Interpretive Autoethnography in Medicine: An Accessible Way to Introduce Healthcare Professionals to the Craft of Critical Qualitative Writing

Brock Education

A journal of educational research and practice

2024 Vol. 33 (1) 85–102

https://journals.library.brocku.ca/brocked

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Abstract

Qualitative research is valuable in medicine because of the deep insights it offers into the social and cultural dimensions of healthcare. Historically, qualitative methods have been influenced by critical theory and have shared its constructivist epistemology and orientation towards social justice. It can be challenging to teach such critical qualitative inquiry to healthcare professionals because its underlying philosophy can seem at odds with the objectivist biological perspective emphasized in medical education. This is unfortunate because several social inequities are perpetuated by modern healthcare systems and critical qualitative inquiry is essential to the project of addressing them. This article argues that Norman Denzin's interpretive autoethnography is a promising method through which educators could introduce healthcare professionals to critical qualitative inquiry. In this method, the author uses the craft of writing creatively about their personal experiences as a tool for cultural interpretation and social justice activism. Such a creative analytic practice might seem alien to many medical professionals. On the other hand, the idea of analyzing their own experiences in detail is likely to feel familiar to them because of the prominence of reflective writing in healthcare professional development practice. This familiarity might make interpretive autoethnography accessible to healthcare professionals and practicing the method could help them to appreciate the value of interpretive writing as a way of investigating sociocultural meaning and promoting just change.

Keywords: Autoethnography, creative analytic practices, medical education, qualitative research, reflective writing

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Introduction

Qualitative research methods are increasingly recognized as valuable in medicine, though quantitative studies are still much more numerous in the field (Lin et al., 2023). As educators have pointed out, the fact that healthcare professionals and researchers tend to be most comfortable with the realist, objectivist epistemology on which the biomedical sciences are based has made it challenging to establish the credibility of qualitative inquiry in the health sciences (Eakin & Mykhalovskiy, 2005). This makes it difficult to teach them to engage with other ways of knowing, such as the socially critical, constructivist theories that underpin qualitative inquiry (Eakin, 2015; Eakin & Mykhalovskiy, 2005). This is problematic because modern Western healthcare systems perpetuate many systemic inequalities, including those relating to gender (Ekberg & Ekberg, 2017), ethnicity (Chauhan et al., 2020), sexuality (Medina-Martinez et al., 2021), age (Mikton et al., 2021), and disability (Swenor, 2021), all of which demand to be challenged. Properly critical qualitative inquiry is essential to the project of addressing these injustices.

In this article, I will argue that Norman Denzin's (2014) interpretive autoethnography is a promising method through which healthcare professionals could be introduced to qualitative inquiry. This method starts with the identification of significant events in the researcher's life that warrant further analysis. Many healthcare professionals are comfortable with this because of their experience with reflective writing, and this has the potential to make interpretive autoethnography seem accessible to them. However, the method also requires the researcher to embrace a constructivist epistemology and a socially critical perspective in a way that reflective writing (as commonly used in healthcare) does not. This is likely to feel alien to many healthcare professionals. I propose that this combination of familiarity and challenge makes the method an ideal entry point into the world of critical qualitative research for healthcare professionals.

One key to interpretive autoethnography's potential as an introduction to qualitative inquiry is Denzin's (2014) positioning of powerfully evocative narrative writing at the heart of the method. As Beuving and de Vries (2020) point out, for someone steeped in the scientific method, writing might simply connote the "writing up" (p. 56) of objective research findings once they have been finalized. This is not what it means in qualitative inquiry, where the act of writing is an essential part of the process of sociocultural interpretation and is allowed to give voice to the subjectivity of both author and subject (Beuving & de Vries, 2020). Interpretive autoethnography exemplifies this vision of writing as an integral element of a research method rather than just a means of communicating findings.

In this article, I will examine the philosophical and theoretical background of my proposal, make a practical suggestion about how to implement it, and offer an example of interpretive autoethnography from my own work.

My Positionality

I should be clear about my own identity and experience so that readers can judge for themselves how they might influence my claims (de los Rios & Patel, 2023). I am a United Kingdom–based paramedic who, as is now usual in the U.K., received my professional education from a university. I became interested in the importance of the contribution that critical qualitative approaches can make to the evidence base of healthcare while studying for a Master of Science degree in prehospital medicine. My postgraduate student cohort was multidisciplinary, and one consequence of this is that I tend to deemphasize traditional assumptions about the capabilities and limitations of the various healthcare professions. My attitude is that, although more-or-less specialized groups of practitioners are part of the sociocultural reality of contemporary medicine, everyone employed in the field shares the same objective: to promote health and cure or mitigate the negative impact of illness and disease. In this context, I believe that there is more to unite us than there is to divide us, and I have not found it helpful to emphasize professional distinctions that are often redolent of historical class dynamics and gender assumptions.

The Place of Qualitative inquiry in Medicine

William Osler (1849–1919), a Canadian physician whose life encompassed the transition from the 19th to the 20th century, noted that "the practice of medicine is an art, not a trade, not a business; a calling in which your heart will be exercised equally with your head" (Osler, 1932, p. 368) and, more famously, "medicine is an art, based on science" (p. 34). At the same time Osler was working and writing, anthropologists—specifically, ethnographers—were establishing the approaches to the study of human culture that, over the course of the 20th century, would evolve into the qualitative research methods of the social sciences (Geertz, 1989). Given the popularity of Osler's humanistic aphorisms, one might have expected qualitative research, which allows researchers to go "beyond quantitative data, accounting for human and social factors" (Lin et al., 2023, p. 2), to have been popular with medical researchers and clinicians. However, in practice this has not been the case. Though there has been growing interest in qualitative methods in medicine in the 21st century, quantitative methods have remained the dominant research paradigm in the field (Eakin, 2015).

This is so even though the importance of social factors to the understanding of fundamental medical concepts, such as health and illness, has been recognized in mainstream medicine since Engel (1977) outlined his biopsychosocial model in the journal *Science*. Several authors have sought to explore medicine's apparent reluctance to accept the validity of qualitative methods. For example, Rowe and McAllister (2002) note that although "qualitative inquiry provides a means of apprehending… complex social, cultural and political influences on healthcare… that are not easily identified and measured within quantitative research" (p. 9), this

potential is undervalued by policymakers and decision-makers, who embrace versions of evidence-based medicine[1] that privilege quantitative research and devalue or exclude qualitative evidence. The result is that sociocultural determinants of health and disease occupy a marginalized position in medical education, and students spend far more time internalizing the biomedical perspective. This poses a challenge to educators charged with the task of teaching qualitative methods in the health sciences.

The Pedagogical Problem

Drawing on their experiences teaching qualitative methods to healthcare professionals, Eakin and Mykhalovskiy (2005) write:

> It is very difficult for [qualitative research] teachers, using a social science and qualitative research vocabulary, to speak comprehensibly to students whose first language and culture is epidemiological, biomedical, or clinical. The process of exposing these particular students to alternative ways of knowing, involves constant work of translation from a technical vocabulary for analysis to one that understands analysis as a complex, interpretive social process. (p. 9)

Eakin (2015) delves further into the roots of this difficulty, emphasizing that the qualitative methods used today by social scientists were developed in an intellectual context that was deeply influenced by the critical theory of the 20th century. This has two important consequences. Firstly, qualitative methods are underpinned by the constructivist epistemology that was espoused by many critical theorists. Secondly, qualitative methods were explicitly designed to identify and challenge power imbalances and support socially just change. Both of these features of qualitative research are alien to many who have been trained in modern medicine, in which the dominant paradigm of evidence-based practice rests on the realist, objectivist epistemology that underpins the natural sciences and seeks to maximize generalizability, minimize subjectivity, and exclude socially contingent value judgments. Eakin (2015) argues that because of this, qualitative methods are often denigrated in medicine on the grounds that they produce anecdotal, biased, or subjective findings that are only useful insofar as they generate preliminary hypotheses that can later be tested using quantitative methods. In a bid to survive in this inhospitable environment, qualitative researchers have had to learn to pass as objectivists, framing their methods as a procedural toolbox capable of testing social hypotheses in the same way that quantitative methods are used to test biomedical hypotheses. In this way, medical qualitative research has been colonized by objectivism, creating a post-

[1] Evidence-based medicine (more generally, evidence-based practice) is fashionable in modern Western healthcare. Though the phrase sounds ideologically neutral, it has been argued that it has an underlying neoliberal bias (Newman & McNamara, 2016).

positivist discipline of applied qualitative research. This has compromised its identity and forced it to jettison its key strength: the ability to creatively interpret culture, challenge the social status quo, and foster positive cultural change. But is this a problem? What is there to be critical of in modern Western medicine?

Social Injustice in Medicine

Even a casual familiarity with the history of medicine suggests that the technologies yielded by the application of the biomedical sciences to the care of the sick have had a powerfully positive impact on human wellbeing. To many people living in developed countries, the idea of living without the range of antibiotics, analgesics, antiseptics, and anaesthetics in the contemporary clinician's armamentarium is probably unthinkably grim. But modern Western medicine is not reducible to these technologies. As Osler (1932) implies, it is more than the trade of repairing damaged or malfunctioning biological machines. It is a complex sociocultural phenomenon that is delivered through networks of personal relationships between patients, their families and caregivers, and professionals of various backgrounds. Being based in science does not make modern Western medicine immune from reinforcing the negative effects of any unjust power dynamics at play in these relationships.

The problem is not simply the unequal availability of healthcare between historically privileged and underprivileged groups. There is growing evidence that, even where modern medicine is available, there are problematic differences in the quality of the care provided to, for example, minority ethnic (Chauhan et al., 2020), LGBT (Medina-Martinez et al., 2021), elderly (Mikton et al., 2021), and differently abled (Swenor, 2021) patients.

The negative impacts of structural inequalities are not limited to patient care. They also cause problems for professionals. For example, a recent government study from England reported that there was a gender pay gap of 24.4% for hospital doctors and 33.5% for primary care doctors (Dacre et al., 2020). The reasons for this are complex, but the scale of the gap is striking, given that, as the study notes, direct discrimination based on gender is illegal in the U.K.

Inequity also exists between professional groups. Gender assumptions saturate the social constructions of the various healthcare professions (Ekberg & Ekberg, 2017). As Clayton-Hathway et al. (2020) points out, nurses continue to be underpaid and undervalued because of the persistence of the cultural construction of nursing as a feminine calling to which women are naturally well-suited. Because of this bias, nursing is seen as the enactment of behaviours that come naturally to women rather than the use of professional skills, which take years of training and a thorough education to master. This cultural drag means that nurses retain a stubbornly low socioeconomic status in the U.K., despite the fact that nursing has been a graduate profession, backed by its own Royal College, for decades.

Healthcare professionals who wish to address any of these issues cannot rely on the intellectual habits of the biomedical sciences with which they are familiar. The epistemology at the foundation of those sciences assumes that unchanging objective answers to questions about the nature of reality are accessible empirically through observation and experimentation. It is blind to the kinds of historically and culturally contingent, socially constructed realities that influence human interactions and generate (or combat) social injustice. Fortunately, alternatives are available. Under the influence of critical theory and postmodernism, methods that took account of these realities emerged during the narrative turn of the human sciences in the 1980s and 1990s (Bochner & Ellis, 2016). The critical qualitative researcher in healthcare requires one of these critical methods rather than an instrument from the objectivist, post-positivist qualitative toolbox. Autoethnography is just such a method.

Autoethnography

Chang (2016a) defines autoethnography as "a qualitative research method that uses a researcher's autobiographical experiences as primary data to analyze and interpret the sociocultural meanings of such experiences" (p. 444). A diverse range of research has been referred to as autoethnography, and what is meant by the term has varied from author to author (Chang, 2016b). This has caused controversy, and in 2006, a special issue of the *Journal of Contemporary Ethnography* published several papers that, taken together, illustrate the key debates between scholars of the method.

Anderson (2006a, 2006b) set out a vision of autoethnography as a sub-genre of analytic ethnography. Invoking the legacy of the Chicago School of Sociology (e.g., Blumer, 1969), he argued that autoethnographers should apply the established techniques of analytic ethnography to autobiographical data in order to discover ways in which their personal experiences might relate to and contribute to generalized sociological theories. He called this approach analytic autoethnography. Other articles in the same special issue supported and expanded on his position (Atkinson, 2006; Vryan, 2006).

Ellis and Bochner (2006) opposed Anderson. They wanted autoethnography to keep its distance from traditional realist ethnography. They advocated a more activist approach in which the method's central concern should be to provoke emotional responses through powerful writing with the intention of furthering a social justice agenda rather than contributing to a body of abstract sociocultural theory. They wanted autoethnography to move ethnography "away from the gaze of the distant and detached observer and toward the embrace of intimate involvement, engagement and embodied participation" (pp. 433–434). They worried that a widespread acceptance of Anderson's methodological conservatism among academics and journal editors might lead to their own more avant-garde approach being disparaged for being insufficiently objective, perhaps making it more difficult to publish. As far as they were concerned,

Anderson's method was at odds with the very purpose of autoethnography, and they questioned whether it should even bear the name. Denzin (2006) was similarly unimpressed by Anderson's proposal. In a later textbook, Denzin (2014) detailed an approach to autoethnography, similar to Ellis and Bochner's, that advocated creative analytic practices, including the composition of literary works (e.g., poems, novels, and plays) using experimental postmodernist techniques and eschewing more conventional academic forms.

Detailed treatments of autoethnography have tended to gravitate toward one or other of the poles represented by the disagreements aired in the 2006 special issue. The activist, social justice-oriented forms of autoethnography are represented by the work of Muncey (2010), Adams et al. (2015, 2022), Spry (2016), and Bochner and Ellis (2016). A more analytical mode is represented by Chang's (2016a, 2016b) work, which includes a review of autoethnography in health sciences research (Chang, 2016a). Chang (2016a) notes that autoethnography is gaining ground in the field of health sciences research but critiques the predominance of "descriptive and evocative" (p. 443) work and calls for more analysis. Her five normative criteria for a "desirable" (2016a, p. 443) autoethnography do not mention critical theory or social justice; rather, they include authenticity of data, accountability of process, ethics, sociocultural analysis and interpretation, and scholarly contribution as the sole markers of esteem.

I embrace the more experimental, activist, and evocative kind of autoethnography. This is because my intention is to inspire interest in multiple ways of knowing other than the objectivist, scientific mode, and ways of writing other than the traditional third-person academic style. Through their education, medics learn to see objectivity and third-person writing as the default epistemology and voice of their discipline, and this has the potential to distance them from other intellectual approaches. Fortunately, they also become familiar with a genre that can narrow this distance because it is neither wholly objective nor impersonal: reflective writing.

Reflective Writing

Reflective writing is a form in which an author analyzes their own workplace experiences with the intention of identifying ways in which they can improve their professional practice (University of Edinburgh, 2022). It is widely used by doctors (Lim et al., 2023), nurses (Bjerkvik & Hilli, 2019), and other healthcare professionals (Mann et al., 2009) to allow them to "step back, review their thoughts, goals and actions and recognize how their perspectives, motives and emotions impact their conduct" (Lim et al., 2023, p. 1). It is so well established in the healthcare field that many statutory regulators encourage (or require) professionals to engage in reflective writing as part of their continuing professional development (e.g., General Medical Council, n.d.; Health and Care Professions Council, 2023; Nursing and Midwifery Council, 2021). However, reflective writing is limited as a form of academic writing by the fact that

individual pieces are rarely published in the scholarly literature. The assumption seems to be that reflective writing will be of limited interest to anyone other than the author because its value lies in "its ability to enhance self-monitoring and self-regulation of... conduct" (Lim et al., 2023, p. 2). This ignores the possibility that professionals' personal responses to the kinds of deeply felt professional experiences that prompt them to reflect might contain valuable evidence of and insights into the systemic problems that they face in their work (i.e., the forms of social injustice I have cited).

From a socially critical perspective, this is problematic. As it is taught and practised in healthcare, reflective writing often starts with a professional identifying an incident during which they believe that they have committed an error (or acted undesirably in some way) and about which they have negative feelings. They then apply one of a variety of published models, such as Gibbs's (2013) reflective cycle, during which they compare their own actions and decisions with institutionally sanctioned protocols or guidelines, highlighting any discrepancies. The process culminates in the formulation of an action plan, which is usually a commitment to avoid any such deviation in future similar situations[2]. The assumption is that the existing institutional consensus about what to do in the situation under scrutiny is sound and that the individual (by acting at variance with it) has gone astray—that is, that individual "self-regulation of… conduct" (Lim et al., 2023, p. 2)—is what is required to address the issue. This is not in the spirit of critical inquiry; as Denzin (2014) points out, "if only actors, and not the social order change, then the systemic processes producing the problem remain in place" (p. 61).

Despite this difference in focus, there is common ground between autoethnography and reflective writing. Denzin (2014) is explicit in stating that "the subject matter of interpretive autoethnography is meaningful biographical experience" (p. 28). The same is true of reflective writing. It is this resonance that leads me to believe that healthcare professionals might find Denzin's interpretive autoethnography accessible, despite its being philosophically and stylistically different from what they are used to accepting as scholarly writing. I contend that, by embracing it, they can transform the way that they engage with their professional experiences, shifting the emphasis from recording self-criticism in private professional development portfolios to expressing sociocultural critique in the health sciences literature.

Interpretive Autoethnography

Interpretive autoethnography (Denzin, 2014) is a method built on conceptual foundations laid by Victor Turner and Edward Bruner in their *Anthropology of Experience* (Turner & Bruner, 1986, as cited in Denzin, 2014). Drawing on the work of Wilhelm Dilthey, Turner and Bruner

[2] I accept that, according to most textbooks (e.g., Esterhuizen, 2019; Handler et al., 2011), this is not the explicit intention. However, in my experience, it is often the reality.

accept Dilthey's idea that "reality only exists for us in the facts of consciousness given by inner experience" (Dilthey & Rickman, 1976, as cited in Bruner, 1986, p. 4). Since an individual only has direct access to their own consciousness, the only way for them to connect with the experiences of others is to interpret the expressions of those experiences that those others put out into the world (e.g., the ways they talk about or present themselves)[3]. For Turner and Bruner, culture is therefore understandable as a hermeneutic cycle in which individuals produce outward expressions of their own experiences, others interpret those expressions, those interpretations are incorporated into the interpreters' experience, and this altered experience gives rise to correspondingly modified expressions, which feed back into the process. The implication (which might be especially disconcerting for someone coming to this theory from a scientific background) is that no unchanging, objective truth about culture is accessible to the anthropologist. Only evolving, contingent, subjective interpretations are possible.

Working within this framework, Turner (1986) describes social drama as an interpretive process through which narrative structure is imparted to the resolution of conflict within communities. The inciting incident of a social drama is a breach in which an individual or sub-group acts in a way that transgresses the norms of the wider community. This is followed by a crisis, during which the people involved take sides and a conflict develops. Then the redressive or remedial processes that the community has at its disposal to resolve the conflict are invoked. The story culminates in either reintegration (the individuals that caused the breach are brought back into the fold and peace is restored) or schism (the community definitively splits along the fault line represented by the conflict). Turner draws particular attention to the redress phase of the social drama, which often is highly ritualized and has a liminal quality because, while it is happening, the participants are suspended in the space between before and after, the future uncertain.

Such Turnerian social drama is at the heart of interpretive autoethnography. Epiphanies, which are the meaningful biographical events out of which interpretive autoethnographies are built, are conceived as having the same four-act structure as social dramas (breach, crisis, redress, and reintegration/schism) (Denzin, 2014). But interpretive autoethnography is more than just the analysis of personal epiphanies in terms of the structure of the social drama and the writing up of the results in a traditional third-person academic style. Denzin (2014) takes the narrative aspect of social drama seriously, encouraging the use of literary devices such as "plot, setting, characters, characterizations, temporality, dialogue, protagonists, antagonists—showing not telling" (p. 60) to express the author's experiences of their epiphanies. This places the author's voice at the heart of autoethnography and allows the autoethnographer to explore how the meanings expressed in a text are constructed in the act of producing it, rather than discovered as objective facts about the world (Denzin, 2014).

[3] Including the works of art or literature that they produce.

Interpretive autoethnography is also an explicitly socially critical method that "begins from a progressive political position stressing the politics of hope [and] uses the methods of performance and personal narrative to present its critique and utopian vision. It presumes that the social order has to change if problems are to be successfully resolved in the long run" (Denzin, 2014, p. 61).

Interpretive autoethnography thus starts with a practice that is familiar to healthcare professionals trained in reflective writing: the contemplation of significant personal experiences. However, it proceeds in a radically different direction than reflective writing because of its deep roots in anthropological theory and desire to nurture socially just change. It is this juxtaposition of familiarity and challenge that I believe makes it a promising method through which healthcare professionals might be introduced to the practice of critical qualitative inquiry, and I have a practical suggestion for how this could be achieved.

Introducing Interpretive Autoethnography to Healthcare Professionals

My proposal rests on three assumptions. Firstly, the prospective learners are already familiar with and experienced in reflective writing. Secondly, they are capable of being motivated to engage in a deep and challenging exploration of their own professional behaviours and experiences from a socially critical perspective. Finally, they have access to mentorship from experts who are versed in the complexities of the craft of qualitative inquiry, such as experienced scholars and educators of its methods (for a discussion of the importance of this, see McAllister & Rowe, 2003).

The first assumption implies that the learners should already be practicing professionals rather than undergraduate students who are still learning reflective writing. The second and third assumptions suggest that they would benefit from the support of an educational and research setting in which critical qualitative research is practiced and valued.

In such a context, for example, a postgraduate course in health science research methods, a promising approach could be to ask students to look back over the reflective writing that they have already produced and select examples that are particularly meaningful for them. They could then re-examine them using interpretive autoethnography. In practice, this would mean coaching them to compose evocative narrative accounts of their experiences, using the writing process to construct their cultural meanings and illuminate their critical potential. This could help the students appreciate the integrated role of writing in critical qualitative methods.

It would also allow them to practise applying a critical method to authentic qualitative data that has real meaning for them, with fewer of the ethical and practical challenges that come with the collection of new data from human subjects. Its value would be somewhat limited by the fact that there are skills and techniques in qualitative research (e.g., sampling, interviewing, data

analysis) to which interpretive autoethnography is not the ideal introduction. Nevertheless, I believe that it has potential, especially early in the process of introducing students to the qualitative mindset, to help break through the pedagogical barriers I have discussed in this article. It would also introduce them to a form of writing that they could seek to publish, contributing their personal experiences and social critiques to a sub-genre of the health sciences literature that although not palatable to all scholars in the field, is expanding (Chang, 2016a).

To illustrate this proposal, I offer an example from my own work. It shows how applying interpretive autoethnography to an incident that I had previously reflected on revealed to me that my construction of the incident's meaning has dramatically altered since it happened. This has helped me to appreciate how years of interacting with patients and their caregivers on a human level have allowed me to discard the self-serving, guideline-bound conclusions that I reached in my original reflection and replace them with a humanistic approach that is more capable of meeting the individual needs of members of a vulnerable and marginalized patient group (the frail elderly).

Names have been changed and locations obscured to preserve the privacy of the people portrayed.

Anne, Christine, Ed, and Myself—An Example Epiphany

I'm at the ambulance station at the end of a shift. My watch shows 19:00, and it's time to go home. I'm a student paramedic, a newcomer to the ambulance service, and I feel under constant pressure to prove myself to my new colleagues. At the end of a shift, I always feel my stress levels go down. I've not measured it, but I reckon my blood pressure drops significantly at the exact moment my shift ends. Maybe there's a study in that. As I walk out of the ambulance station, the smells of diesel and disinfectant are swept away by fresh air from the nearby sea. It's a pleasant evening, and I'm looking forward to going home.

Someone shouts, "Hey! John!" from inside the garage behind me. I stop in the car park and turn. It's Steve. I joined the ambulance service with him, and he's in training too. At first, I expect that he just wants to say hello and perhaps ask about the latest essay that we've been set, but as he walks up to me, he looks serious. I cock my head to one side. "What's up?"

"It's about a patient you saw yesterday, mate. A lady who fell. You left her at home."

My blood pressure goes back up…

"Me and Sarah," that's his mentor, an experienced paramedic, "went out to her this morning. Her doctor sent us. We took her in. I just checked on her at the hospital. She's got a bleed on the brain. They say her doctor's not happy that you didn't take her in yesterday."

He pauses, maybe uncertain about what to say next, then goes on, “I just thought you should know. You and Ed probably have a complaint coming.”

Ed’s not my mentor but he’s been doing the job for a long time. He was supervising me yesterday.

“Thanks,” I say, and make my excuses, “it’s a long drive home, I have to get back for dinner.”

I’m not really thinking about eating: I just feel sick.

During the drive home, I replay the job in my mind. The woman’s name was Anne. She was in her 80s. When we got to her flat, her daughter Christine was there. Anne was lying on the floor in the bathroom and couldn’t get up. She said that she wasn’t hurt. She didn’t remember falling, and she said that she didn’t know how long she had been on the floor. I checked her over and couldn’t find any injuries. Ed and I helped her up, put her walking frame, which she had evidently left behind when she went to the bathroom, in front of her, and she walked, unsteadily but without any help, to an armchair in her living room. Sitting down with a contented sigh, she picked up the TV remote. I thought she looked very frail.

Ed spoke with Christine: “I’m worried that your mum doesn’t remember falling…”

“Oh, that’s normal,” Christine replied before whispering, “we don’t talk about it, but she’s got, you know… dementia.”

“I understand,” said Ed, “is she any different from usual today?”

“No,” shrugged Christine, gesturing towards her mother, “this is just… her, now.”

Ed paused. “OK… is she on any medication?”

“Loads,” laughed Christine gently, “she rattles when she walks. It’s all in the kitchen.”

While they were talking, I took Anne’s observations: pulse rate, respiratory rate, blood pressure, and temperature, and recorded a 12-lead ECG—a tracing of the electrical activity in her heart. The ECG showed atrial fibrillation, a common cause of an irregular heartbeat in older people, but nothing else was abnormal. I helped Anne find something to watch on the telly, while listening to Ed and Christine. That’s one skill that I had already picked up in my first few months on the road. When Ed looked at me and nodded towards the kitchen, I knew what he wanted. “Back soon,” I said and went to have a look at Anne’s meds.

She was on a few daily tablets, and as I expected, one of them was a blood thinner: apixaban. I knew that, if Anne had hit her head, national guidelines said that she should have a CT scan to

make sure that the injury hadn't caused a bleed inside her skull, a serious condition that the apixaban, as well as her age and frailty, made more likely.

I went back to Anne and asked, "Do you take the blood thinner because you have an irregular heartbeat?"

"I don't know," she replied, "I just take whatever pills the doctor sends me."

Christine smiled. "She's got atrial something or other…"

"Fibrillation," Ed put in, "is pretty common as we get older." He looked at me.

"Yeah, that's what the ECG showed." I answered Ed's unspoken question.

"So, what are you thinking?" Ed asked me.

"Well, she's on Apixaban, but we don't know if she hit her head when she fell because she can't remember. There's no visible injury. But I think maybe we should take her in as a precaution…"

Christine jumped in and said, "No, please don't take her to the hospital. She gets so confused. Last time, she wouldn't stop shouting. And she caught pneumonia. They kept her in for a month. She didn't need that damn Zimmer frame until after that."

Ed turned to Anne and asked, "What do you think? Should we take you to the hospital?"

Anne shrugged. She didn't seem to mind.

"What now?" Ed said to me.

"Umm," I replied, "I'm not sure Anne will understand the risks because of her dementia. We can assess it formally, but I don't think that she has the capacity to refuse, so we have to act in her best interests."

"Which are?" asked Ed.

"The guidelines say to take her in for a scan," I replied.

Christine looked horrified and started to protest. Ed nodded and politely lifted a hand, palm down, to waist level. She paused.

"I know what the guidelines say. But what are Anne's best interests? What's the point of a scan?"

"To see if there's a bleed," I answered.

"And, if there is?" He continued, "Do you think she'd be a candidate for neurosurgery?"

I looked at Anne. I'm no brain surgeon, but… I shook my head.

Ed went on, "If we take her in and she does have a bleed, they'll probably admit her. It's not likely that they'll want to do anything too invasive, but it will be difficult for them to discharge her. Worst case: she might never come out."

He turned to Christine, who said quietly, "That's what I'm afraid of. She wouldn't want that. I don't want that…"

I didn't know what to say. Thankfully, Ed broke the silence. "Christine, you're doing a great job of taking care of your mum. We'll leave her here with you. If you're at all concerned, especially if she complains of a bad headache, says that she feels sick, starts vomiting, or doesn't seem herself, you can call us back on 999 or get her doctor to come and see her at home. How does that sound?"

"That would be wonderful; thank you," said Christine, obviously relieved.

Ed and I had started to pack up our equipment when Anne said, "A cup of tea would be nice."

"A cup of tea would be nice," agreed Christine.

I went back to the kitchen, tidied up Anne's tablets, filled the kettle, and started looking for some tea bags…

I recall all of this during my drive home. Once I'm there, I pick up my dinner. Because of what Steve said to me, the prospect of a complaint from Anne's doctor hangs in the background of my life and work for weeks afterwards. When nothing materializes, my anxiety about that fades. But I remain uncertain about whether we have done the right thing. The anxiety is replaced by shame and disappointment. In myself and Ed.

When I am asked to complete a piece of reflective writing as part of my paramedic training, I choose Anne's case. In my essay, I leave out Christine's pleas to leave her mother with her. My conclusion is that a scan was in Anne's best interests and that Ed and I should have taken her to the hospital against her daughter's wishes. The essay gets a good mark.

Years later, I am more ashamed of that essay than I am of what actually happened. I can see that my action plan was designed to reduce the risk to future me, not to vulnerable patients like Anne. I can tell that I didn't ever again want to be stopped as I left work, was told about a case that had gone wrong, and felt ill with anxiety for weeks afterwards. Without being conscious of it, I had confused my own best interests with those of my patients. Since then, I have learned from my patients how to support them in making their own decisions about their care. Decisions that are in keeping with their wishes and values, even when these don't fit clinical

guidance and don't seem to accord with the medical evidence. I have also come to appreciate how relatives and caregivers, the people who know my patients best, can help me understand the wishes and values of those who can't express them for themselves. In short, I am no longer the worried student who wrote that essay. I am now a paramedic who recognizes that Ed was right all along.

Conclusion

In this article, I have explored the contested role of qualitative inquiry in healthcare. I have examined some of the reasons for this, including the pedagogical difficulties inherent in training students and professionals with a hard scientific background to understand and respect alternative epistemological perspectives and modes of expression. I have suggested a way of breaking down this pedagogical barrier using interpretive autoethnography, a method that is essentially socially critical and constructivist in its orientation but should be accessible to healthcare professionals because of their familiarity with reflective writing.

As well as fostering a shift in philosophical perspective, I also hope that teaching interpretive autoethnography to healthcare professionals can equip them to contribute powerfully evocative and socially critical writing to the expanding genre of health sciences autoethnography.

Although interpretive autoethnography is not the ideal method through which to teach all aspects of qualitative research, I maintain that, as an entry point into the wider world of critical qualitative inquiry for healthcare professionals, it has much to offer.

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