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The insight and challenge of reflexive practice in an ethnographic study of Black traumatically injured patients in Philadelphia

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Abstract

The integrity of critical ethnography requires engagement in reflexive practice at all phases of the research process. In this discussion paper, I explore the insights and challenges of reflexive practice in an ethnographic study of the recovery experiences of Black trauma patients in a Philadelphia hospital. Observation and interviews were conducted with twelve patients who were admitted to trauma-designated units of the hospital over the course of a year. During fieldwork, I learned the ways that my background as a professional nurse structured my way of being in clinical space and facilitated a particular interpretation of clinical culture. In analysis, reflection on subjectivities through which I designed this ethnographic research allowed me to see beyond my preconceived and theoretically informed perspective to permit unexpected features of the field to emerge. Reflexive practice also guided my reconciliation of key practical and epistemological differences between clinical ethnographic research and the anthropologic tradition in which it is rooted. I conclude that with careful reflection to the subjectivities that influence the research process, interdisciplinary clinically relevant applied interpretations of critical ethnographic work can be used to generate detailed knowledge across contexts in clinical care, nursing practice, and patient experiences.

Keywords

Critical research approaches; ethnography; inequalities in health; reflective practice

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Introduction

Subjectivities are our inner lives; they are the thoughts, feelings, and interpretations that are at once, exposed and changed, by the effort to understand lived experience of others (Biehl, Good & Kleinman, 2007). The integrity of an ethnographic inquiry is quickly diminished by avoiding the subject of self and one's own subjectivities in the research process. Yet allowing oneself to "fall into an infinite regress of excessive self-analysis at the expense of focus on participants" (Finlay, 2002b, p. 212)" risks losing sight of the purpose of the research all together. Recognition and integration of self-subjectivity at different phases of research can be difficult, especially for those entering the field for the first time as a novice investigator (Baumbusch, 2011). Nonetheless, fieldwork is an essential opportunity for development of engagement in naturalistic inquiry that challenges new investigators to

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reflect on: the origins of our subjectivities, the intersubjective in the research encounter, and how to use these insights to inform social critique (Finlay, 2002b).

Throughout 2012, I conducted fieldwork for an ethnographic study of the hospitalization experiences of Black trauma patients in an urban academic medical center in Philadelphia. The purpose of this research was to explore how race consciousness and other features of the urban social context influenced the process of recovery. Research on racial disparities in injury illustrate that Black people in the US, particularly in urban settings like Philadelphia, endure a disproportionate risk for violent injury and its physical and emotional consequences (Rich & Grey, 2005; Smith, Richardson, & BeLue 2009). Once hospitalized, Black patients are more likely to die from their injuries when compared to other racial groups with comparable injuries, economic characteristics, and geographic proximity to trauma care services (Shafi et al., 2007; Arthur, Hedges, Newgard, Diggs, & Mullins, 2008; Haider et al., 2008, Haider et al., 2012). The etiological factors that underlie racial disparities in injury are poorly understood (Gooberman-Hill, Fox, & Chesser, 2011).

Use of critical ethnography was ideally suited to the study of the socio-medical context from which racial disparities in injury recovery arise. The ‘critical’ in critical ethnography does not imply departure from traditional ethnographic approaches to a field of interest. Rather, it signifies that the focus of research is to address processes of injustice or unfairness within a particular social dynamic (Cook, 2005; Soyini, 2011). This framing draws on Foucault’s notion of critique, wherein the purpose of research is to challenge the epistemological certainties within institutions, systems of knowledge, and disciplinary practices (Soyini, 2011). Specifically, this ethnography was framed by Critical Race Theory (CRT) which required attention to the ways in which racialization influenced patient experience, knowledge production, and the relationship between the culture of trauma care and broader society (Ford & Airhihenbuwa, 2010). A CRT informed ethnography also required that the lived experience of people of color was privileged in research (Delago & Stefancic, 2001), rather than compared in the context of a Black-White binary which could oversimplify the social and political realities through which racial categories are culturally produced. For this reason, the experience of injured people who were identified as Black or African American by hospital staff, became the sole focus of research.

As a White researcher studying the experience of Black trauma patients and as nurse engaging in critical analysis of a familiar healthcare institution, reflexive practice became essential to how I addressed and interpreted the products of research. It also shaped the way in which I understood data as co-constituted by subjectivities that both I and study participants represented and expressed. The integration of reflexive practice within this ethnographic study was not a simple or precise pursuit. Rather, it was a fluid and encompassing process that required examination of the subjective and inter-subjective aspects of all phases of the research process (Finlay, 2002a). In this paper, I discuss the insights and challenges of reflexive practice, beginning with the design of the research through data analysis, and the ways in which I understood my position as both insider and outsider to the clinical field of inquiry and among the participants whose experiences I sought to understand.

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Discussion

In designing the research

For several years, I worked as a trauma nurse at a major medical center in Philadelphia and it was in this setting that I proposed to study the experiences of trauma patients during their hospitalization. When conceptualizing how I would conduct fieldwork in the clinical setting in which I was professionally familiar, I used reflexive practice to evaluate the benefits and disadvantages of this position. Nurse researchers have used ethnographic methods to explore the context and dynamics of clinical space (Robinson-Wolf, 1988). Familiarity with this context can filter out some of the complexities of clinical world, which may be unavoidably distracting to a non-clinician investigator (Kaufman, 2005) and permit specific attention to other domains of interest. At the same time, alliance with a particular institution, health discipline, or set of disciplines may hinder the ability to see the ways that institutional and disciplinary norms influence, or even mask, social phenomena like race consciousness in clinical culture. I decided that in order to interpret trauma care in the hospital, centered on the point of view of patients, I needed to distance from my position as both a clinical care provider and an employee of the institution in which I would conduct research. I ended employment and all formal clinical practice prior to beginning fieldwork.

The participatory nature of ethnographic study also required that I create a participatory identity in the context of each fieldwork encounter. In other hospital ethnographies, researchers have assumed a participatory stance by positioning themselves as a patient, clinician, or visitor (Van Der Geest & Finkler, 2004). I chose to approach my participatory identity as a visitor with an expressly articulated nursing background. My identification with the nursing profession, I believed, would confer a certain level of acceptance from both patients and clinicians during observations and interviews that took place in the hospital. I also perceived that knowledge of nursing practices would permit focused observations within the hospital, a field which non-clinician anthropologists have described as an "out-of-this-world place" where one is easily confounded by "what counts as normal and ordinary in terms of the progress of disease, medicine's responses, co-workers activities, and institutional procedures" (Kaufman, 2005, p. 12).

As a nurse-researcher planning to conduct an ethnographic study in a hospital using anthropological methods, I also needed to reflect on some of the potential incongruities between the practical and ethical norms of contemporary biomedical and social science traditions. I planned several strategies through which I interpreted a fair balance between informed content and the study of trauma care in the hospital in its natural state (Hoeyer, Dahlager, & Lyncoe, 2005). When introducing my research and the broad purpose of the study, I made clear that my role was as a researcher and not a clinician (Hoeyer et al., 2005). I always wore street clothes and not scrubs or any other garments that would suggest alignment with a clinical role or responsibility. When I observed and interviewed patients and clinician participants I made sure they were informed and consented to their position as a participant in research (Hoeyer et al., 2005). At the same time, I chose not to specifically introduce race consciousness as focus of the research, but rather, would describe that the study as exploratory and centered on the experience of Black trauma patients and their

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interactions in the clinical environment. Prior to initiating fieldwork, I introduced this broad aim of my research and recruitment criteria (any recently admitted trauma patients who were: 18 years of age or older, identified as Black or African American, and deemed clinically capable to provide informed consent) through email and presentation to all nursing and surgical clinicians in trauma-designated units of the hospital.

During fieldwork

When I began fieldwork and was a known presence on the trauma units, nurses and nurse practitioners helped guide me to eligible study participants. Without exception, I was directed to young Black men with gunshot wounds. Young Black men with violent injuries are well represented in the census of the trauma service of the Philadelphia hospital but they do not make up the majority of hospitalized injured patients. In order to create a more nuanced body of data, I learned that I need to purposefully recruit women and patients without violent injuries. This difficulty in recruitment was, in and of itself, an opportunity to reflect on the culture of trauma care in the hospital. The consistent identification of Black men with gunshot wounds as emblematic of the Black trauma patient population helped me to understand how race, gender, and violence intersected in a symbolically meaningful way in the Trauma Center's clinical culture.

I also learned that insider-status in the clinical environment offered access to hospital space and information. In a large medical center in which I carried myself with comfort, I could move through the hospital and acquire information from clinicians, secretarial staff, and security guards with ease. With a clinical background, I could also quickly interpret the multiple sources of publically displayed information about patients' injuries, whereabouts, and length of stay which likely would have been difficult to interpret as a researcher who had not spent lengthy immersion in a hospital environment. I infer that White privilege also played part in my access to the field. I physically resembled the predominately White clinical staff and it is likely that this offered the social advantages, benefits, and courtesies that accompany being part of the dominant racial group (Delago & Stefancic, 2001) in the context of the hierarchically-oriented hospital structure.

When I interviewed nurses and physicians, even in brief conversations, the content of our dialogue demonstrated a perception of shared insider's knowledge of trauma care. Clinicians were open, casual and disciplinarily-specific when offering their medical and social interpretations of participants' recoveries. A nurse who was exasperated with a participant, for example, described him to me as a "pain in the ass" for pulling out an IV and allowing the contents of medication to drip on the floor of his hospital. I believe her candor was influenced by the extent to which she thought I could sympathize and relate to the cause of her frustration.

In fieldwork, I learned that my insider-status in the clinical environment extended beyond how I was viewed and accepted by clinicians and hospital employees- it also shaped how I was viewed by participants and the ways in which I enacted my position as both a researcher and nurse. I learned that my nursing habitus, or my common sense way of being in the clinical environment which had been inculcated through years of professional training and

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experience (Bourdieu, 1977), was a surprisingly durable disposition which, in turn, structured my comportment in the context of research encounters.

One of my earliest reflexive insights was that I felt compelled to intercede when witnessing participants in severe pain or anxiety. As I became aware and recorded the way in which I felt obliged to help participants who appeared to be suffering, I recognized that the way that I offered nursing help could engender trust and rapport with participants. Jon (pseudonym), for example, was a 39-year-old man who had experienced an open fracture of his ankle. His injury caused severe and persistent neurological pain for much of the time he was hospitalized. When I would spend time with Jon, he would have to take breaks from our conversation to deal with his pain. Often, he would yell out or shake violently. I would suggest breathing and visualization techniques that I thought would help. I was witness to Jon's pain and would talk him through it, and with time, he began to open up more and more about his injury and the fears that it evoked in the context of his life world. He shared sensitive and painful details of abuse in his childhood, involvement in a criminal gang, and how he had experienced and inflicted violent injuries in the past. Jon also shared how his current injury renewed his deep anxiety that he wouldn't be able to provide sufficient income to support his family. Toward the end of his hospitalization, he referred to our interviews as "therapy," though he understood that my role was of a researcher and not a clinical care provider. The skills I had learned as a nurse, to witness pain experiences and to listen to patients in the context of their physical and emotional reactions, built the foundation for a rapport that developed a context for intimate fieldwork encounters.

Supporting Leonard (pseudonym), a 42-year-old man who had experienced multiple gunshot wounds through a painful experience, was similarly instructive. I was able to spend time and learn about Leonard's recovery over the course of more than a year, both in the hospital and at his outpatient clinic visits. On one visit to the outpatient clinic, Leonard was having a gastrostomy tube pulled out of his abdomen. In the outpatient setting, clinicians did not have access to pain medication other than a local anesthetic and Leonard was terrified of feeling more pain. Though reassured by the surgeon that the removal of the tube would only take a moment, he began to cry and tense his body in fear. I offered to hold his hand. After he agreed, I talked him through the procedure, as I would a patient in my care, and a rubbed his arm to soothe him as he wept for several minutes after the tube had been removed. This scenario was one in which I had participated in many times in my clinical practice. As a researcher, it was beyond the bounds of how I had planned to participate in patient experiences.

My motivation for shifting from a visitor-participant to clinician-participant in these examples stemmed from both research interest and an empathetic imperative. I was able to provide something to Jon's and Leonard's experience that I might not have been able to as a non-clinician doing the same work. These moments in which my clinical instinct compelled me to act in a nursing role were also essential for helping me to understand the ways in which patients' needs were not being addressed. I learned that this impulse to fulfil what I interpreted was an unmet nursing need was not an impediment to understanding the field in its natural state. These moments were important for interpreting aspects of the clinical

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culture that neglected patient needs or potentially added further injury to course of participants' recoveries.

Fieldwork experiences in which it was difficult to establish trust and rapport with participants despite my clinical orientation were equally as instructive. I disrupted the tenuous trust that I had established with Tim (pseudonym), a 34-year old man with multiple gunshot wounds, when I was not thoughtful about how I applied my clinical knowledge to my actions as a researcher. Initially Tim was eager to share the story of his injury and hospitalization. On the fourth day in which I would observe Tim's experience, I was able to interpret from the hospital navigation board that he was due to be discharged home. I didn't know that Tim was angry about being discharged home. I also was unaware that he had been hostile toward the nurses who had cared for him overnight. After I causally told Tim that I saw he would be going home, he told me he didn't want to participate in an interview, turned his back, and called a friend. I attempted to find closure in the encounter and offered to come back a later time. He would not speak to me directly but referred to me on the phone as "this White lady" who wouldn't leave him alone.

I left Tim's room feeling unsettled. I recognized through this interaction that Tim may not have trusted me or valued, at that moment, participation in the research through which our relationship was based. By referring to me as "this white lady" I also recognized that he was evaluating or, at very least, responding to my role as a researcher in light of his gendered and racialized interpretations of who I was. I interpret that these perceived identities had meaning for how Tim accepted my presence in his hospital room and at a time when he felt disregarded by a predominately white female clinical staff in their choice to send him home. This interaction was uncomfortable but it yielded two important interpretations. First, clinicians doing research in a clinical environment need to be vigilantly conscious and thoughtful about how taken-for-granted clinical knowledge is communicated to patient participants. Second, race consciousness may not be overtly discussed, but for both the researcher and participant it can have significant implications within the ethnographic research encounter.

Patrice (pseudonym), a 72-year-old woman who had suffered several rib fractures following a fall, interpreted that I had a connection with her clinical care team and was therefore hesitant to speak freely. She consented to participation in the research but would only share her interpretations of her interactions with clinical staff in hushed tones and when she felt assured that none of the hospital staff could hear her. After two days of observation and interview, she would only speak to me for brief periods of time and unlike her earlier interviews, would offer simple platitudes about her experience in the hospital. When I asked her why, she explained: "I think they are upset that I am talking to you." At the time, I was frustrated and felt that I had failed to explain the intent and anonymity of the research in sufficient detail to gain Patrice's trust. When I reflected on this experience, I recognized that I had interpreted the situation centered on my sense of rejection. When shifted perspective to what Patrice was telling me, I recognized the importance of her interpretation that participation in research would threaten the care she received. Her belief that care was contingent on acquiescent and non-judgmental expressions of hospital care processes illustrated the vulnerability she felt in her agency and control as a patient in the hospital.

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In data analysis

In field notes, I integrated my nursing-informed observations and the ways that I felt this background influenced interpretation of the clinical environment. Analyzing the ethnographic data I collected during fieldwork offered other opportunities to use reflexivity to contend with the ways that my subjectivities influenced the products of research. The advantage to the flexibility of ethnographic research is that I could learn about how hospitalization was experienced by participants from multiple vantage points and with extension into areas of life that might not have been reached had interviews or observation been more circumscribed. However, the data that emerged from each field experience differed in tone and content, which was a challenge to compare across time and participants. I also had very different relationships with each participant so the subjectivities that influenced my interpretation, also changed from day to day and person to person.

I chose to transcribe all of my recorded interviews and field notes as a first step in analysis in order to contend with the challenge of the volume and variability of the ethnographic data I collected. Close listening to the conversations and interpretations that emerged in early fieldwork allowed me to adjust the intent and construction of future interviews and observation to explore consistent or counterfactual content across participants' experiences. The process of listening to recorded interviews also helped me understand the tone and content through which I structured interactions with participants. I realized, for example, that silence seemed to make me nervous and would motivate a jump in topic whether or not a participant might have completed their line of thought. This was useful to encourage more mindfulness during future observation and interviews, to allow for silence to exist, unmitigated, and create more space for in-depth and unexpected conversation to emerge.

I analyzed transcripts and field notes from the first few participants to reflect on the ways I established trust and rapport. I realized that I often used positive affirmation, like "of course" or "that's understandable" to encourage participants to share their stories in more depth or detail. I also noticed that I often referred to the hospital's clinical staff as 'they,' as in, "what did they tell you about your surgery?" to establish alignment with the patient perspective and distance myself from connection to the hospital staff. In later fieldwork, as I became more aware of my communication, I was able to maintain more purposive consciousness in these areas. I became less likely to affirmatively qualify participant responses. I also more consistently avoided alignment with or departure from other clinicians so that I could privilege how and what participants described their own experiences with hospital staff.

Reflexive practice was most instructive when I found that my analysis yielded a story that was not satisfactorily explained by my preconceived interpretations of trauma care and the critical theory from which I planned my research. This study was designed to explore race and racialization in trauma care processes. The data derived from fieldwork, however, offered a much more nuanced interpretation of the relationship between race and injury in the context of a Philadelphia hospital. I learned the way that patients understood their injury and experience with hospital staff was informed by their complex life-worlds that included racial identity but was also influenced by previous injuries, poverty, residence in segregated communities with high levels of violence exposure, and persistent psychological and emotional distress. In observation of patient-clinician interactions in the hospital

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environment I interpreted that race consciousness was a present and important aspect of the social environment in which trauma care was provided. However, interactions seemed similarly influenced by clinical and institutional habit. The patient's life world, beyond their physical body, was rarely the object of attention from clinicians and other hospital staff. This left recovery from the many psychological and social consequences of traumatic injury, only partially addressed.

Conclusions

Reflexive insights guided the design, data collection, analysis and interpretation of this research to explore the experience of Black traumatically injured patients within the clinical culture of trauma care in Philadelphia. These insights were as important as any observational and interview data I collected. In keeping with the critical foundations of ethnographic inquiry, I recognize that I, with all of my subjectivities, co-created the story that I tell about experiences of the Black injured people and the clinicians who care for them. The process of that co-creation is a relationship and a discourse that generates the "cooperative and collaborative nature of the ethnographic situation" (Tyler, 1986).

Working from the margin of clinician- researcher was one form of subjectivity that I brought to this ethnographic research. Rather than attempt to separate my clinically informed interpretations, I allowed my nursing-informed observations and inferences to be part of the ethnographic record as data. I took notes on what captured my attention both from what participants expressed to me and what I saw during observation of a clinical environment with which I was familiar. I learned that these clinically informed interpretations could only have emerged in my position as a researcher. Moreover, the time and tempo afforded by the ethnographic research process allowed me to see patients, clinicians, and hospital environment in new ways. As a nurse with a defined set of daily and normative tasks, I had never noticed the extent to which patients are left alone and isolated in their hospital rooms. Conducting this research then prompted me to ask patients to describe how their injury and hospitalization made them feel about themselves and the extent to which they felt marginalized or supported during trauma care processes. I also came to understand that in such a deliberate and careful examination of patient experience, my clinical instincts were not a barrier to understanding how patients felt. Rather, they served to signal particularistic critique of the way that trauma care in a busy urban trauma center environment is currently enacted.

The learning curve of reflexive practice in ethnographic research was in and of itself an extra data set and, in a way, a secondary inquiry (Hess, 2009). It created the opportunity to understand subjectivity, not as a static state of being, but as an evolving field of influence on research and its products. Reflexive practice was also important as a source of motivation when contending with the practical and epistemological differences that divide clinical ethnographic research necessarily completed in the biomedical context, from ethnographic methods and an anthropologic tradition in which it is rooted. Many clinical ethnographies completed by nurses do not afford sufficient time and resources to create a robust and reflexive ethnographic recording of the inquiry. As in other qualitative inquires, there are also challenges to aligning the practical and ethical framing of research with, for example,

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the standards of human subject protection as interpreted by biomedically oriented Institutional Review Boards (IRBs) (Opsal et al., 2016). Finally, the small sample sizes, concerns over lack of generalizability and use of interpretive analytic techniques similarly often fall beyond the bounds of what many in clinical disciplines label as science.

Interdisciplinary clinically relevant applied interpretations of critical anthropologic work nonetheless hold important advantages for improving clinical care, nursing practice, and patient experience across multiple settings and contexts (Hopper, 2013; Messac, Ciccarone, Draine, & Bourgois, 2013). Such work privileges problems in institutional and public healthcare that might otherwise be overlooked or considered unmeasurable using the tools and gaze of quantitative sciences. And for clinician-investigators reflexive practice is essential to all aspects of the critical ethnographic pursuit. It can motivate scientific investigation when clinical situations to which we have become clinically accustomed feel inhumane, document the social knowledge that emerges when we are compelled to intercede on a participant's behalf, and remind us how these moments of reflection and consciousness, in and of themselves, have an important story to tell.

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