Abstract

Purpose: To offer methodological reflection on the complexities of being an insider ethnographic health service researcher.

Methods/data: Taking ethnographic fieldnotes that describe an observed episode of midwifery care in a UK-based maternity service, the shared identity between the researcher and research participant will be explored as being at once comfortably shared, while at the same time, a source of pernicious estrangement. The methodological reflections came from a study investigating the work midwives (n32) did, in a range of intra-partum (labour and birth) settings, when making sense of the concept of risk. Data were collected during fieldwork carried out in an NHS maternity service offering intra-partum care in four distinct clinical settings: the home; freestanding midwifery-led units (n2); alongside midwifery-led units (n2); and obstetric-led units (n2). Fieldnotes were compiled over a period of 13 months.

Conclusion: Detailed interrogation of the potential tensions that can arise out of a common identity shared by both the ethnographic researcher and the participant helps to expose some ethical dimensions of insider ethnographic research in clinical health care settings.

Highlights

- Explores the ethical domains of shared professional identity between the ethnographic researcher and research participant
- Contributes to the insider/outsider researcher identity and methodological debate
- Critically evaluates the role of the 'indigenous ethnographer' in high-income health care research

Title

Professional symmetry in clinically based ethnographic research: an asset or a liability?

Introduction

Health service ethnography in England has a legacy that stretches back to the latter part of the last century (Kleinman, 1999; Pope & Mays, 1995; Savage, 1995). By using ethnographic methods, researchers have been able to immerse themselves in the everyday running of health care settings to gain greater insight into the complexities in health service provision (Dixon-Woods, 2003). Or as Cubellis et al. (2021 p.1) put it:

> 'long-term ethnographic inquiries can provide nuanced insights in the context of health services research and related fields of studies'

While it has been suggested that, through its attention to detail, ethnography is helpful for investigating issues such as patient centredness, clinical safety, health seeking behaviours and practitioner errors in both low- and high-income countries across the globe (Grant et al., 2017; Liberati et al., 2015; Taxis & Barber, 2003; Webster et al., 2015), it is not, as Dixon-Woods (2003) points out, 'for the faint hearted'. The ethical dilemmas that can arise out of ethnographic immersion in the field can be challenging because the researchers are implicated in the clinical decision-making of their participants.

In what follows, a brief overview of the identity works that ethnographers face in pursuit of their nuanced insights will be explored. Critical reflections on an ethnographic discourse analysis (Gwyn, 2002) I conducted as a qualified midwife and medical anthropologist will be used to expose some of the latent liability inherent in the professional symmetry I shared with the midwife I was working with during one particular observation episode.

The purpose of the Economic and Social Research Council-funded study from which this article draws was to investigate the meaning making of risk undertaken by midwives working in the south of England. This research came out of a concern over the ever-increasing litigation burden to the

National Health Service (NHS) of maternity care in the UK and the impact this has on how midwives understand risk during intra-partum care. Drawing on a single observation episode from this study, I try to demonstrate some of the ethical domains inherent in the ethnographic project where the researcher positions themselves as an insider in the professional health care community they are investigating.

In the final section of this article, the reflexive oscillations taken from the ethnographic fieldnotes are worked together with methodological literature in an effort to further understanding of the ethical domains involved in being an insider ethnographer in a health care setting. While the original proposition behind the insider ethnographer may have been part of the de-colonisation project aimed at ridding the methodology of its imperialist and politically suspicious legacy, the conclusions from this article are that the application of this approach in high-income health care settings should never be considered to be ethically or clinically neutral.

Mapping the insider/outsider researcher debate

With the expansion of the ethnographic method in health research, interest in the identity work of the ethnographer in this body of literature has gained more attention (Burns et al., 2012; Coffey, 1999; Gair, 2012; Labaree, 2002; Ledger, 2010; Leslie et al., 2014). In health service research, the notion of the insider ethnographer not only includes membership of social groups into which the ethnographic researcher is born – racial, ethnic, gendered, etc. – but also practitioner groups into which the researcher has been initiated through the formalised processes of education and socialisation (Good & Good, 1993). Health service research has helped to expand insider/outsider debate in relation to identity in ethnography to include a broader notion of community membership.

Concerns about identity, and by association the authenticity of representation, have been at the heart of ethnography since its early anthropological inception (Malinowski, 1932). Having originally set out to adopt a detached, impersonal approach, whereby the researcher was present in the field to look *at* people rather than work *with* people (Denzin, 2002), ethnographers during

the latter part of the 20th century adopted a more reflexive approach where their identity as researchers was foregrounded in the creation of the ethnographic text (Clifford & E., 1986; Crawford & Hafsteinsson, 1993). The identity of the researcher, which had been previously conveniently ignored in the ethnographic project, became central to the methodological debate (Denzin, 2002; Stanton, 2004). During this period of ethnographic development, the *indigenous ethnographer,* or insider researcher, particularly those from low-income countries, was positioned as a solution to the potential harms of more realist and colonialist approaches to ethnography that had historically been carried out by those from high-income countries (Tengan, 2005; White & Tengan, 2001). Autoethnography took the debates surrounding embodied identity further by questioning the authenticity of stories of an essential self (Reed-Danahay, 1997).

In the context of ethnographic health service research undertaken in countries with well-developed health care systems there is a general consensus that practitioner status helps researchers with issues such as access into the field of study, language and acceptability (Borbasi et al., 2005). Notwithstanding such benefits, the insider researcher has been described in some of the health service methodological literature as either teetering on the edge of a dichotomy between their potentially antagonistic insider/outsider identities – the practitioner versus the researcher (Acker, 2000; Borbasi et al., 2005; Meijl, 2005) or, alternatively, the insider researcher has been positioned as occupying spaces that exist between different identities that are not so much juxtaposed but tethered together on a kind of continuum through the research activity (Breen, 2007; Kearns, 2000).

Recent methodological debate surrounding the insider ethnographer in health service research has turned towards the tensions which can arise within professional symmetry in the researcher and participant relationship (Blythe et al., 2013; Burns et al., 2012; Ledger, 2010). Within this literature, polemic understandings of the insider/outsider research relationship have been found to be lacking, as the researcher is understood to be constantly negotiating many possible ways of being both within and between their insider and outsider identities.

Using a reflexive account of what might broadly be described as an indigenous ethnographer's experience of working in the field, this article aims to contribute to this critique through an exploration of the slippery and unsettling nature of the commonalities shared between an insider researcher and a participant, where both were midwives. It is the contested nature of the midwifery professional identity in England (Page, 2017) and elsewhere in the world (Blaaka & Schauer Eri, 2008; Larsson et al., 2009; O'Connell & Downe, 2009) which helps to make sense of some of the concerning ethical implications of the slipperiness where commonalities, as well as differences, within a shared identity – within professional symmetry – coexist.

The study

The study from which this exploration of the ethical domains of the insider ethnographic research relationship emerged, was a 13-month ethnographic discourse analysis (Gwyn, 2002) project carried out to investigate how English midwives working in the south of the country make sense of risk through their talk and practice in the intra-partum care setting. This study was undertaken in a public maternity health service within an NHS Trust where all maternity care is free at the point of access. The maternity service offered intra-partum (labour and birth) care in four different settings: the women's homes; freestanding midwifery-led units situated in the community some distance from the acute hospital; obstetric-led units; and alongside midwifery-led units, both situated within the acute hospital site. Further details on this study's setting, design and findings have been reported elsewhere (details removed for blinding, 2011, 2014, 2015, 2019).

The project, funded by the Economic and Social Research Council, used observation of situated talk and practice that took place in all four birthing settings as its central data collection technique. Whether these observations can be described as participant observations, from the insider ethnography point of view, is debatable. Although I secured an honorary contract with the Trust to conduct the research, this contract did not entitle me to practise as a midwife. I had submitted no statutory intention to practise in this clinical setting (a regulatory requirement at the time of data collection), and it was only my registration as a practitioner that obligated me to act as a registered midwife in this context (Nursing and Midwifery Council [NMC], 2004a, 2004b, 2008).

The ethnographic observation described in this article took place in one of the NHS Trust's high-risk obstetric-led units. The fieldnote entry includes a senior midwife (pseudonym Rachael), who was involved in transferring a labouring woman (pseudonym Poppy) from a low-risk birthing facility – an alongside midwifery-led unit – to the high-risk obstetric unit – labour ward.

Ethical approval

Written consent and sequential verbal consent were gained from all those involved in the study, and all transcripts and fieldnotes were 'cleaned', with identifying features removed, prior to analysis. Ethical approval was sought through both national and local NHS Ethics, and full approval for the study was granted prior to commencement of the fieldwork. The project protocol was reviewed and approved, prior to the commencement of data collection, by the NHS Trust's Research and Development governance team, the Head of Risk, Assurance and Legal Services and the Head of Midwifery. The researcher had an NHS licence to practise as a maternity care assistant for the duration of the data collection period.

Meeting Poppy and Rachael

The fieldnote entry below describes Poppy's care as she is entering into the final stages of her labour. Poppy, a second-time mother, has just been transferred to a high-risk, obstetric-led unit for continuous electronic fetal monitoring due to meconium-stained liquor (amniotic fluid that is contaminated by the baby's bowel motion). Up until the point where this fieldnote entry begins, Poppy's care had been provided in a low-risk unit situated in the hospital (an alongside midwifery-led unit) run exclusively by midwives. This care included labouring in a birthing pool.

> "Poppy seemed resolute. Although all her hopes for a water birth had been dashed the minute her waters had broken (showing that the baby had opened its bowels), she seemed to be determined to make the best of what I imagined she considered being a suboptimal situation…
>
> Once transferred from the birth centre into the acute unit, Poppy continued with her plans for an active birth. She simply ignored the bed, which was positioned centrally in the room, and used it as a support to help her stay on her feet. She began to moan with each contraction as she gently swayed her hips from side to side.

> Rachael (the midwife), having attached the CTG (the continual electronic fetal monitoring machine) and checked that the fetal heart tracing was reassuring, left her to it, busy filling out all the necessary paperwork; meaning that poor Poppy was left unsupported.
>
> I felt powerless; I knew the pressure Rachael was under to get all the paperwork up to date. Post transfer, staff relations are at best strained and eyebrows are often raised, but there was nothing I could do to assist."
>
> (Observational notes excerpt)

As I watched this scenario unfold, I had a sense that my allegiances were shifting. The idea of a homogenous, shared identity between me and Rachael began to evaporate as possible ways of being a midwife competed. My desire to be a supportive colleague by being helpful to the midwife I was working with, who was having to cope with the bureaucratic demands of the organisational setting, was gradually displaced by another competing midwifery identity.

Up to the point shortly after Poppy's transfer, my actions during the observation were driven out of a sense of professional empathy. Rachael and I had a mutuality that could only be gained through a shared, professional experiential knowledge. For example, my insider knowledge of the staff dynamics involved in transferring a client from a low-risk to a high-risk caring environment during labour allowed me empathy for Rachael's predicament. Although both units are staffed by midwives, loyalties in these circumstances tend to run along clinical settings, rather than professional boundaries, rendering transfer relationships tense, and revealing some of the less coherent dimensions of the professional identity work midwives do when working in England.

As the birth of Poppy's baby became more imminent, the tentative nature of the overlaps between my and Rachael's identity emerged. As a different facet of my professional identity took hold, one where my empathy for Rachael was all but subsumed, the mutuality of space Rachael and I shared began to fracture. This fracture in the research relationship was born out of our shared identity, our sameness. It was a fluidity within our shared identity that unsettled our relationship.

> "I watched and waited for what seemed forever to see if Rachael was going to offer Poppy support. She didn't say a word. *I couldn't bear it!*
>
> I walked up behind Poppy and put my hand on her lower back, quietly congratulating her on how well she was doing. We began to sway in rhythm together and as we did so her movements became stronger and she went to crouch towards the floor, giving a guttural growl. I was encouraged by the noise and looked behind me to hand over to Rachael. I battled with an almost instinctual urge to position myself to 'catch the baby'. At the sound of Poppy's cry, Rachael looked up and ordered Poppy on to the bed. 'If you are not careful you will have this baby on the floor!' she remarked.
>
> I watched as a perfectly calm mother, engrossed in the act of spontaneous birth in an upright position, suddenly became confused. She started apologizing for pushing; explaining that she couldn't help it. She tried to follow Rachael's instructions and get on to the bed but each time was overwhelmed by another contraction accompanied by an urge to push.
>
> Rachael was very persistent, however, and insisted that Poppy move, even though she was clearly in pain and distressed by the efforts."
>
> (Observational notes excerpt)

There is a clear disconnect between this observation excerpt and the previous one. While both entries were written during the same observation episode, the first was written before the birth of Poppy's baby; the second afterwards. This temporality, I believe, is important because it captures the moment when the heterogeneity within the midwifery identity was most keenly felt by me, Rachael and, of course, Poppy.

At the point when I walked towards Poppy – at the point I reached out to touch her – I chose to abandon the common ground that operated to unite me with Rachael's rationale and activity. This choice had ethical ramifications. Through my hands and my body, a different midwifery identity crystallized; an identity that privileged my experiential knowledge of being a vulnerable birthing mother myself. I chose to embody a specific set of professional priorities I knew might not have coincided with those held by the midwife responsible for the care. Truthfully, at that moment in time, it never occurred to me to be more cautious; nor did I spare a thought for making

more effort to reflect Rachael's practice priorities. My preoccupation with my own understanding of what kind of midwife I am and my embodiment of that understanding simply did not allow it. In positioning Poppy for a standing birth, I had assumed – wrongly, as it turns out – that, if I was able to facilitate this birth process by trying to instill Poppy with a sense of confidence in the upright position, I would make Rachael's task much easier. In reality, however, my actions challenged Rachael's practice, undermined her authority, made her midwifery tasks more difficult and, most importantly, confused Poppy. All these consequences arose directly out of the knowledge I possessed as an insider researcher.

Discussion

By scrutinising the complexities involved in the ongoing and dynamic formation of my identity as an insider, as a full member of the group I was investigating, I have been able to confront some of the methodologically concerning and ultimately harmful elements of indigenous ethnography in developed, high-income health care settings. Without question, capitalising on my insider identity provided me with certain advantages in terms of access and acceptability; none of which should be underestimated. Without this status, it is unlikely that I would have ever witnessed the birth of Poppy's baby. Because I was a midwife, the service users and providers I encountered during my observations found it easy to talk to me and I was able to enter the NHS birthing environment, both inside and outside of the labour care room, with relative ease. Such practical advantages, however, should never be simply assumed to be nebulous.

According to the National Institute for Health and Care Excellence (NICE) guidelines relating to intra-partum care for healthy women and babies, women giving birth in any setting in the UK should be supported to mobilise as much as possible and change position (National Institute for Health and Care Excellence, 2014). The guidelines go so far as to suggest that supine (lying down on your back) should be avoided during labour and birth. In choosing to touch Poppy, I set about following this guideline in a way that embodied a particular kind of midwifery identity. With this touch, some of the commonalities I shared with Rachael slipped away. By taking this step, I appealed to a version of midwifery identity that did not coincide with the midwife I was working

with and who, ultimately, was responsible for the care of Poppy and her baby. As this version of midwifery crystallized into action, I successfully set Poppy up for a standing birth (my favourite!) that, in this context, could never be realised. In so doing, I was responsible for causing harm not only to the midwife I was working with but also to the labouring woman in her care. Had I not encouraged Poppy, had I not suggested through my hands, through my body, through my touch, that what she was doing was acceptable, and that having her baby in the standing position would be possible, perhaps she would not have been so surprised by Rachael's instructions to sit down on the bed. In other words, my insider status and the decision I made as an insider was an ethical liability.

My own experience of being positioned as an insider researcher, described in this article, goes some way towards illustrating the moral and clinical complexities insider ethnographers face when working in health care settings. By focusing on the complexities within the insider's identity, rather than the space that lurks between what are often described as competing identities – the researcher and the insider – (Allen, 2004; Bonner & Tolhurst, 2002; Breen, 2007; Burns et al., 2012; Dwyer & Buckle, 2009; Gair, 2012; Kanuha, 2000), the harms that can be inadvertently caused by the indigenous ethnographer can be exposed. While concurring with Breen (2007), Burns et al. (2012) and the like, that the ethnographer does much work in the spaces that exist between various concurrent identities, the reflexive fieldnotes in this article draw attention to the ethical (or in this case unethical) work researchers do when constructing their situated identities as an insider. Moreover, this article reveals how my identity as an indigenous ethnographer in this project operated to cause more harm than I cared to admit at the time of my data collection. While branches of the ethnographic project, such as critical ethnography and autoethnography, have offered fertile ground for engaging with the multifaceted nature of the identity work undertaken during research, I feel that the anguish exposed by this article calls for a broader engagement with the issue in all types of insider ethnographic health service research.

Conclusion

In this article, extracts from ethnographic fieldnotes have been used to explore the complexities that exist within shared identities when the research is an insider. This exploration helps to expose some of the ethical dimensions of the ethnographic research relationship in health care. Using an embodied experience of being a practitioner/researcher investigating midwifery talk and practice in England, I have suggested that the researcher has much work to do when negotiating their identity, even, or especially, when they are an insider, belonging to the group being studied. Through a detailed interrogation of my fieldnotes, I have grappled with some of the challenging ethical domains, inherent in my professional identity orientation, faced during my ethnographic research.

In conclusion, I propose that insider researcher identity is neither straightforward nor neutral. My experiences in the field confirmed that the identity, whether it be insider, outsider or in-between the two, is neither fixed nor stable but is a process of ongoing negotiation between what can involve at times competing subjectivities. The complexities that I confronted in this article came out of a multiplicity that originated from spaces within my and Rachael's commonly shared, group identity – our professional symmetry.

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References

Acker, S. (2000). In/out/side: Positioning the researcher in feminist qualitative research. *Resources for Feminist Research*, *28*(1/2), 189–208. ISSN: 07078412

Allen, D. (2004). Ethnomethodological insights into insider–outsider relationships in nursing ethnographies of healthcare settings. *Nursing Inquiry*, *11*(1), 14–24.

Blaaka, G., & Schauer Eri, T. (2008). Doing midwifery between different belief systems. *Midwifery*, *24*(3), 344–352. https://doi.org/10.1016/J.MIDW.2006.10.005

Blythe, S., Wilkes, L., Jackson, D., & Halcomb, E. (2013). The challenges of being an insider in storytelling research. *Nurse Researcher*, *21*(1), 8–12.

Bonner, A., & Tolhurst, G. (2002). Insider-outsider perspectives of participant observation. *Nurse Researcher*, *9*(4), 7–19.

Borbasi, S., Jackson, D., & Wilkes, L. (2005). Fieldwork in nursing research: positionality, practicalities and predicaments. *Journal of Advanced Nursing*, *51*(5), 493–501.

Breen, L. (2007). The researcher 'in the middle': Negotiating the insider/outsider dichotomy. *Australian Community Psychologist*, *19*(1), 163–174.

Burns, E., Fenwick, J., Schmied, V., & Sheehan, A. (2012). Reflexivity in midwifery research: The insider/outsider debate. *Midwifery*, *28*(1), 52–60. Https//DOI:10.1016/j.midw.2010.10.018

Clifford, J., & E., G. M. (Eds.). (1986). *Writing Culture: The Poetics and Politics of Ethnography*. University of California Press.

Coffey, A. (1999). *The Ethnographic Self: Fieldwork and the Representation of Identity*. Sage Publications Inc.

Crawford, P., & Hafsteinsson, S. (1993). *The Construction of the Viewer. Media Ethnography and Anthropological Audiences. Proceedings from NFA 3*. Intervention Press.

Cubellis, L., Schmid, C., & Peter, S. von. (2021). Ethnography in Health Services Research: Oscillation Between Theory and Practice. *https://Doi.Org/10.1177/10497323211022312*, 104973232110223. https://doi.org/10.1177/10497323211022312

Denzin, N. K. (2002). Confronting ethnography's crisis of representation. *Journal of Contemporary Ethnography*, *31*(4), 482–490.

Dixon-Woods, M. (2003). What can ethnography do for quality and safety in health care? *Quality & Safety in Health Care*, *12*(5), 326–327. https://doi.org/10.1136/qhc.12.5.326

Dwyer, S. C., & Buckle, J. L. (2009). The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Methods*, *8*(1), 54–63. https://doi.org/10.1177/160940690900800105

Gair, S. (2012). Feeling Their Stories Contemplating Empathy, Insider/Outsider Positionings, and Enriching Qualitative Research. *Qualitative Health Research*, *22*(1), 134–143. https//doi.org/10.1177/1049732311420580

Good, B. J., & Good, M. J. D. (1993). Learning medicine. In *The construction of medical knowledge at Harvard Medical School. In Knowledge, Power, and Practice: The Anthropology of Medicine and Everyday Life* by Shirley Lindenbaum and Margaret M. Lock. *e: T* (pp. 81–107). University of California Press.

Grant, S., Checkland, K., Bowie, P., & Guthrie, B. (2017). The role of informal dimensions of safety in high-volume organisational routines: An ethnographic study of test results handling in UK general practice. *Implementation Science*, *12*(1). https://doi.org/10.1186/s13012-017-0586-8

Gwyn, R. (2002). *Communicating Health and Illness The Body , Disease and Discourse* (1st ed.). Sage Publications Inc.

Kanuha, V. K. (2000). "Being" Native versus "Going Native": Conducting Social Work Research as an Insider. *Social Work*, *45*(5), 439–447. https://doi.org/10.1093/SW/45.5.439

Kearns, R. (2000). Being there: Research through observing and participating. In I. Hay (Ed.), *Qualitative Research Methods in Human Geography* (pp. 103–121). Oxford University Press.

Kleinman, A. (1999). Moral experience and ethical reflection: Can ethnography reconcile them? A quandary for "The New Bioethics". *Daedalus*, *128*(4), 69–97.

Labaree, R. v. (2002). The risk of 'going observationalist': Negotiating the hidden dilemmas of being an insider participant observer. *Qualitative Research*, *2*(1), 97–122. https://doi.org/10.1177/1468794102002001641

Larsson, M., Aldegarmann, U., & Aarts, C. (2009). Professional role and identity in a changing society: Three paradoxes in Swedish midwives' experiences. *Midwifery*, *25*(4), 373–381. https://doi.org/10.1016/J.MIDW.2007.07.009

Ledger, A. (2010). Exploring multiple identities as a health care ethnographer. *International Journal of Qualitative Methods*, *9*(3), 291–304.

Leslie, M., Paradis, E., Gropper, M. A., Reeves, S., & Kitto, S. (2014). Applying ethnography to the study of context in healthcare quality and safety. *BMJ Quality & Safety*, *23*(2), 99–105. https://doi.org/10.1136/bmjqs-2013-002335

Liberati, E. G., Gorli, M., Moja, L., Galuppo, L., Ripamonti, S., & Scaratti, G. (2015). Exploring the practice of patient centered care: The role of ethnography and reflexivity. *Social Science & Medicine*, *133*, 45–52. https://doi.org/10.1016/J.SOCSCIMED.2015.03.050

Malinowski, B. (1932). *Argonauts of the Western Pacific* (2nd ed.). George Routledge and Son. https://doi.org/https//doi.org/10.4324/9781315772158

Meijl, T. van. (2005). The Critical Ethnographer as Trickster. *Anthropological Forum*, *15*(3), 235–245.

National Institute for Health and Care Excellence (NICE). (2014). *Intrapartum care for healthy women and babies clinical guideline*. www.nice.org.uk/guidance/cg190

Nursing & Midwifery Council (NMC). (2004a). *Midwives Rules and Standards*. Nursing and Midwifery Council.

Nursing & Midwifery Council (NMC). (2004b and 2008). *The NMC Code of Professional Conduct: standards for conduct, performance and ethics*. Nursing and Midwifery Council.

O'Connell, R., & Downe, S. (2009). A metasynthesis of midwives' experience of hospital practice in publicly funded settings: Compliance, resistance and authenticity. *Health*, *13*(6), 589–609. https://doi.org/10.1177/1363459308341439

Page, L. (2017). Women and babies need protection from the dangers of normal birth ideology. *BJOG: An International Journal of Obstetrics & Gynaecology*, *124*(9), 1385–1385. https://doi.org/10.1111/1471-0528.14668

Pope, C., & Mays, N. (1995). Reaching the parts other methods cannot reach: An introduction to qualitative methods in health and health services research. *British Medical Journal*, *311*(6996), 42–45.

Reed-Danahay, D. (1997). *Auto/ethnography: rewriting the self and the social,* p. 277. Berg Publishers.

Savage, J. (1995). *Nursing Intimacy: An Ethnographic Approach to Nurse-patient Interaction*. Scutari Press.

Stanton, G. (2004). Writing Culture in the 21st century. *European Journal of Cultural Studies*, *7*(2), 155–165. https://doi.org/https//doi.org:10.1177/1367549404042489

Taxis, K., & Barber, N. (2003). Causes of intravenous medication errors: an ethnographic study. *Quality & Safety in Health Care*, *12*(5), 343–347. https://doi.org/10.1136/qhc.12.5.343

Tengan, T. K. (2005). *Unsettling Ethnography: Tales of an 'Ōiwi' in the Anthropological Slot*. *15*(3), 247–256. https://doi.org/https//doi.org/10.1080/00664670500282030

Webster, F., Rice, K., Dainty, K. N., Zwarenstein, M., Durant, S., & Kuper, A. (2015). Failure to cope: The hidden curriculum of emergency department wait times and the implications for clinical training. *Academic Medicine*, *90*(1), 56–62. https://doi.org/10.1097/ACM.0000000000000499

White, G., & Tengan, T. K. (2001). Disappearing worlds: Anthropology and cultural studies in Hawai'i and the Pacific. *The Contemporary Pacific*, *13*(2), 381–416. https://doi.org/https//doi.org/10.1353/cp.20001.0072