she presents reflects her role as an outsider. As Lee (1993:6) points out the feelings engendered in researching sensitive topics such as death and dying mean that the researcher as well as the researched may have to share feelings 'of unease, discomfort or emotional pain'. These feelings may then affect what we are allowed and prepared to observe. Secondly it is important to be reflective about who offered data and the context in which it was offered. Finally there should be a full account of theories that

informed the research (LeCompte & Goetz 1982). These are all components of reflexivity and help the reader to assess the credibility of research findings according to Seale (1999). In fact part of an 'audit trail' of the research process should include independent examination of entries in the researchers' research journal identifying daily activities, and sampling techniques for example (Seale 1999, Lincoln & Guba 1985). I believe that documenting one's feelings and emotions about the identities and roles assumed and taken can also be a useful part of the audit trail. Participant observation is conscious work requiring the observer to understand the process of transformation, which s/he undergoes, by being present in the field (Baszanger & Dodier 1997). Thus during the research journey the researcher describes in what capacity s/he was present and the place s/he occupied in these events.

Discussion

In this article I explore the importance of reflexivity throughout the ethnographic research journey. The experience of being an outsider, an insider and on the boundary between these two roles can cause some strain for the researcher. I have reflected on some moments where I experienced being an insider and an outsider and the self-management involved to maintain my footing as a researcher and sometimes unexpectedly as a practitioner. The 'temptation to convert' is discussed as a seductive option as this allows a feeling of homeostasis across the insider outsider boundary, which enables the researcher to be 'at home' in the practitioner role. Having an identity as an insider allows access to data that may not be accessed by an outsider. Keeping a research journal, which documents the researcher's feelings and emotions, enables the ethnographer to remain cognisant of how the field and relationships shape the researcher and the research. Keeping a journal also enables the researcher as an embodied presence to be tracked and placed within the research as an emotional, feeling subject. For practitioners as ethnographers the credibility of one's research is dependent upon a degree of reflexivity about one's theoretical and methodological assumptions, and how these are experienced in field experiences.

Conclusion

In conclusion the ethnographer needs a level of preparedness for undertaking demanding fieldwork in the context of healthcare whether they have a practitioner/therapist background or not. A reflexive approach enables one to

understand how the researcher who is also a practitioner has an impact on those researched. It also means that a researcher with such a background should interrogate their own beliefs and feelings in the same way that they interrogate those of others. Thus at all stages in the research the impact of the researcher in terms of access to data, relationships in the field, and how one is addressed as a researcher, as a practitioner or both should be documented and become part of one's analysis. Good support is essential for the researcher including informal support such as that provided by one's colleagues and peer group. This is because the researcher requires a degree of self management and sometimes emotional labour to fit into the research setting, manage relationships and deal with untoward situations with some skill while maintaining the balancing act across the insider outsider boundary. Supervisors should be knowledgeable about how to support students appropriately for example listening to the student's experience, reading the fieldwork journal and encouraging regular supervision during fieldwork experiences. It is recommended, as part of good practice, that self care strategies such as 'time out', relaxation techniques, debriefing and counselling strategies should be discussed with the ethnographer and carefully considered before, during and after fieldwork experiences.

References

- Adler PA & Adler P (1994) "Observational techniques". In NK Denzin & YS Lincoln (eds) "Handbook of Qualitative Research" Thousand Oaks CA, Sage Pg. 377-92
- Arber A (2001) "Getting in and staying in: Negotiating and maintaining access to a hospice setting" Ethnography and Health Care Conference, Saturday 8th December, 2001 Royal College of Nursing, London
- Arber A (2004) "Building Reputation: the significance of pain talk in hospice and palliative care team meetings" PhD Thesis, Goldsmiths College, University of London
- Atkinson P (1995) "Medical Talk and Medical Work" London, Sage
- Back L (2002) "Dancing and Wrestling with Scholarship: Things to do and things to avoid in a PhD Career" Sociological Research Online, 7,4, www.socresonline.org.uk/7/4/back.html accessed 30/11/2002
- Baszanger I & Dodier N (1997) Ethnography Relating Parts to the Whole. In D. Silverman (ed) "Qualitative Research" London, Sage Pg. 8-23
- Brewer JD (1994) "The Ethnographic Critique of Ethnography. In C. Seale (ed) Social Research Methods A Reader" London, Routledge Pg. 405-411
- Charmaz K (2004) "Premises, Principles, and Practices in Qualitative Research: Revisiting the Foundations" Qualitative Health Research 14,7 pg.976-993
- Clark D (1999) "'Total pain', disciplinary power and the body in the work of Cicely Saunders, 1958-1967" Social Science and Medicine 49 pg.727-736
- Coffey A (1999) "The ethnographic self" London, Sage
- Coffey A & Atkinson P (1996) "Making Sense of Qualitative Data" London, Sage
- Edwards B. (2002) "Deep insider research" Qualitative Research Journal 2,1 pg.71-84
- Frank A (2004) "The Renewal of generosity: Illness, Hospitality and dialogue"
- Gerrish K (2003) Self and others: the rigour and ethics of insider ethnography. In Latimer J (ed) "Advanced Qualitative Research for Nursing" Oxford, Blackwell Pg, 77-94
- Gilbert KR (2001) "Introduction: why are we interested in emotions?" In KR Gilbert (ed) The Emotional Nature of Qualitative Research" London, CRC Press
- Goffman E (1959) "The Presentation of Self in Everyday Life" London, Penguin
- Gouldner AW (1972) Towards a Reflexive Sociology. In C. Seale "Social Research Methods." London, Routledge Pg. 381-383
- Gubrium J & Holstein J (1997) "The New Language of Qualitative Method" Buckingham, Open University Press

- Hammersley M and Atkinson P (1995) "Ethnography Principles in Practice" (2nd ed)
London, Routledge
- Hochschild A (1983) "The Managed Heart: the Commercialisation of Human Feeling."
Berkley, University of California Press
- Jarvie I.C. (1969) "The problem of ethical integrity in participant observation"
Anthropology 10,5 pg.505-508
- Junker B. (1960) "Field Work" Chicargo: Univerisity of Chicargo Press
- Kirk J & Miller ML (1986) "Reliability and Validity in Qualitative Research" London
Sage
- Kleinman S & Copp MA (1993) "Emotions and Fieldwork" London, Sage
- Lawton J (2000) "The Dying Process Patients' Experiences of Palliative Care"
London, Routledge
- LeCompte M and Goetz J (1982) "Problems of reliability and validity in ethnographic
research" Review of Educational Research 52,1 pg.31-60
- Lee RM (1993) "Doing research on sensitive topics" London, Sage
- Li S (2002) "Symbiotic Niceness: A Study of Psychosocial Care in Palliative Care
Settings" PhD Thesis, Goldsmiths College, University of London
- Lincoln YS and Guba E (1985) "Naturalistic Enquiry" Beverly Hills, Sage
- Lofland J (1971) "Analyzing Social Settings: A Guide to Qualitative Observation and
Analysis" Belmont, California
- Lofland J & Lofland LH (1984) "Analyzing social settings: A guide to qualitative
observation and analysis." Belmon CA:Wadsworth
- Pollner M (1987) "Mundane Reason" New York, Cambridge University Press
- Quirk A (2001) "Anxiety in Ethnography: studying life on acute psychiatric wards"
Ethnography and Health Care Conference, Saturday 8th December, 2001 Royal
College of Nursing, Cavendish Square, London
- Rager KB (2005) "Compassion Stress and the Qualitative Researcher" Qualitative
Health Research 15,3 pg.423-430
- Rosaldo R (1989) "Culture and Truth: The Remaking of Social Analysis." London,
Routledge
- Saunders C (1996) "A personal therapeutic journey" British Medical Journal 313
pg.1599-601
- Seale C (1999) "The Quality of Qualitative Research" London, Sage
- Seale C. (1998) "Researching Society and Culture" London Sage

- Silverman D (2001) "Interpreting Qualitative Data Methods for Analysing Talk, Text and Interaction (2nd ed)" London, Sage
- Stanworth R. (2004) "Recognising spiritual needs in people who are dying" Oxford, Oxford University Press
- The AM (2002) "Palliative Care and Communication: Experiences in the Clinic" Buckingham, Open University Press
- Walsh D (2004) Doing ethnography. In C. Seale (ed) "Researching Society and Culture" London, Sage Pg. 225-238
- Wincup E (2001) Feminist research with women awaiting trial: the effects on participants in the qualitative research process. In KR Gilbert (ed) "The emotional Nature of Qualitative Research." London, CRC Press Pg. 17-35