Reflecting on Work Practices. Possibilities for Dialogue and Collaborative Knowledge Production in Institutional Ethnography

Riikka Homanen

This chapter explores dialogue and collaborative knowledge production in institutional ethnography. Ethnographic research is widely viewed as a specific type of research that always produces knowledge collaboratively in the sense that knowledge is generated through the researcher's interaction with the field under study (Mesman 2007, Holmes and Marcus 2008). In institutional ethnography (IE) (Smith 1987, 2005), there is little research on how collaboration and dialogue take place as part of the research process. This is an obvious shortcoming in methodological literature on IE, because there are key methodological issues relating to dialogue and collaborative knowledge production in IE that are important to consider in reflexive analysis of IE practice. These issues relate to the tendency of institutional complexes to exclude or marginalize the individual's perspective and experience-based knowledge and thus hinder collaborative efforts.

In this chapter, these methodological issues are addressed through analysis of how participants in an institutional ethnography—researchers (including myself) and institutional workers (in my case, nurses)—engage in reflection collaboratively on the institutional workers' work activities. Further, I will address the significance of this kind of collaborative reflection for the process of IE knowledge production in my own research project as well as with respect to wider methodological and epistemological questions.

The topic of my IE research project is the institutional constitution of maternal-fetal relations in the nursing work practices of Finnish maternity health care. In the project, I explore the social organization of institutional nursing work practices as nurses and clients participate in them and from their perspectives in such as in articulations of medical ethical models. The starting point of IE is in the experiences of the people doing the institutional work, and it is the experience and experience-based knowledge of work practices that form the basis for the ethnographer's analysis of wider institutional orders. Moreover, experience is seen to emerge through dialogue among the research participants, in this case researchers and nurses in particular temporal and spatial contexts. Dialogue, in IE, refers to an ongoing interchange between participants that is cumulatively responsive to diversities of viewpoint (Smith 1987, 2005).[1]

The research project was conducted by three researchers including myself, with each of us having her own subproject. The project was based on ethnographic work at three diff erent maternity and child health care clinics for several months and included multiple methods of data production such as video recording, observations of nursing work activities, interviews and documentary material, as is common in ethnographic inquiry (see Hammersley and Atkinsson 1995, Harbers, Mol and Stollmayer 2002, Marcus 1995). After the fieldwork was carried out, researchers arranged workshops in each of the participating clinics for the nurses who participated in the study. In the workshops, researchers and nurses together watched and reflected on extracts of video recordings of each individual nurse's own appointments with clients. The initial purpose for the workshops was for the researchers to communicate their preliminary analyses to the participating nurses and to offer the nurses a space to reflect on their work practices, based on the activities seen on the videos and our preliminary analyses.

During the workshops, I began to realize that the interaction between the nurses and us researchers that took place could be conceptualized partly in terms of collaboration and dialogue: the discussions of the work practices in the video recordings gave the nurses the opportunity to give reflexive accounts of their own work based on their experience-based knowledge; and, at the same time, the discussions gave researchers the chance to reflect, on the basis of those accounts, on their preliminary analyses presented at the workshops. Thus the workshops represented a site for collaborative knowledge production in which negotiations took place between the knowledges of the nurses and researchers. And the provision of a site for the articulation of participants' experience-based knowledge is important from the perspective of IE because IE seeks to discover the particular ways in which institutional orders are in play in everyday working life. In my further analysis of the material, I drew on the reflections in the workshops. Thus it can be argued that this collaborative knowledge production formed an integral part of the research process.

Over the last twenty years or so, collaborative approaches to ethnographic practice have become widespread. Ethnography and collaboration are viewed here as intertwined practices (e.g., Henriksen 2002, Holmes and Marcus 2008, Messman 2007). According to those approaches that stress the collaborative dimensions of ethnography, 'doing ethnography' entails not just giving descriptions of practices of the given field but also changing them either deliberately (as in action research) or unintentionally (just by being in the field). It has even been claimed that research participants in the contemporary ethnographic research settings increasingly expect outside interlocutors, other professionals or researchers, to be part of their everyday life. The settings where such people operate include contexts that require that they reflect on their own actions and engage in a communicative relationship with the outside world. (Holmes and Marcus 2008). In my view, such settings are often to be found within contemporary institutional/organizational contexts, such as NGOs and state services, where communicative practices are increasingly constituted within a discourse of dialogue, participation and empowerment (Phillips 2011). For instance, workers are encouraged to work in multiple and equal 'partnerships' with participants from various field of expertise and lay people who are constructed as 'active' informants or even co-researchers. As I will show, the Finnish maternity health care organization I analyse in my study is a good example of one such institutional site (see, e.g., Handbook of Maternity Health Care 2007).

As key figures in the move to post-foundational, collaborative and participatory forms of ethnography, Douglas Holmes and George Marcus (2008) argue that traditional ethnography's understanding of collaboration in terms of research participants' responses to, cooperation with and toleration of the ethnographer's agenda underestimates participants' abilities to reflexively produce analytical insights about their life worlds. They suggest that these analytical insights should be integrated into the research to define the issues to be explored and the means by which the issues are to be explored. Understanding research collaboration in this way avoids the classical distinction between phases of design, implementation (data collection, analysis and writing the research report) and evaluation of results. Instead of providing an outsider report for participants and other audiences to evaluate, the ethnographer seeks collaboration with the participants in different or all phases of the research process (cf. Mesman 2007: 281).

In this chapter, I explore the engagement of research participants—nurses—in one phase of research, the analysis phase. In particular, I look at a specific type of engagement: joint reflection on research participants' own work practices as documented on video. I aim to

investigate the possibilities this kind of reflexive engagement provide for (1) the dialogic production of experience-based knowledge on institutions and (2) the collaborative production of research knowledge in IE research processes. I argue that, in my IE research project, between experience-based and scientific knowledges resulted in collaboratively produced knowledge that guided the analysis deeper into the ways in which institutional organization is realized in everyday care practices.

In focusing on the possibilities, I will try also to attend to the limitations and problems, concentrating on three different sources of difficulty. First, the researchers and participants may have conflicting interests. For instance, the nurses in our study wanted the researchers to influence local administrative decision-making concerning their work whereas we were interested in obtaining their knowledge of concrete work practices beyond the argumentative politics they offered us. Second, the different (power) positions of researchers and participants may result in difficulties in collaboration. For example, asymmetrical power relations were established and maintained by the researcher-driven design for the workshops. The researchers decided on the themes for reflection and did not invite nurses to suggest themes. Third, there remain irreducible differences between the knowledges of the nurses and the researchers and the meaningfulness and origins of those knowledges. Like the researchers' knowledge, the nurses' professional knowledge draws on a scientific body of knowledge (nursing studies and social science) but there are considerable differences as well. Research-based inquiry aims at the coherent and systematic production of knowledge on the bases of disciplinary concepts, theories and methodologies. For the nurses, work with clients requires practical and experience based knowledge gained through direct personal encounters with clients over a long period of time (see also Homanen forthcoming).

As I will argue, difficulties and limitations in doing collaboration can be found in unexpected places and spaces. But despite those difficulties, possibilities for collaboration emerge. Before analyzing the possibilities and the difficulties in detail, I will present a short description of my project's IE approach.

An Institutional Ethnographic Approach to the Institution of Maternity Health Care

The motivation to carry out a study of maternity health care stemmed from an interest in a number of interventions developed and implemented in maternity and child health care in Finland over the last decade. Such interventions have their origin in the health care policy that nursing support should be directed at the psycho-social relations and wellbeing of families in addition to the medical screening of individual women (Rimpelä 2008, Viitala et al. 2008).[2] In my own subproject[3,] I was interested in particular in how maternal-fetal relations were enacted in maternity health care practices which aimed, through collaboration between nurses and families, to further psycho-social well-being. The empirical fieldwork was mainly conducted by myself personally over a three month period in the course of 2006–2008, and the data include video-recordings, observations and interviews from various sites of maternity health care practice, such as nurse-client appointments and counselling classes for a group of parents. [4] A long period of fieldwork was conducted in order to explore the dynamics of a variety of care practices that cannot be grasped through short visits to the field. Moreover, three workshops were arranged for the participating nurses to communicate preliminary findings in lay terms and to offer them a space to reflect on their working methods. The workshops were not originally systematically planned as a space for collaboration or dialogue but, as noted earlier, I

experienced during the process that they had become such a space. During my observations, I made handwritten notes on the workshop but did not audio or video record them.

The ethnographic orientation of my study draws on IE as theorized by Dorothy E. Smith (1987, 2005). More specifi cally, Smith's conceptual 'design for ethnography' works for me as a broad frame for conceptualizing how institutions exist as objects of enquiry (Smith 1987, 2005). The overall aim of IE is to explore the social relations organising institutions as people participate in them. IE takes its starting-point in, and focuses on, the experiences of the participants in such institutions. Institutions, in Smith's view, are vast complexes embedded in the ruling relations that are organized around a particular function—in the case of my study, health care. IE aims to go beyond and behind individual actions, knowledge and experience to discover how individual actions are connected with and coordinated by the actions of others in institutional orders. 'Experience' is understood in IE as what people come to know through everyday bodily being and action and emerges for the ethnographer in dialogue among particular people in particular times and in particular places (Smith 2005: 123–141).[5]

These dialogically produced accounts of people's experiences, then, work as entry-points that organize the further inquiry into the social relations coordinating the work of all the participants involved in institutional activities. In theorizing the social relations and the epistemological grounds for studying them, Smith draws on Bakhtin's theorization of dialogue. For Bakhtin (1981, 1986), language is an ongoing and historically developing complex which is responsive to time and people's intentional utterances. According to Bakhtin, language is inherently dialogic as meanings are produced through the interplay of multiple voices. In that interplay, a unity is formed but, as a result of the play of difference across voices, that unity is a multivocal one, full of contradictions (Bakhtin 1981, Clark and Holquist 1984). The rules and regulations of language (grammatical, cultural and other) are integrated into language. However, language is not determined by such regulations and each utterance reproduces and elaborates language (Bakhtin 1981, 1986, Smith 2005).

In Smith's application, the concept of dialogue is more inclusive than that of Bakhtin. Whereas Bakhtin's (1981, 1986) concern is mainly language as dialogue, for Smith dialogue characterises the social practice in general. Social complexes, such as institutions, are ongoing historical processes in which people's actions are caught up in, and responsive to, what others are doing, and responsive to, and shaped by, what has been going on. By adopting this kind of dialogic ontology of the social, IE aims to treat people as agents and subjects and take account of the particularities of their lives and actions. Thus it strives to avoid constructing abstractions that objectify people. Such abstractions, it is argued, are often in play both in institutional activities and in conventional research practices through representation in texts and face-to-face interaction (Smith 2005: 50, 62, 66, 68, 123).

Smith claims that in institutional contexts, privileged, totalising interpretations and representations have a tendency to suppress diverging perspectives and experiences. Here, she draws on Bakhtin's critique of monologue as an attempt to force through a singular voice in the face of plural meaning-making (Smith 2005: 62, 66). Dialogue for her is not just a naturally occurring human encounter but can be potentially realized through methods and eff orts to avoid monologue.[6]

Accordingly, in the interviews I conducted, I applied different kinds of methods of interviewing to try to go beyond articulations of the abstract institutional discourse such as statements by nurses that they work in line with particular principles or recommendations set for maternity care work such as ‘client centeredness’ or ‘family orientation’. I first asked the nurses to talk about their work in their own words, then asked them to elaborate on different issues such as what different principles meant for them in practice and to give concrete examples (see also DeVault and McCoy 2006). Although, the nurses responded to this line of interviewing, it was still hard for me to gain an understanding of what it was that they actually did when performing particular discursive principles such as client centeredness and what the significance was of doing whatever they did from their viewpoint. Often, in spite of my eff orts to apply ethnographic interviewing techniques, the nurses tended to adhere to abstract descriptions and short examples within the terms of administrative and policy discourses on maternity and child health care.

In contrast to the interviews, the activities and discussion that took place in the workshops, particularly around video-recordings of the nurses own appointments, seemed to evoke specific stories and explanations of the nurses’ own experiences of doing antenatal care. The workshops became sites for collaborative knowledge production and dialogue as the nurses’ experiential knowledges were articulated together with my scientific knowledge. Before analyzing the workshops as such sites, I will first give a description of the nurses’ work practices in order to delineate the experience-based knowledge interests, competences and knowledges that the nurses brought with them to the workshops and which thus formed the background for, and shaped, collaborative knowledge production and dialogue in the workshops.

Maternity Health Care Institution and Nursing as Reflexive Work Practices

In Finland, maternity health care has remained in the primary health care sector and is institutionalised in maternity health care clinics in which public health nurses and midwives provide the services (Benoit et al. 2005: 725–729).[7] Clinics are often located in clients’ own neighborhoods in cities and in their own municipalities in rural areas. The care involves providing support in the form of advice and information on, for example, healthy eating habits, on preparing for the birth especially on the part of the future mother, and on control of somatic changes experienced by the pregnant woman and the fetus. Furthermore, attention is paid to the social and psychological environment of the child-to-be by encouraging both parents to reflect on and to discuss issues of parenthood and family life such as home arrangements and drug and alcohol abuse in the family. In addition to meetings with clients, the nurses’ work also includes team work with other professionals dealing with early social and health care of children, such as social work, family care work, child psychology and obstetrics. These teams meet regularly to try to solve the problems of individual families (Handbook of Maternity Health Care 2007, Ministry of Social and Health 2004, field notes 2006).

According to my observations at the clinics, collaboration with clients and other professionals and interactional skills in maternity health care nursing are increasingly emphasized in order to arrive at solutions for both clients and professionals. The nurses are trained and encouraged by the administration and in different nursing interventions to reflect constantly on their methods of interaction with client families at the appointments and with other professionals. For instance, every six months the nurses attend a regular

meeting arranged by the municipality to reflect on and assess their working methods, and they are encouraged to make an assessment of the client interaction together with their clients when possible (field notes 2007).

In all the interviews and discussions I had with the nurses, it was pointed out to me that, in practice, collaboration and interaction with clients and other professionals involve a process of building rapport and trust and informal conversation. First of all, the socio-material setting of the clinics is very relaxing, cozy and friendly in contrast to the generally more formal setting of clinical health care contexts. Stepping into the clinic is like stepping into a half-nursery, half-health clinic-like space. Toys, crawling babies, colourful curtains and posters meet the office and examination equipment. In the hallways, nurses stop for an informal chat with clients, and during the meetings with clients give the impression that there is never a too tight agenda for the appointments so individual concerns may be addressed. Informal conversation is used to keep track of concerns and even quite unrelated chatting is common. It is not uncommon for nurses to share their own experiences of pregnancy and motherhood.

It comes as no surprise, then, that both the pregnant women and the nurses I talked to and interviewed referred to their relationship as ‘friendship- like’, and described it in terms of ‘equality’ and ‘peer support’. Further, they seem to view nursing as a humanist counterbalance to the technology-driven medical practice (see also Bowker and Starr 1999: 274). Although there are standard tests to take, health information to enter into patient records, and advice to be given in line with the progression of the pregnancy and the official care plans, the nurses’ work also consists of informal methods they call ‘probing’. They understand ‘probing’ as intuitive and practice-oriented clinical decision-making as opposed to more visible, measurable and transparent doctoring.

‘Probing’, in my view, is part of the discussion style used in supporting client parents’ psycho-social transformation to parenthood. It often takes a form that resembles a (family) therapy session. That is, the parents are encouraged to talk about their past and present thoughts, experiences and feelings related to them. More specifically, they are encouraged to reflect on their pregnancy as a mental and emotional journey towards parental selves. The nurses, then, in the light of these reflections, reflect on their previous assessments of the situation of the family and give support and advice accordingly which, in turn, may result in further elaborations from the family members, and so the process goes on (observations from video recordings in 2006–2008).

Team work with other professionals involves collaboration and interactional skills that are not based so much on building trust and rapport or careful ‘probing’ in order to get others to refl ect or share information; rather, they involve negotiations over how to coordinate different professional agendas and knowledge on aspects of family life as well as possible solutions for the individual family in question. The atmosphere in the multi-professional team meetings held for team work at the clinics was very friendly, and resembled an informal conversation among equal colleagues as opposed to a formal consultation with professionals from different structural positions in the institution with different educational backgrounds and different kinds of work experience. In the meetings that were held in the clinics’ coffee rooms or seminar rooms, all the professionals commented on nearly all the issues that came up about the families’ lives regardless of their field of expertise and formal professional agenda. The result of this was that the practical details and objectives of each professional suggestion were opened up and even forced open when different

professionals called on each other to argue for their suggestions for action. Furthermore, regular meetings treated teamwork as a process. If something went wrong earlier, what was it that went wrong with the activities? How could *we* make a better assessment?

In general, then, it can be said that nursing in the institution of Finnish maternity health care is work in which client families and various health and social care professionals participate as equal partners in enhancing child health, development and family welfare. This is in line with recent national and municipal recommendations that suggest a discursive shift from protectionist education to working in a collaborative manner in multiple partnerships (see also Handbook of Maternity Health Care 2007, Jallinoja 2006, Ministry of Social Affairs and Health 2004). This discursive shift can be understood in terms of what Louise Phillips (2011) has termed *the dialogic turn* in the production and communication of knowledge. She argues that practices in the dialogic turn are constituted within a discourse of dialogue, participation and empowerment; within the discourse, communication is conceived as a dialogue among participants in which knowledge is co-produced collaboratively, rather than as a flow of knowledge to a less knowledgeable target group (Phillips 2011: 3–5).

Workshops as a Reflective Method in Institutional Ethnography

On the basis of the above description of the nurses' work activities, experiences and knowledge, it can be concluded that the nurses' work is characterized by collaboration involving interactional skills and ongoing reflections on practice. Although they have had training and meetings in order to develop collaborative skills and reflection, I was often told by them that they felt insecure about their interactional competence, especially concerning clients with psycho-social problems. They felt that they did not have the means to bring up and productively discuss difficult issues such as drug abuse and marital problems. I was also told that they hoped to learn interactional skills from the workshops we researchers arranged for them as we were engaged in social scientific analysis of the interaction taking place at the clinics. I wonder if this assumption was one of the reasons the nurses asked us 'to give something back' when they consented to participate in our study. Whatever the grounds, they were eager to attend the workshops (field notes 2006–2007.) The main activity at the workshops was to watch one clip of an appointment video from each nurse's appointment recordings together and talk about researchers' interpretations of the activities filmed in the videos. [8]

In the light of the nurses' knowledge interests, competences and knowledges, I will now look at the context, design and implementation of the workshops and discuss the possibilities and difficulties relating to dialogue and collaborative knowledge production as theorized by Smith in IE contexts. I will do so by addressing, in turn, conflicting interests, different positions and differences between knowledges.

Conflicting Interests or Complementary Projects?

In the beginning of my fieldwork, the nurses talked a lot about politics with me in relation to a new nursing intervention involving new and additional working methods implemented by the municipality.[9] They seemed to view me and the other researchers of the project as representatives of the local administration responsible for the intervention, or at least as social actors able to influence the decision makers. They voiced their resentment toward the new nursing intervention, pointing out that they felt that all their and their predecessors'

experience-based knowledge and work were being overlooked by the administration. At times, I was also an object of their resentment and was treated with hostility and suspicion. For example, I was told not to use some discussions that took place in the coffee room in my research because the nurses were afraid the administrative staff would make their lives hard, and sometimes I was denied access to the coffee room altogether by the door being slammed in front of my face (field notes 2006).

Regardless of my repeated assurances that neither I or the other researchers in the project were advocates for the reform or representatives of the administration, I cannot blame the nurses for being suspicious of me. Acquiring their consent to participate in the first place had followed a top-down model where contact was first made with the people in charge of reforms in the administration, and the consent of the regional administrative personnel (regional head nurses and doctors) had been obtained before the nurses themselves were contacted. Furthermore, the administrative personnel selected the specific clinics that were to be contacted for individual consent. The nurses at the clinics were informed of all this, and I would not be surprised if they had felt obliged to give their consent given that the authorities had given theirs.

The nurses' interest in influencing the administration through us seemed to conflict with our research-based interest to gain knowledge of actual work practices. Although I do believe that I eventually gained the nurses' trust, the question of conflicting interests still haunted me when we began to plan the workshops. The nurses' interest and the agenda to influence administration as well as our research interests were still the same despite the trust gained in the field. As Caswill and Shove (2000) point out, there is a danger that such conflicts of interest lead to the loss of a space for interaction among the research participants.

How, then, could the nurses and I work together in the workshops given our conflicting knowledge interests? At first, I feared that the nurses would merely speak within the abstract administrative discourse, albeit from a critical position. But in practice when administratively trendy abstract terms and care principles were brought up, the nurses sometimes, criticized how, in formulating new initiatives, the administration overlooked nurses' practice-oriented knowledges and experiences. For example, the nurses told me that care standards and objectives such as 'client centeredness', addressing 'psycho-social concerns' and 'family orientation', that were presented as 'new' by the administration had been realized in the nurses' work practices for a long time prior to the intervention. When I asked the question 'how', this sometimes led to accounts of how such standards were met in everyday work. It could be argued that my and the nurses' differing knowledge interests led to complementary projects: my research interviews and workshops provided them with a space for articulating their critical stance toward the administration and also provided me with experience-based knowledge on nurses' work practices (concerning the actualities linked to administrative interests).

Dialogue in a Smithian sense can be said to have taken place. Experience based knowledge that cannot be reduced to the givens of the institutional discourse was articulated. These articulations were certainly constructed partly within the terms of, and therefore were constrained by, institutional discourse but the complex actualities of doing, for instance, 'family orientation', and the administrative influences of organization on such work were elaborated upon. Moreover, experiential elaborations were made for, and also by, us researchers in dialogue with the nurses. As Smith (2005: 127) points out, following

Bakhtin, dialogue (also) happens when speakers create ‘utterances that have not been spoken before and are responsive to distinctive situations and storytelling motives’ [my italics]. The motivation of the nurses to tell us about their ways of taking all the family members into account was political and shaped by the assumption that we might speak for them in reporting on our study to the local authorities.[10] At the same time, our differences in knowledge interests also resulted in situations where nothing personal was shared and where we researchers did not respond to the nurses’ political appeals.

Positioning and Dialogue

When planning the design of the workshops, we researchers thought it was important that I attended all the workshops because I was the only one of us who had conducted the fieldwork at the clinics and whom the nurses had grown to know and trust. We thought that my presence would contribute to creating a relaxed and informal atmosphere for discussion. With respect to the organisation of the workshops, the nurses wanted me to be the contact person and some of them specifically asked me to be present at the workshops (field notes 2008). This indicates that the nurses and I had developed a relationship of trust—something that, in ethnographic research, takes time and eff ort to establish (Hammersley and Atkinson 1995, Peacock 1993).

This does not mean that we ever established a relationship as equal partners. Rather, as we built up trust and familiarity, my role and position changed from that of a suspicious character with possible administrative interests and multiplied: sometimes, I was positioned as a poor little PhD student who was interested in learning about the nurses’ work, and not changing it, and also interested in learning about experiences of pregnancy. This positioning may have been reinforced by my repeated assurances to the nurses throughout my fieldwork that they were the experts on, and providers of knowledge about the everyday realities of health. Moreover, I was a bit of an oddity because of my childless status. The fact that I was not a mother myself received confused looks and comments. It seemed hard to comprehend that someone would want to study maternity if she was childless. Both pregnant women and the nurses told me about their experiences of motherhood and family life. Having no children gave me the singular identity as ‘the student’ of pregnancy and maternity health care. This was fruitful for my research as participants assumed that I did not know anything and did not use professional terminology (field notes 2006–2007).

From the start, my position in the setting of the workshops was quite peculiar. On the one hand, I was a relative insider in relation to the nursing staff because of my earlier involvement and compared to the other two researchers who for the most part remained ‘outsiders’. On the other hand, the workshop was a new landscape compared to the earlier encounters I had had with the nurses in their everyday working situations, and as such it had the potential to change my position both in relation to the nurses and in relation to the outsider group of university researchers. But the nurses’ request that I served as the contact person and that I participated in the workshops hints at a position of mediator or facilitator in a social order that is not the institutional order of the university nor the maternity health care but a communicational order established between the two within the framework of my research project.

Nevertheless, the design and setting of the workshops enforced the position of us researchers as experts. As I have already mentioned, the meetings were originally

planned as forums for communicating preliminary findings in lay terms to the nurses and offering them a space to reflect on their working methods and to share experiences of care work by talking with us. The nurses were aware of this. In fact, it was not until the actual workshop encounters that I started to think that maybe we researchers too could get feedback from the nurses on our interpretations. For that reason I started to take notes at the meeting but not detailed notes. [11]

The position of us researchers as experts was reinforced through our choosing the topics and video clips for the workshops. We chose clips according to three themes: 'building rapport' (client centredness), 'discussing difficult concerns' (addressing psychological and social concerns) and 'who is the client at the clinic´ (family orientation). All of these themes were originally derived from administrative interests linked to the nursing intervention implemented in the municipality but, as already discussed, these themes were also of interest to the nurses. We as researchers also determined the (same) structure for all the workshops: I was to give a five-minute talk on the observations and interviews conducted and then we would watch a video extract from the recordings of the meetings with clients of each of the participant nurses and then discuss our observations (nurses' comments first, then the comments of us researchers and finally freely).

In general terms, the original design of *communicating to* the nurses was not conducive to mutual engagement or dialogic encounters where 'no one story overrides; no story is suppressed' as Smith (2005: 143) puts it. The design and the structure gave the impression of a setting of a lecture or a seminar that positioned the nurses as the students and us researchers as the expert teachers. I myself helped to reinforce these positions and relations by preparing and giving a talk that was quite general, descriptive and very abstract with no concrete real-life examples. I told them that they had found their own ways of meeting administrative demands, that the basic foundations for care appeared to be trust and rapport that are achieved over time and in equal partnership with the clients, and so on.

By positioning ourselves this way as experts, we positioned ourselves also in an authoritative position of knowing in the situation of the workshop, and thus reinforced asymmetrical power relations between us and the nurses. This may have undermined some of my earlier work in dissipating the nurses' suspicions that I was an advocate for the local administration.

However, at the workshops, we tried to avoid positioning ourselves as authorities. We refrained from using terms and vocabulary used in administrative documents and discussions. We designed the interiors of the workshop rooms spatially in order to create a relaxed, informal setting, placing chairs around tables at which we would sit together with the nurses. We also emphasized that the workshops had an informal character and were meant as a forum for reflection about the everyday work concerns of the nurses. We tried to convey that we wanted to 'give something back' to the nurses for participating in our research without giving the impression that we were presenting the definitive truth about their practices or that we were in full control of the workshops.

Furthermore, and this is something that was not anticipated in any way, when watching the video clips of each nurse's meeting with a client, the nurses started to tell specific stories and give concrete examples of their work. Often the accounts of their interactions with clients were related to the case in the video clip but the nurses also made comments on

the extent to which it was possible to generalise on the basis of their experiences. Working with video clips formed a platform for the articulation of experience-based knowledge on care work in terms of the specificities and actualities of everyday work at the clinics. This is of extreme importance in IE as the aim is to gain insight into how the institutional order shapes and is shaped by the actions of people in particular contexts; it is only through particular stories of particular people that the ethnographer can identify similarities and differences across actors' experiences and the reproduction of unequal relations of power (Smith 1987, 2005, DeVault and McCoy 2006).

In practice, the viewing of video clips proceeded so that, after viewing the videos, the nurse whose session we had just watched had the first opportunity to comment on the session. Often the nurse started to criticize herself/himself for talking in a funny way, behaving awkwardly, spending too much time in front of the computer and not being in close contact with the family members or paying too little attention to somebody or something. We researchers responded to this self-criticism by reassuring the nurse by telling her/him that it is common for people to view their speech and gestures as funny and awkward on video. With respect to comments about a lack of attention to the clients or to a particular topic, we began by asking why she thought so. We also used questions to indirectly introduce our observations regarding the administration-drive and research-driven themes of 'building rapport', 'discussing difficult issues' and 'who's the client at the clinics', such as 'Did you really take the pregnant woman's worry into account here?', 'Could you have done something differently?' Implicit in these kinds of questions is a preference for particular actions that the nurses quickly picked up on. They would take the preferences and implicit critique into account by starting with comments such as 'it may be so but it is also that' and move on to tell the story of the individual family and the care plan involved, sometimes with reference to similar cases.

Moving to the main activity of watching and discussing the extracts appeared to change our positions once more. This time the nurses were no longer in the position of being merely informed about our research based, partly administration-driven observations but also in the position of communicating how our observations related to the specificities of their everyday working life. Their position, then, took a turn toward a more authoritative or equal position in terms of knowledge production. At this point I was certainly listening and learning. What I was hearing was experience-based knowledge on the articulations of administrative and other ruling relations in the everyday practicalities; I was hearing knowledge that is dialogic in a sense that it drew on a diversity of voices: nurses' own intentions and perspectives as well as discourse of institutional origin (Smith 2005: 123–130).

The showing of the video extracts, then, worked as a catalyst for moving the discussion beyond the institutional concepts and categories. Our provocative questions and observations did this too. Thus, one of the voices heard in the accounts at the workshops was our research-based voice. The nurses did not just recall past activities in some random or 'pure' way but oriented their answers to our interest to talk about certain themes, video extracts and commentary that bore the traces of models of social organization of care obtained from research literature and policy/administrative discussions. The nurses' experience was, then, brought into being in the setting of the workshop as an interchange between what they remembered and our interests and attention—that is, it was a product of dialogue (cf. Smith 2005: 128).

To conclude about the dynamics of positioning, as I moved from one research setting and one stage of my research project to another, my fluid and ambiguous position as an ethnographer was transformed from 'expert' outsider with possible links to administration to relative non-participatory insider whose knowledge interests ran parallel to those of the nurses and, in relation to the workshops, to mediator in research communication and one of the 'experts'.[12] The nurses too changed positions from being objects of study and of administrative measures (as perceived by them) to being experts in their own professional field, to being something closer to a equal partner in communicative exchanges. The steps were closely linked to, and overlapping with, one another. For instance, had I never gained the position of relative insider I most likely would have never been able to ease the nurses' anxieties about administrative interests, never been accredited the position of a mediator at the workshop setting, and perhaps never obtained experience-based knowledge of the specificities of care work.

Collaborative Knowledge Production in the Process of Institutional Ethnography: An Example

In this section, I will discuss my final point about the difficulties for collaboration that may still carry with them the possibility for dialogue: the differing forms of knowledges of the nurses and researchers. I will do so by exploring an example of the interplay between a video extract, our preliminary interpretation of it, a nurse's comments on the extract in the light of our interpretation, and, finally, my subsequent interpretation of the activities that was transformed compared to the preliminary one. Thus, in this section, the attention is not just oriented to the workshops or their background but also to what happened after the workshops were over, after I packed up my notes and everybody went home.

From the point of view of the IE research process, this is important in that IE is fundamentally an analytic project where every encounter with a participant in the field is meant not only to produce insight into a particular circumstance but also to point to the next step in an ongoing, cumulative inquiry into the institutional processes (Grahame 1998, Smith 1987, 2005). This cumulative inquiry and the analytic process are also, according to Smith (2005, 1998), dialogic in nature. The institutional ethnographer must remain responsive to the dialogue between herself and the research participant and the knowledge produced in the dialogue. That knowledge is experience-based yet oriented to the focus of the research-based field encounter. Moving to the setting and the moment of analysing field notes on the encounters carries the danger of once more succumbing to monologism, this time to the singular voice of scholarly theory that shares the same tendency as other abstract institutional discourses to marginalise the intentions and perspectives of the original speakers (Smith 1998: 67).

How, then, to sustain dialogue and be responsive to the multiplicity of voices, including scholarly discourse, in analysis and in writing ethnography? Smith (2005: 135) advises ethnographers to 'find generalizations and standardising processes *in* the ethnographic data, in people's local practices, including language' (Smith 2005: 135).

To take account of or to integrate multiple voices obviously involves addressing the question of how to bring together different forms of knowledge, in my case the nurses' practice-oriented, experience-based ideas about maternity health care and our academically informed concepts and theory. I suggest that, as far as it is ever possible to produce such heterogeneous analysis, the answer lies in an ongoing reframing and re-

evaluation of the analytical insights of all the participants in a cumulative process and an attempt to avoid objectifying descriptions of peoples' lives. In the following exemplary sequence from a workshop through to analysis in a university setting, we can see an attempt to retain the multiplicity of voices and knowledges in-the-making.

The case involves a video from an appointment where a nurse and a pregnant woman at 22 weeks of gestation discuss fears about giving birth. In Finnish health care, in the case of extreme fears a referral to a special outpatient clinic is made, and it is only if the pregnant woman and the outpatient clinic staff fail to work out a delivery plan for a vaginal birth which eases the pregnant woman's anxieties that a caesarian section is planned. A discussion, or a series of discussions, at the maternity health clinic precedes the referral. The video clip was as follows.

> A pregnant woman and a nurse are talking about a counseling class arranged at the local hospital maternity ward. The nurse explains that around 35–36 weeks of gestation one should contact the hospital to attend the class. The agenda for the class is to go over 'the normal course of delivery, pain relief, the suction cup use and the abnormal births'. At this point the pregnant woman first expresses her fear of medical instruments by saying that she has heard criticism about the class and that she cannot stand doctors' equipment. They disgust her and she does not want to be near such things. She further asks the nurses' opinion about whether she should attend at all. The nurse comments that 'of course one does not have to go' and then goes on to explain all the 'useful and good information' one gets from the classes and that even women with fears and phobias about hospitals and delivery have considered the class good. She then goes on to describe this useful information [tour of the ward, information about when to leave for the hospital etc.] and suggests that the woman could skip the second hour of the class during which a video of a real birth and instruments involved in birth are shown. 'Good stuff that all the women wonder about' is her last comment on the issue. Then she moves on to ask the pregnant woman if her partner wants to attend the birth. The pregnant woman replies 'yes, but we will see', and the nurse then explains about the parental classes the maternity health care clinic provides. The pregnant woman remains quiet at first and then cuts in on the nurse by repeating her worries about the delivery class and instruments. She magnifies her fear and the extent of the problem by saying that she even hates going to the dentist. At this point the nurse asks the pregnant woman about how she thinks she will handle the birth itself if she is so worried about attending the instruction class. It turns out that, in fact, the pregnant woman does not know if she will be able to handle a vaginal birth because of her fears. She intensifies the problem further by reminding the nurse about her chronic stomach problem and her GP's concerns. All the while, it seems that the nurse is implicitly striving for the woman to express doubt about wanting a caesarian section: she uses closed questions and comments, such as '[b]ut you don't have this feeling that you absolutely want a section, do you' and so on. The pregnant woman says that she is not sure how much she is scared of vaginal birth and that she has actually thought that she will just have to 'survive' the vaginal birth if there are no physical obstacles for it. Here, the nurse seems to reassure the obviously worried woman by telling her that she will certainly refer her to the outpatient clinic and that nowadays it is possible

> to perform a caesarian without a purely medical reason. She talks about patient autonomy, and how a birth should be ‘an active event’ so that ‘nobody is forced into a vaginal delivery’. However, the nurse wants the pregnant woman to calmly think through things, because ‘there is still a lot of time before [the estimated birth date]’ and because ‘one might think differently later on [in pregnancy]’. The pregnant woman seems more relaxed now and tells the nurse that she is happy to hear about these kinds of things. Still, they return to the issue of delivery 2 times before the end of the appointment. Finally, it is agreed that they will talk again in a few months about the birth mode, and the nurse tells the pregnant woman how the caesarian birth is planned. (Videotape Tm14N, 22 weeks of gestation, first pregnancy)

At the workshop, because the nurse did not want to say anything before us researchers, we started the conversation by pointing out to the nurse that she did not really answer the pregnant woman’s question about her opinion on whether or not she should attend the counselling class in the hospital and that she pushed the decision on referring the pregnant woman to the outpatient clinic forward into the future. This comment was based on our puzzlement over the nurses’ tendency to push the decision about the birth mode (vaginal or caesarian) into the future. We interpreted this as some sort of reluctance to take the pregnant woman’s concerns into account. That is, reluctance to abide by the principle of Western medical ethics, namely beneficence.

The nurse then explained in a frustrated manner that the pregnant woman asked her questions that she could not really answer because, as the official protocol has it, women have to make the choice themselves. In this way, she, in fact, addressed the medical-ethical logics of doing care brought implicitly into discussion by us researchers but from another angle, from the principle of respect for informed choice and autonomy. Then she went on to elaborate that her professional experience is that women change their minds about the birth mode, sometimes many times, as the pregnancy proceeds. Thus it made no sense to her to make any definite decisions about the birth mode at this early stage of pregnancy.

Her experience-based knowledge on choosing a birth mode and care plan attuned to such procedural choice was made *for* us in that she oriented to us by framing her story and interpretation of the activities taking place in the extract in terms of the medical ethical discourse and logics that were of interest to us. This is the first step of the ongoing dialogue, the one that took place at the workshop.

Reading my notes back at the university office, the nurse’s comments started to make me reflect on my interpretations of what was going on in the video clip. By reframing my inquiry to include her commentary I analysed the nurse’s meeting with the client as not just disregarding her client’s concerns or needs. The nurse’s elaboration allowed me to look at care work as work within which choice is not just some static activity but something that is achieved in a process of coming to know. I realised that the activities (in the video) and the nurses’ experience-based knowledge and accounts are constrained by the old ethical-medical mantras realized in terms of ‘patient autonomy’, birth as ‘active event’ and ‘parental choice’. This is the voice of the institutional order deriving from policy documents and nursing education. However, the nurses’ intention and perspective remake it or give new context to it whereby the realities of care lead to respect for informed choice as a process rather than a static activity.

That is how ‘beneficence’ concerning the choice over birth mode in the working lives and experiences of the nurses is realized, and that is how it, as a institutional and standardising standard, ‘works’, I concluded in social scientific terms. Yet another voice, then, has entered into the (dialogic) analysis process, that of social scientific theory. I should say re-entered, because the scholarly institution with its concepts and categories had obviously been present earlier and that presence was acknowledged by all the participants.

As already mentioned, social scientific theory, according to Smith (1998, 2005), carries the danger of subordinating or marginalising other perspectives because of its insistence to jump to the level of generalization with its abstract concepts and terms. Have I, then, managed to do social theory on how medical ethical models coordinate everyday activities at the clinics without losing sight of, subordinating or marginalising, the nurses’ perspectives? I think I have to some extent and I have done so by not stopping at a theory-based conceptualization that appears somehow expressive of what was found to be happening in the appointment videos or in the nurses’ accounts. Rather, I attempt to fi nd out how the care activities and experience-based knowledge make use of and realise such concepts and terms (see also Smith 2005: 135). As I have tried to show, this direction of inquiry involves cumulatively orienting oneself to the other’s interests, positions (of power) and knowledges that are transformed, often unpredictably, in time and place. It also involves (re)-evaluating and reflecting on one’s way of coming to know the research field. Orienting oneself this way is not about becoming submerged in the field or the interests of the research participant but about finding common ground through reflection.

Finally, it is dialogue achieved in the analytical inquiry, in Smithian terms, that makes it possible to overcome potential difficulties in bringing together different knowledges and epistemic commitments embedded in them. Our research-based, theory-driven conceptualization of the nurses’ meetings with clients as ‘malbeneficence’ was challenged by the nurses’ own practical experience-based knowledge gained through encounters with clients over a long time period. I was able to overcome the conflict of episteme, if you will, without silencing the other form of knowledge and disregarding the origins of it by a kind of hermeneutic process where generalising theoretical interpretation was brought into a collaborative encounter and linked to a specific case of care activities presented on video. Dialogue took place when the nurse in question oriented herself to the theoretical interpretation and reframed her activities in the video on the basis of that interpretation and presented us with an account which included the voice of social scientific theory, and institutional orders and her own perspective and experiences. Further, the dialogue continued in another setting where the researcher committed herself to an inquiry that avoided producing nominalisations out of commonalities found in the accounts of the nurses and activities seen on the videos.

Conclusions

In this chapter, I have focused on workshops arranged for research participants (nurses) by a group of researchers as a reflexive method in an IE analytical research process. I have explored how the workshops created possibilities for the dialogic production of experience-based knowledge on institutions and the collaborative production of research knowledge merging different forms of knowledge. Additionally, I wanted to contribute to the discussion about collaborative approaches to ethnographic research in general, and in IE

in particular, which recognise participants' reflexive abilities and attempt to draw on them by including participants as active co-producers of knowledge in the research process. I tried to address both the possibilities for, and the difficulties of, achieving dialogue and collaboration through a focus on (1) differing interests, (2) different (power) positions and (3) difference in knowledges embedded in the research context, design and implementation of the workshops.

My reflexive inquiry showed, first, that conflicting knowledge interests between researchers and research participants may not just provide obstacles for collaboration and dialogue. A conflict of interest may lead to complementary projects in situations where all parties align themselves with the other's interests and agenda. In such IE situations where interests run parallel, experience-based knowledge may be co-produced through motives to engage in storytelling. In the workshops in my study, it was a case of the nurses' political motives to influence nursing administration through the research.

Second, doing ethnography and doing IE in particular, is about the researcher moving from one setting to another and taking up different positions accordingly. These fluid positions—that also entail differing positions for the other participants—create constraints and possibilities for dialogue in unexpected ways. An outsider expert/administrative power position and circumstances that reinforce it, such as the original communicating- to model of design for the workshops, are not conducive to mutual engagement or the articulation of multiple voices. However, even with these premises, it was possible in my case to shift the overall positioning so that the research participants did contribute to the co-production of knowledge to some extent. In the case of the workshops this was done through working with video-recorded activities of the nurses and researchers' provocative commentary that bore 'responses' that the nurses quickly picked up on and reflected on by telling specific stories and giving elaborations of particular cases.

Third, institutional workers have been trained to use the very concepts and terms that IE researchers wish to unpack. The IE analytic project, then, seeks a form of knowledge that differs in epistemological and ontological terms from scholarly theory-based knowledge. Presenting theory-based interpretation to the nurses that addressed an organizing element of care (in my case, the medical ethical model) provoked accounts that addressed the organizing element from a different angle and specified how such organization is actually realised in care. Reframing the ongoing analysis through such dialogically produced experience-based knowledge in IE meant that theoretical concepts were used not to make generalising statements on commonalities in the accounts of participants, observations, video-recordings and so on but to put them to the test.

This said, however, there remained limitations to dialogue and, thus collaborative knowledge production that could not be overcome in the case of the workshops. Some of the limitations originated from problems inherent in IE theorizing of dialogue between participants and some from the poor original design of the workshops in the particular context of our research project. Experience-based knowledge that IE seeks to acquire in dialogue is never obtained fully and without difficulties: institutional workers' accounts remain to some extent suppressed by abstract institutional terms and concepts. The poor original design of the workshops and the context of suspicion linked to our position in relation to nursing administration was not productive in that sense. They resulted in a situation of power imbalance that could not be erased. This further affected what was

discussed and what was not and which voice was given most importance and from which perspective.

Notes

1. Participants may include people in a face-to-face encounter and/or conceptual entities such as texts, discourses, ideology and so on.
2. Similar concerns have been raised across Europe (Department of Health 2004).
3. Of the three subprojects, mine was the only one that was ethnographic in orientation. We all used the same video data in our research, but I was the only one to carry out interviews and analyse interview and documentary material.
4. The data consist of the following: partially transcribed video tapes (68 appointments and 18 team meetings) and observations from maternity health care appointments; professional team planning meetings (19); training sessions for nurses and family counselling classes at four different maternity heath care units; seven interviews with pregnant women and seven interviews with public health nurses; information pamphlets distributed to families; forms on pregnancies kept by public health nurses; and local and nationwide guidelines for care work. Video recording was used because the other researchers in the project needed material suitable for conversation analysis.
5. Hence experience is not some a priori feeling between the body and the world.
6. This is not meant, however, to imply that Smith considers that dialogue is something that can be achieved through a set of fixed methods. That would be in contradiction to her ontological commitments in which realities, discursive and non-discursive, are only realised in practice. Thus, methods for achieving dialogue are realised in each individual practice at certain times, and they may or may not be transformable to other practices or times.
7. As opposed to specialized health care that is provided by hospitals.
8. In line with the nurses' wishes, the meetings were held on one occasion in the waiting room of one of the clinics after office hours and on other occasions in a university seminar room.
9. The new methods were aimed at 'client centredness', addressing 'psychosocial concerns' and 'family orientation'.
10. A promise to report on the nurses' perspective on the intervention was made to the nurses, and that promise has been kept in the research report written for and published by the municipality in a publication series on city welfare services (Ruusuvuori et al. 2008).
11. For example, there are no extracts of the interaction or comments that took place at the meetings. I focused on the nurses' comments on our interpretations and on novel ideas and notes they made about the video clips. Later on, I did add notes about the overall course, setting and impressions of the meetings. However, the exploration that is based on those notes is unfortunately not very detailed and focuses on the nurses' commentary on the video clips and their feedback on our interpretations. Had the original design been geared towards dialogic knowledge production, I would have more detailed material.
12. This is a position within which the other researchers from my project were quite stably fixed on throughout the research process.

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