Disturbing Observation as a basis for Colaborative Research

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Jessica Mesman

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Disturbing Observations as a Basis for Collaborative Research

JESSICA MESMAN

Department of Technology and Society Studies, University of Maastricht, The Netherlands

Introduction

In the last decade, there has been a growing awareness that ethnography and intervention are not distinct but interwoven practices. Especially approaches such as interactive social science, participatory design, computer-supported cooperative work and action research have attracted a lot of attention.¹ These approaches consider doing ethnography as a matter not just of describing practices, but of changing them as well. Moreover, doing an ethnographic study inevitably intervenes in the field studied. In other words, intervening is not a choice but an unavoidable condition of ethnographic research (Henriksen, 2002). Just by being there the ethnographer is already making a difference. Moreover, instead of trying to be just ‘a fly on the wall’, researchers aim explicitly to affect the practices they study.

In these approaches that explicitly aim at intervening in practices the researcher operates in close collaboration with the professionals in the field. Collaboration with the practitioners provides a basis for what Zuiderent-Jerak (2007) calls ‘preventing implementation’, which avoids the classical distinction between phases of design, implementation and evaluation of results. Instead of presenting an outsider’s assessment report, one acts from within to make a difference. However, acting in close collaboration with practitioners to make a difference is not without difficulties. This is not a problem as such—after all, non-problematic methods do not exist—but calls for an explicit reflection on the actual consequences of this methodological route. What does it mean to operate ‘in close collaboration with’ the professionals in the field? What kind of opportunities and constraints are linked to this position? Moreover, regardless of our intentions, research effectively intervenes by accepting, challenging or diversifying problem definitions of the actors we study. We need to ask ourselves what this means in our particular case. What are the consequences of practising this kind of approach for the day-to-day activities of the researcher? In other words, what are the methodological and normative choices we can be confronted with while practising an approach of intended intervention? Do

Correspondence Address: Jessica Mesman, Department of Technology and Society Studies, University of Maastricht, PO Box 616, 6200 MD Maastricht, The Netherlands. Email: j.mesman@TSS.unimaas.nl

inconsistencies and conflicts always imply the very end of collaboration? Or do these disturbing observations still provide us with possibilities for intervention? To answer these questions I will reflect on my personal experiences of participating and doing observations in a critical care practice at the same time.

The exploration of these methodological concerns is based on my current research project 'Resources of resilience', which is an explication of the 'hidden competence' to secure patient safety in intensive care for newborns. This project involves ethnographic work on a neonatology ward for several months. Being a participant observer entails two types of problems: a methodological one ('am I observing the right things?') and a moral one ('am I participating in the right way?') The first refers to the presence as an observer, while the latter refers to the issue of collaboration. In this article I will discuss three possible sources of difficulties for collaboration and observing at the same time: (1) conflicting interests between the researcher and the professionals in the field; (2) the position of 'insider' and 'outsider'; (3) the multiple roles and responsibilities. However, as I will argue, expected difficulties in doing collaborative research can be found in unexpected locations. Moreover, presumed constraints can transform into corridors to interventional opportunities. Before discussing the sources of difficulties, I present a short description of my research project.

Resources of Resilience

Safety issues top the agenda in healthcare. Recent studies show an unacceptably high level of adverse events and near misses. Examples of adverse events are transfusion errors, adverse drug events, wrong-site surgery, restraint-related injuries or deaths, preventable suicides, burns, falls or treatment-related infections. Much of the current patient safety research is on the detection of causes of incidents and near misses. Based on the outcome, protocols and devices are adjusted or developed to eliminate these causes of adverse events. However, considering the high-risk work environment we have reason to wonder why things don't go wrong more often in these complex care settings. Therefore, I am interested not so much in the gaps in the safety net, but in the structure of the net itself, notably its informal or unarticulated dimensions. After all, besides the intended formal measures, patient safety is also achieved by an unplanned but effective set of initiatives. In other words, the aim of my project is to explicate the hidden competence and informal built-in structures that are part of systems of safety.

This analytical scope and effort can be understood as an act of 'exnovation' (De Wilde, 2000): that which is already present in practice is foregrounded and the implicit is made explicit. Importantly, it offers a new perspective on the staff members' own competence, inventiveness, and the structure that comes with specific styles of ordering day-to-day practices. Explicating and analysing the role of informal competencies will contribute to our understanding of effective preservation of patient safety. Additionally, it can increase practitioners' awareness of their available resources of resilience. In this way I hope, in a humble way, to contribute to the optimization of patient safety.

To identify the 'hidden competence' of a practice, participant observation acts as the focal point of my methodology. The participant observation is specifically geared to the location of high-risk situations in the treatment trajectories in order to identify the resources involved in the constitution of a safe practice. The Neonatal Intensive Care Unit (NICU), which specializes in care and treatment of severely ill newborns,

will be my field of study.² My observations on the NICU ward allow me to identify and understand the situational rationalities involved in the preservation and recovery of patient safety in the specific context in which it occurs.

However, to gain insight in the informal knowledge systems and unplanned initiatives that contribute to a high level of patient safety, participant observation as such is not sufficient. To find a window enabling me to catch a glimpse of the staffs' reflection on safety issues I have asked permission to participate as an active member in NICU committees that address safety issues: the NEOSAFE committee (a committee on a blame-free reporting system in neonatology) and the working group of nurses on infection prevention.³ Additionally, I participate in the interdisciplinary committee on 'Prevention of Infections in Paediatrics'. My participation in these working groups enables me to 'join them' in their exploration of safety trajectories. Through active involvement I try to comprehend their way of reasoning with the aim to develop native competence. In other words, producing knowledge with, from and for this specific healthcare practice, I aim to find ways of understanding patient safety.

As a result my data collecting encompasses different sites (NICU ward and NICU working groups) and different styles (collaboration and observation).⁴ However, these styles of data collection offer not only a corridor to insider's knowledge. They also provide an opportunity for intentional interventions. Therefore, I take up the suggestion of Michael Lynch to create local-interactional spaces (Lynch, 2004). This approach implies that one will not choose the classical trajectory of intervention, evaluation and transformation. Instead, it acknowledges that being there and communicating with those involved in the work practice makes a difference. Lynch alerts us to create local-interactional spaces in which 'STS' can become a 'source' of rhetorical authority by questioning the social and the technical as distinct entities or the dominant images of practices and (re)imagining the world we live in.⁵ In this methodological approach intervention can be considered as a form of ongoing explicit reflection of the researcher while interacting with the staff. This reflection focuses on the specific conceptualization and framing of everyday practice. The discussions in the meetings and on the ward can be considered as local-interactional spaces in which I explicate their hidden competences and question (breach) their dominant ways of understanding patient safety. These forms of intervention aim to increase their 'safety sensibility' and to offer alternative images of patient safety.

In these local spaces both the practitioners and I interact as reflective practitioners. This 'ongoing reflection' also involves the methodological aspects of the researchers' own project. After all, moving around and shifting in and out in different settings are consequential and raise questions about methodological and normative implications. For example, what are the implications of my active involvement in 'the politics of NICU practice'? In what way will my collaboration activities interfere with my role as observer on the NICU ward? A combination of collaboration and observation generates opportunities as well as constraints, which also come in different forms and are related to different settings. In the following I would like to reflect on some of the complexities and ambiguities I encountered during my fieldwork while observing and acting with the practitioners. This specific focus implies that I will not discuss the (preliminary) outcomes of my study on resources of resilience. In other words, the 'hidden competencies' remain hidden in this text. Instead, the focal point of this analysis will be on the methodological and normative complexities involved. I will do so by addressing, respectively, conflicting agendas, one's position in the social order, and the nature of collaboration.

Conflicting Agendas

Caswill and Shove (2000b) point out the dangers involved in collaborative research for one's research agenda. Setting the research agenda will involve, for instance, multiple rounds of negotiations. This raises the question of how to keep one's research project from becoming simply part of theirs. When does 'giving in and being flexible' become a threat to one's own ambitions? There is a danger that one will end up playing no significant role and losing every space for genuine interaction. Can such an approach result in the abandonment of one's critical stance or in getting aligned with sheer managerial agendas? How can one prevent a project from evolving beyond recognition?

I entered the field with these words of Caswill and Shove in mind. Being aware of the risk that someone else's agenda might creep into mine was the starting point of my attempt to protect my own agenda. Since my research objectives are not limited to one specific group or setting, I knew right from the start I had to engage in different aspects of the health practice and as such had to face several rounds of negotiations about agenda setting. Having no formal position in the hierarchical structure, I started to collaborate with 'others' such as, for example, the hospital's risk managers.

Box 1

Example: The Department of Risk Management

The primary focus of the department of risk management is on the development of an overall safety management system from the perspective of registration of incidents and fixing the problem. While not satisfied with the organization of patient safety in the hospital, the risk managers try to enlarge their influence. In this process they consider me their ally and they try to engage me in their network of actions. I am, for instance, invited to participate in different kinds of projects and meetings and they share a lot of data and information with me. Although their generosity is very helpful, I am aware of the risk of co-optation. After all, they have an agenda of their own. Moreover, their agenda is based on the deficit approach (increase of patient safety by detection and elimination of errors in work setting). It is clear that they, while allowing me to join them, are not willing to change their agenda.

Collaboration with the risk manager seemed to imply a re-direction of my research focus. After all, their focus is on the vulnerabilities of the safety net, while I explore its strengths. How to work together if we both look in the other direction and have different ideas of 'patient safety', or what 'a medical practice' is. At first sight I feared that I had chosen the wrong group to work with and that I ran the risk of co-optation. But was this really the case? Did our difference in orientation (deficit versus resilience approach) obstruct our collaboration? On the contrary, it could be argued that our approaches were mutually inspiring since we shared a fascination for patient safety, even though we tried to tackle the issue from a different angle. It was not our agendas (optimization of patient safety), but the proposed trajectories towards patient safety and their implied assumptions about medical practice, which turned out to be different.

A difference in underlying assumptions about the practice and the problem can be an impediment to collaboration. In practice, however, this is not always the case. It is on the basis of mutual respect that one explores where and what domains and resources could be shared. What at first seems a clear-cut example of conflicting agendas can turn out to be a case of complementary projects. I feared being co-opted, becoming submerged into the agendas of the risk managers or being left out as a critical yet powerless outsider. However, in practice such fear was unwarranted. This example highlights the need to be more sensitive when talking about the assumed purity of research objectives. It turns out that collaboration is not simply a case of being co-opted or being in full control—it is finding common ground that is interesting. It is how agendas are shaped we have to reflect upon.

Nonetheless, the risk of conflicting objectives does not only occur *between* different research groups and their projects. It can occur *within* one and the same project as well. Instead of being on safe grounds as my smooth collaboration with the department of risk managers would like me to believe, it was my own ambitious project that became the source for conflicting agendas. Doing fieldwork on the NICU ward and participating in NICU working groups at the same time resulted in conflicting activities and responsibilities.

Box 2

Example: The NEOSAFE Project

NEOSAFE is a project in which several neonatal intensive care units in the Netherlands participate. It is a registration system of incidents and near misses, which enables the staff to identify sources of error. The reports of the incidents and near misses are analysed with the help of a model (PRISMA) to classify sources of error into specific categories (e.g. organizational, technical, human factors). Throughout the day, no matter which shift, doctors and nurses are expected to report every error and mistake they notice. In most of the cases a person other than the person involved in the incident will report on it. This is not a matter of betrayal, revenge or lack of loyalty, but has a practical reason: most mistakes are noticed in the following shift.

The NEOSAFE committee in 'my' hospital is a multidisciplinary team of seven nurses, one fellow, a physician assistant and a neonatologist. Once every month the NEOSAFE team meets to discuss the reported incidents and to categorize them with the help of the PRISMA model.

My participation in the working group was like that of any other member. I joined in the discussions, asked for clarification when needed, teamed up in the process of analysis and helped them explain the purpose of the project on monthly team meetings of the nursing staff. However, while on the ward I—*unlike* all the other members of the NEOSAFE team—did not point out someone's responsibility to report an incident. Although I was a full member of the NEOSAFE working group, I did not take up the responsibility to motivate staff members to report incidents when something happened. I did not do so deliberately, for it would have distracted me from my own

research focus: the *positive* role of staff members to maintain patient safety. Besides, I simply lacked the authority to ‘remind’ staff members they have to report every (near) incident.

In other words, my position in the working group generated a certain tension: while doing my observations on the ward I witnessed ‘NEOSAFE situations’ which were not reported. Still, unlike other NEOSAFE members, I did not intervene. This made me feel a bit uneasy: as if I was unfaithful to the NEOSAFE project and disloyal to my NEOSAFE team mates. Being a member in this working group involved a commitment that I deliberately chose not to fulfil. The other objective of my own research agenda (the analysis of processes involved in the constitution of patient safety in day-to-day practice) and my position on the ward (no authority) prevented me from fulfilling this part. Moreover, my attitude on this part was based not solely on my own decision, but on theirs as well. The staff members assumed that my interference would influence the implementation of the reporting system: ‘People should also report incidents when you are not here to tell them they have to’. It turned out that our agendas ran parallel, but our objectives did not.

This example shows how conflicting agendas do not have to be a matter of tension between theirs (NEOSAFE) and mine (Resilience). On the contrary, in this case the tension came from *within* my own project. I had to solve the problem while being in the middle of it. To save my project I decided I would not be the fully fledged participant of the NEOSAFE committee I had in mind at the beginning of my project. Some of its related roles and responsibilities would blur the focus of my observations in the NICU ward. I prioritized the focus on the practice’s strength over a full membership of the NEOSAFE. This decision was based on the fact that my membership of the committee was motivated by the wish to join them in the analytical manoeuvres while classifying the incident reports and those of near misses in particular. Because this activity is mainly done outside the NICU ward, my ‘non-NEOSAFE’ behaviour on the ward did not jeopardize this part of my project.

When objectives clash they are expected to do so during a meeting of different stakeholders. However, we should be aware that these conflicts might as well reveal themselves when sitting behind your desk at home and there is no one else but you. Internal frictions in a project can be the cause of many problems. What you gain in one part of the project can be destroyed while you are working on another aspect in another setting in another role. Although we are prepared to face problems when we collaborate with other actors in the field, it is as much important to be aware that the locus of conflict can be within our own project as well.

The Dynamics of Positioning in Collaborative Work

Doing research that explicitly aims at intervening in the practices it engages with, i.e. that is ‘action-oriented’, raises the issue not only of clashing objectives, but also of social order and room to manoeuvre. I might wonder, for instance, what my position is in the different settings I am involved in. Do I have any authority to intervene and on the basis of what? What is the effect of the fact that I am not a part of the formal social order? To explore the ‘stability’ of my position I will describe my involvement in a meeting of the working group on infection prevention.

Box 3

Example: The Working Group on Infection Prevention

The working group on infection prevention consists of four NICU nurses. All four are experienced, highly specialized nurses. The working group started three years ago. It is this team's responsibility to develop and implement procedures to prevent infections. I join them for the first time. The meeting starts at seven in the morning according to the time schedule of a regular dayshift. When I ask about the agenda I am told that there is no agenda yet. According to the chairperson we need the minutes of the last infection committee meeting (the multidisciplinary team on infection prevention) to be able to decide what needs to be discussed. Without this report we have no focus for our meeting.

Although these nurses are also members of the infection committee, none of them was able to attend its last meeting. I, on the other hand, did attend it, but I have no copy of the minutes either. I tell them that the report is ready; at least, this is what one of the neonatologists on this committee has told me some days ago when I asked him about it. I suggest to the nurses to ask him for a copy. They hesitate and are not sure if this is a good idea: 'He might feel we are too pushy.' They expect that if we ask him to email the minutes that he will promise to do so but not in time: 'He might send it late in the afternoon or forget all about it.' To move on with our meeting I suggest that we go to his office instead: 'Let's go to his office and ask him to hand it over. In this way he cannot refuse, nor forget.'

However, they do not know where his office is because the medical staff moved to another building some months ago. This problem is solved easily because I happen to know where his office is. We decide I will join one of them to the medical office building. When we arrive we are lucky to find the neonatologist in his office. I ask him if we can have a copy of the minutes. 'No problem at all. How many copies do you need? Five is enough? Okay.' A few minutes later we are on our way back with five copies of the minutes of the last infection committee meeting.

What happened in this first hour of the meeting of the working group? The nurses hesitated to contact the neonatologist, even though they were aware that the minutes were crucial to the agenda for the rest of the day. Why? It is evident that nurses are allowed to enter the medical staff building like anyone else.⁶ However, in practice this is a very unusual situation. If nurses need the help of a doctor, it is on the ward, next to the incubator. Doctors who are not there are simply paged, meaning that nurses never go to their office to get them. So, in practice they do not need to know where their offices are. The world of the doctors and their activities outside the NICU is a remote and unknown territory to most of the nurses. In this respect I differ from the nurses. I know my way around in the medical office building because it is here where I discuss my project with the medical staff. It is also the location where they have meetings that I attend.⁷ The material order of the NICU practice interfered in the configuration of my

social position. While one moment I was just a 'plain outsider' attending a meeting, the next moment I was 'a relative insider of a part of the medical culture' and as such a means of access to the minutes of the meeting. My partial connection with the medical staff reconfigured my role in the working group while I reconfigured their reality. Now a new landscape emerged: one in which I was the insider and they were the outsiders. My new position incorporated a form of significance that amplified my participation in the working group.

It was not just spatial familiarity that made it easier for me to go to the neonatologist to get the information we needed, though. It was also on the basis of my position as a guest researcher that I did not consider the neonatologist as a superior on whom I did not want to put pressure. In the absence of having a specific position in the hierarchical order of the hospital, I was not susceptible to the culture that comes with it. This created space for manoeuvring and gave me the opportunity to act as a facilitator, while also being accepted as such.

BOX 4

[...] After reading the minutes of the committee meeting the nurses become very upset: it does not refer to the activities of the working group at all. Moreover, some of their initiatives are granted to someone else. A lot of frustration comes out and one of them decides to quit her involvement in the working group's activities. 'Why bother if none of our ideas and efforts is taken serious.' I myself am baffled, altogether surprised by such outrage. It soon becomes clear to me that this is a frustration that has been building since the beginning. Over the years the nurses have proposed all kinds of adjustments, but they lack any authority in this respect. It is the head nurse or the neonatologists or the hospital hygienists who have to approve their ideas before they can order a new device, set out another timetable, try out another way of handling intravenous lines for medication and food supply, and so on. Some issues were proposed three years ago and still no action has been taken. In their eyes the report of the committee meeting reflects a lack of interest in the activities of the working group.

The fact that I attended the committee meeting transforms me into an important informer. 'Tell us, what did they say about us?' I try to convince them that during the meeting no one has referred to them in a negative way. 'You have to consider the minutes as a personal note from the neonatologist instead of as an official report on the committee meeting. Besides, I am not sure if I have interpreted everything discussed in the correct way because it was the first time I joined the committee. I was not informed about what was discussed before and as such unable to grasp all the things that were put on the table.'

What happened in the second hour of our meeting? At first it seems that my position did not change: again I was 'a corridor to information'. However, the nature of the information had shifted from 'how to get access to the minutes of the meeting' into 'the content of the

actual discussion in the meeting'. Although I was in the same room, with the same people, this shift changed the 'colour' of my position dramatically. Where I possessed the significant position of 'being an insider in a specific part of the medical system' (medical office building) and accommodating their request in the first hour of the meeting, I now transformed into an 'uncooperative outsider from another group' (the committee) in the second hour.

During this part of the meeting I was not willing to act as means of access to information for several reasons. First, I did not want to jeopardize my relationship with the other members of the infection committee, such as the neonatologist and the hospital hygienist, by 'gossiping' about the content of the meeting. These staff members are too valuable for my project to lose them as informants. Second, I was not certain about my interpretations of what had been discussed, owing to a lack of knowledge of the context. My unreliable information could cause a conflict between the members of the working group and the committee members. For that reason, I declined to take up the position of informant and instead advised them to ask the head nurse who had attended the committee meeting as well. This changed my position. Now instead of being explicitly on their side, I became 'one of the others' (the committee members). Not I but the head nurse became their corridor to information.

Box 5

[...] Fortunately, the head nurse is not in a meeting and able to join us right away. He reports what has been discussed. Still, he fails to remove the frustration among the nurses of this working group.

After the head nurse leaves the room we discuss what to do next. The nurses consider putting an end to the working group activities all together. I try to convince them not to give up and advise them to use the next committee meeting as a way to get things done instead. I propose an agenda for the next committee meeting and show them how to get the issues on the table that need to be decided. I try to convince them that staying away as a form of protest is strategically not a smart move and that instead they ought to show up with as many as possible. They agree and together we make a list of topics that have to be decided in the next meeting.

In the last part of the meeting the level of my interference increased again and once more my position changed. This time I was 'an insider in another social system' and again able and willing to help them. After all, this was a territory I knew well enough: preparing meetings, agenda setting and the dynamics of the social order.

It was not only in the working group on infection prevention that the fluidity and ambiguous character of my social position became apparent. My involvement in the NEOSAFE committee reflects how a position in the social order is not only based on the role and level of interference during the meetings. Although I had gained the position to meddle in agenda setting during the meetings and join them in their analysis of the incidents reports, on the NICU ward my position was entirely different. As described in the former section, on the ward I lacked the authority to tell doctors or nurses that a specific

situation calls for a NEOSAFE report. On the ward all NEOSAFE members were competent insiders, except me, the observing outsider who did not interfere.

The above examples undermine the idea of a stable social position. Doing ethnographic research does not imply a simple linear trajectory of being the outsider who becomes an insider. The 'insider–outsider' positions are not fixed and stable, but fluid and ambiguous. As ethnographers we move in and out of different settings, transform from certain kinds of outsider into certain kinds of insider. Another move and we transform into another insider or outsider, into something else again. We circulate between places and are able to establish connections and disconnections. These shifts are consequential but not one-directional. Additionally, they undermine the idea of a stable correlation between position and room for manoeuvre. Moreover, my position in the working group meeting demonstrates that although a researcher necessarily introduces disturbing effects, one can also benefit from his or her ambiguous position. This ambiguity relates to at least three different 'insider/outsider' structures: (1) insider of a part of the medical culture; (2) uncooperative outsider from another group; (3) an insider in another social system. These structures have become visible because of the uneasy position that I experienced. It turned out that an outsider's position does not always imply lack of room for interference.

The outsider position has many faces: some are more authoritative than others. In some we are at the fringes of the practice, while in others we are more relative insiders. It is not always clear whom to consider as the insider and whom as the outsider. In the working group meeting, my added value was based on my position as 'outsider within'. Moreover, spatiality is clearly a factor here: the actual distance from the NICU ward seems to correspond with the level of interference. On another floor in a meeting room nurses rely on my expertise to set the agenda with which they might meet their goals. In the office building next to the hospital they rely on me to get the information they want. Further away, in some other city, they allow me to represent the hospital at a national meeting of the NEOSAFE project. In these cases the social order is configured by spatiality. The room for manoeuvre I was accredited turned out to be a temporal and spatial matter tightly linked to the setting and matters of dispute.

Well, do I have any position in the hospital to interfere when they regard me as an outsider? Yes, I have, but only in specific locations (outside the NICU ward), for specific reasons (information) or in specific settings (meetings or in collaboration with physicians). In those settings my skills and knowledge of how to run a meeting, of the relevance of specific discussion techniques and of how to think strategically do matter. So yes, I am able to influence their agenda, their selection of priorities and am allowed to participate in data analysis. I am also allowed to represent the hospital on the national level. At the same time, I do not have the position to participate in decisions in the NICU, in auditing their skills and expertise, in clarifying complex meetings. The social order is multiple, and locally and temporally bound.

The Nature of Collaboration

Collaboration is considered an important corridor for intervention. However, the nature of the collaboration is not always as straightforward. Collaboration is the outcome of a specific co-construction of relations. One can wonder about the nature of collaboration in a project aiming at interventions. Is it an equal partnership? Or are there other forms to think of, like 'mutual engagement'? What form of collaboration is the most appropriate

for a research agenda that is 'interventionist'? What strategy do I use to choose among the different forms of distributing power, credits and costs? Are 'engaging in' and 'being critical' mutually exclusive activities? These are all-important questions, but seem to presuppose a stability of the role and responsibility of the researcher as well as the research subjects (staff members). Therefore I would like to discuss in what way a mixture of roles affects the nature of collaboration instead.

While doing participant observation on the ward *and* being involved in working groups and other activities outside the ward, I meet the same persons in different capacities. Their different roles have implications for our collaborative relationship.

Box 6

For Example, Peter, One of the Neonatologists:

Peter is the project leader of the NEOSAFE project. In this capacity there is an unequal partnership. I am just one of the members of this working group. However, the next day on the ward, Peter is one of my research subjects. In his capacity as attending physician I observe his activities and decisions. In this situation there is no form of collaboration, nor is he in the position to 'control' my activities as he does in the NEOSAFE project. After all, I have the official permission of the head of the department of neonatology (his boss). Now Peter and I have decided to write an article together. The next day in his office when we discuss the first outline, we are in an equal position as being co-authors.

The example of the diversity of partnerships with one and the same person demonstrates how a multiplicity of collaborations is not merely defined by differences on the level of collectives. Different roles of one and the same person multiply the collaborative encounters as well. This implies that there is a fluidity of forms of collaboration over time and within the different interpersonal spaces.

However, the staff members were not the only ones to switch roles. I myself took up different roles as well. I presented myself in different capacities. These capacities not only came with different responsibilities, but they brought in different styles of acting as well. In the NICU I was the 'observer' who did not participate in the treatment trajectories of the babies. The NICU is a setting dominated by highly specialized actions. My low profile on the ward contrasted with my collaborative involvement in the working groups. The setting of the working group included activities I know well: discussion techniques, analytical skills and formulating strategies. Here we were on common ground, in the world of texts, discourse and analysis. In the multidisciplinary committee on infection prevention, on the other hand, I showed less initiative. Not that it was dominated by specialized actions, for it was not. But this is a decision-making body. In this case I missed the authority to be as actively involved as in the working groups. People who meet me in different capacities might notice different styles of acting. This can be confusing and might generate false expectations and as such disappointment. Needless to say, a diversity of roles was a potential source of frustration on both sides (for instance, on the ward I was not able to exceed my responsibility as NEOSAFE member), and for conflicting loyalties and responsibilities (for instance, loyalty to the 'absent other': in the working group to the absent doctors and in the committee to the absent nurses). It is naïve to assume that one can

avoid problems of loyalties. Ethnographic research always implies becoming normatively situated and therefore researchers should better be equipped for what Zuiderent (2002) calls 'situated choices' in politicized ethnography.

Also the NICU itself has many faces: it is a multicultural setting with parallel hierarchies. Although working in an NICU involves teamwork, doctors belong to a different 'tribe' from nurses. Hospital culture can be characterized by its strict hierarchical order. I am cross-cultural and have no clear position in the formal hierarchy. Nevertheless, this multicultural practice does affect my position. Yes, I am free to cross the boundaries between cultures and positions, but it is not without costs.

As the working group on infection prevention has shown, there is a certain level of distrust between the parties involved. The response of the nurses to the minutes of the committee meeting is illustrative for their frustration and distrust. The distrust is partly due to differences in access to information and presumed modes of thinking. The different groups involved characterize themselves and each other in rather stereotyping ways. The members of the working group consider themselves as action-oriented. The working group members propose valuable changes of the NICU practice, but lack the decisive authority in these matters. All their initiatives have to be approved by others: the head nurse, the neonatologists or the hospital hygienist. The head nurse shares their ideas, but he too is imbedded in a hierarchical structure and as such dependent on the approval of others, like the neonatologists. Likewise, the neonatologist chairing the committee depends on the approval of his colleagues. Although he likes the proposals advanced by the nurses of the working group, he first wants to see 'evidence' that it works before presenting it to his colleagues for approval. According to the nurses, the hospital hygienist is only thinking about 'audits and indicators'. The working group's ideas are implemented in his round of audits, which will take another year again. Although the neonatologist agrees with the hygienist's proposal to start an audit first, he is apparently irritated about the presentation and interventions of the hygienist in the committee meeting. The neonatologist: 'He thinks he knows best, but has no clue about the complexities of our patient population.' The nurses distrust him as well and experience his interventions more as a hindrance than as support. The hospital hygienist considers this unit as 'a very difficult group to work with'.

Notwithstanding the differences of opinion, I had to get myself linked up with the different actors involved, on different levels and in different decision-making bodies. That made them wonder how trustworthy I was. They saw me talking to persons they consider opponents rather than collaborators. They heard me on the phone making appointments with persons about whom they were just telling me how irritating they were. They wondered how safe their secrets were with me. On whose side was I? Would I pass on what they told me in moments of trust?

As described above, being cross-cultural has the advantage of entering a large manoeuvrable space. But it involves risks as well. Lack of clear expressions of loyalty to one particular group can give rise to doubts about discretion. After all, I might be a potential 'traitor' and the cause of frictions between involved actors. This suspicion—no matter how slight—can influence the staff's behaviour while I am on the ward doing observations. Intentionally or not they might shield off their activities and decisions. In other words, the web of interconnectedness of sites and people has an impact on the process of building and maintaining trust. My participation in one working group may affect my participation in another one or my observations on the ward. The advice 'stay

out of conflicts' is good enough, yet it is easier said than done. Interventionist research involves many risks, like getting contaminated without noticing it.

Concluding Remarks

My aim to understand and contribute to the preservation of an adequate level of patient safety has forced me to find a trajectory of action based on collaboration. This raised the question about the kind of opportunities and constraints that are linked to collaborative research. In other words, what are the consequences of practising an interventionist approach for the day-to-day activities of the researcher? What are the practical implications of this way of engagement? To answer this question I have reflected on some of my personal experiences while doing research in a neonatology ward. The focus of my reflection was in particular on (1) conflicting interests of the observer and those that have granted me an observing position; (2) the ambiguous and fluid position of the researcher in the authority structure; (3) the unavoidable position received in the various coalitions of interest. What do we gain from this reflective exercise?

First, it teaches us to leave behind the idea that the world we enter possesses a stable order, with distinct boundaries. The dynamics within the local-interactional spaces create a complex process in which one gets entangled in multiple engagements, conflicting feelings of loyalties, and a multitude of positions. In practice, there is no stable order that fits our 'dichotomized' fears and expectations. Here collaboration does not simply mean being co-opted or in full control. Different objectives do not need to result in conflicting agendas. Likewise, there is more between the 'insiders–outsiders' position. There are many kinds of insiders (insiders in another system) and different kinds of outsiders (facilitators, cooperative, uncooperative ones, trustworthy, disloyal, etc.). Moreover, these positions can shift within the hour. Similarly, one does not act in one specific capacity while being in the field. Neither do the ones you observe or collaborate with. A multitude of collaborative encounters create different kinds of local interactional spaces in which roles and responsibilities emerge as contextual consequence instead. As such a contextualization of profiles of action is firmly linked to issues of trust and loyalty.

Second, doing research in different settings, taking up different roles and responsibilities create constraints and possibilities in unexpected ways. Conflicting objectives do not exist only between you and the people you want or need to collaborate with. They can also be found within your own project. Neither is it always the ethnographer who holds the 'outsider' position. And even if it is, 'being an outsider' need not always be equated with 'having no influence'. On the contrary, in some cases it provides unforeseen space for action. What at first may seem 'disturbing observations' turn out to be corridors for collaborative work.

Having said this, we should neither forget nor underestimate that being engaged in a knowledge production process 'for' practitioners is a complicated position. Doing research that explicitly aims at intervening in practices requires a collection of simultaneous activities, like collaboration and observation. These concurrent processes produce ambiguous identities, generating expectations, confusion and surprises. It is important to realize that using different platforms as a corridor to knowledge and intervention implies that the researcher has to be aware not only of conflicting interests but also of his/her own conflicting objectives, roles and responsibilities. It can evolve into a situation where one becomes one's own 'opponent', or source of concern, the moment roles and settings change. Therefore collaborative research requires a process of ongoing reflection.

Such reflection exceeds the content of data, and includes the methodological implications of collaborative research.

The aforementioned concerns reflect the necessity of a constant awareness of the situatedness of one's position and of the room to manoeuvre in 'acting with' practitioners. What is more, not only does the researcher intervene in the specific practices. These practices and its practitioners interfere with the research project of the ethnographer as well. In other words, doing research-in-action requires that one does not have the ambition of being in full control, but allows one's observation to be *disturbed* in analytically productive ways. Moreover, lack of control is the concern of all the other actors in the field. In other words, the ethnographer is in a symmetrical position with all the other actors: all fail to have full management or control of their professional reputations, their authorities and performativities.

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Notes

¹For a discussion of these different approaches, see Downey and Dumit (1997), the special issue on ethnography and intervention of the *Scandinavian Journal for Information Systems* (Pors *et al.*, 2002) and a special issue of *Science and Public Policy* on interactive social science (Caswill and Shove, 2000a).

²To excavate hidden—and as such invisible—resources an adequate level of understanding of the practice involved is a requirement. Therefore I will use my expertise on the NICU which is based on a former research project. See Mesman (2005) and Coeckelbergh and Mesman (2007). Mainstream anthropology argues that it is crucial to understand the content of actions. In the 1980s when laboratory studies were fashionable, this argument was also defended by STS scholars like Collins (1983, 1984), Knorr-Cetina (1981) and Traweek (1988). Latour and Woolgar (1986), on the other hand, defended the perspective of 'the very naïve observer'. See Downey and Dumit (1997) for a discussion on this issue.

³In a 'blame-free reporting system' the hospital considers reporting the circumstances of the event as more important than identifying the people involved. The system stresses the need to learn from mistakes. Therefore an investigation of the event is focused upon learning the lessons instead of blaming the healthcare workers.

⁴Additionally I interview members of patient safety related units in the hospital, like hospital hygienists, risk managers, apothecaries and microbiologists. They offer information on the in-coming and outgoing streams of formal knowledge (protocols, guidelines) in relation to actual NICU situations.

⁵See Markussen and Olesen (2007) for a critical reflection on this matter.

⁶Nurses working on the NICU not only have a degree in paediatrics, but also a degree in neonatology and on top of that a certificate for neonatology intensive care.

⁷Circulating at different locations for different purposes might expose the ethnographer to the dilemma about overt and covert observation. See Goodwin *et al.* (2003).

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