# Analytical and Methodological Disruptions: Implications of an Institutional Ethnography in a Swiss Acute Hospital

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"Do you want to write a whole book?" Jasmine,[1] a female medical-technical assistant in her late forties, ironically asked the scribbling ethnographer. "What do you note in your small book anyway?" I explained that I tried to write as much as possible. For example, I noted the conversations the assistants had with the physician and with each other, and I observed how they interacted. Jasmine told me that it had been strange having me shadow her in the beginning. "I was a little bit nervous," she admitted. "I am not used to someone overseeing everything I do. But after time, I got familiar with you. Now, I sometimes almost forget your presence" (field notes, shadowing, 2018).

## 1 Introduction

We argue in this article that a close analysis of disruptions, understood as cracks and disturbances in routines and procedures, is useful and productive. Firstly, methodological disruptions force us to consider the appropriateness of our methodological tools, our own positionalities, and the relationship between the researcher and the researched. Secondly, disruptions provide powerful analytical tools to research subtle "power geometries" (Massey 1999) and social differences (based on gender, age, education, position, migratory background and so on) that are not always apparent in people's everyday work.

Our study on the ruling relations that shape personnel policies in a Swiss acute hospital is based on an institutional ethnography. We understand "relations of ruling", based on Smith (1990: 5), as "relations that provide […] a specialization of organization, control, and initiative", for example the predominant administrative procedures in an organisation such as a hospital. The ruling relations in institutions are never given, but the involved actors instead produce and reproduce them. Researching institutional relations requires transecting various levels by highlighting the interplay between individuals, institutions, and the wider context (Apelt/Wilkesmann 2015). People's power to influence and shape institutional relations is unevenly distributed, and it comprises cooperative practices as well as conflicting or aberrant ones. To trace these power geometries, we use an intersectional lens (Winker/Degele 2009) that is attentive to how various forms of social differences produce inequalities. We aim to research how social differences intersect and how they are negotiated in the everyday work of physicians and nurses within a hospital. We explore where and why the making of social differences lead to personal and institutional power imbalances.

Both approaches, institutional ethnography and intersectionality, represent feminist perspectives aiming at analysing power, inequalities, and their making in socio-spatial contexts. They provide fruitful lenses for studying power asymmetries in an institutional context by asking the key questions: Whose voices do we listen to? Whom do we see acting in what way and why? Who is structurally marginalised and excluded from decision-making processes?

1 All names are pseudonyms to ensure the research participants' anonymity.

This enables us to look closely at how institutional structures translate into everyday interactions and how these micro practices then influence the macro level within the hospital and the broader social context.

Methodologically, the two-year study follows two strategies of data collection that complement each other. Outside the hospital, we do expert interviews with stakeholders in the field, we conduct interviews with healthcare professionals, and we collect media articles, policy documents, and reports on issues related to the Swiss health care sector. Inside the hospital, we conduct interviews with the middle and senior management, we collect documents, and we shadow nurses and physicians in their daily work in three wards. Shadowing is an ethnographic method often used in organizational and managerial studies (Czarniawska 2014) to research institutions like hospitals. When shadowing, the researchers follow people in their everyday (working) life within an institution while receiving explanations. The material collected outside the hospital adds to the breadth and the material gathered inside the hospital contributes to the depth of the data.

## 2 Digging into the Field: A Methodological Disruption

> Today has not been easy. I had not been announced, so the woman sitting at the reception desk was looking at me critically. Philippe, a male expert nurse in his late thirties, came to fetch me. "What knowledge of health care do you have?" I shamefully admitted that I had no knowledge. Philippe soon realised that I indeed had no experience working in a hospital when I awkwardly wanted to help him bring a patient to radiology – I was probably a hindrance rather than a help. Although I looked like the other people working in the emergency ward (white or blue clothing), I was very much aware of my clumsy, useless outsider presence (field notes, shadowing, 2018).

Ethnographic research is disruptive. A two-fold disruption took place during shadowing, namely for the researcher as well as for the researched persons. On one hand, the experienced ethnographer found herself in a completely new environment where she constantly had to negotiate her own positionality. Instead of blending in, she stuck out. She had to repeatedly explain who she was, what she was doing, and what the study's goals were. The researcher's age, gender, training, and language skills heavily influenced her interactions in the field, such as when elderly men teased her about her research. Though she wore the same clothes as the physicians and nurses, the healthcare workers quickly identified the shadower as an outsider, as the field notes above exemplify. Consequently, access and openness had to be negotiated at every encounter, requiring more openness and improvisation than a formal interview usually does. Furthermore, the researcher had little control over the data she collected because it was largely coproduced (McDonald/Simpson 2014). First, the hospital's CEO chose the participating wards. Second, the leading nurses and physicians selected who to shadow. Third, the individuals being followed also coproduced the data. By repeatedly coming back, the researcher could dig deeper and increase her understanding of the ward's social and institutional structures and slowly occupy a third space of observation and analysis besides the health care personnel and the patients.

On the other hand, the researcher's mere presence disrupted the ward's routine as for example the initial example of Jasmine illustrates. The study further challenged the nurses' and physicians' understanding of research. Most of them were familiar with quantitative studies but not with qualitative research. For them, our study was fuzzy and not objective or measurable. Furthermore, constantly being followed disrupted the researched persons' routines. Thus, the research triggered the shadowees to reflect on their daily work.