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The 'insider' ethnographic diagnostic radiographer thinking like 'an outsider'.

Abstract

Purpose - The purpose of this paper is to explore how the ethnographic researcher navigates their insider-outsider status and provides a methodological contribution to this important aspect of ethnographic research; this will be framed from the researcher's perspective using a semi-autoethnographic approach.

The ethnographic study being reflected upon explored the culture in a Diagnostic Imaging Department (DID), looking at how radiographers work and what the issues were within their working environment. The original study was carried out within one DID in a District General Hospital in the East of England (Strudwick, 2011).

Design/methodology/approach - In the original study the researcher used ethnography to study the culture in a DID. Observation was carried out for a four-month period. Field notes were recorded and used to formulate topics for the interviews that were to follow.

After the observation, the researcher conducted semi-structured interviews with key informants from the DID. Ten key informants were purposefully sampled from the DID to provide a cross section of opinion from the staff.

The data collected were analysed to identify key themes.

This paper reflects on the data from the original study to explore the tensions between the insider and outsider researcher role and how this contributes to the way the ethnographic researcher views the environment, reports on their findings and how they feel about the data from their own perspective.

Findings - Ethnographers carrying out research in their own area of practice need to try to think like an outsider in order to see the environment with a sense of strangeness but also try to make sense of what the participants are thinking and doing. There is a tension between becoming part of the group in order to understand it and looking at the environment as an outsider in order to make a note of what is happening. Findings from the original ethnographic study will be used to illustrate this point and will be used to reflect on the feelings of the researcher, considering her insider and outsider status.

Originality - The author, who is a diagnostic radiographer and radiography educator reflects on how she managed the insider-outsider tension during her ethnographic observation and after the event when reflecting on the data from the original study.

Key words

Radiography; insider; outsider; reflection; positionality; autoethnography.

Introduction

This paper came from my reflections on the observations and interviews carried out for my professional doctorate which was completed in 2011 (Strudwick, 2011). The study being reflected on was an ethnographic study of the culture in a Diagnostic Imaging Department (DID), studying the professional culture of diagnostic radiographers.

When reflecting on my positionality during this study I realised that I had to think like an 'outsider', even though I could be classed as an 'insider', as I was studying the culture of my own profession,

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diagnostic radiography. Deodhar (2022) argues that researchers take on different roles depending upon the situation they are in and their familiarity with the linguistic, sociocultural norms of the group being studied. Snounu (2021) also suggests that there is fluidity between the insider and outsider status of the researcher, and this may depend upon the participants and how the researcher is received.

Within an ethnographic study the researcher needs to become part of the culture or group being studied to gain understanding and insight of what it means to be part of that group and so that they can document their findings. The researcher needs to have direct contact with the group of people being studied over a period of time and within their cultural setting, i.e., where they are situated or where they meet as a group. In my case this meant spending time with diagnostic radiographers in the place that they worked, a DID. The ethnographic researcher watches what is happening, listens to what is said and asks questions (O'Reilly, 2005). The researcher collects data to provide explanations for the issues that are the focus of the research (Hammersley and Atkinson, 1995). The group should be studied and observed in their natural setting and the actions of the group should not be disturbed by the researcher if possible, so that 'normal' behaviour is observed.

The insider-outsider status can be a real tension for the ethnographic researcher studying their own area of practice. Holland (1993) and Roberts (2007) both speak about this and the tension that they felt when carrying out ethnographic research in a healthcare environment. Each studied their own profession of nursing; they discuss how they found it a challenge to step back and see the environment which they knew so well as an outsider and as a researcher. Both Holland (1993) and Roberts (2007) explained that their research field was a familiar environment to them, but in taking on the role of a researcher they tried to view this familiar environment with a sense of strangeness in order to try to see the behaviours that an outsider might notice and comment on, but that they would just see as something normal and familiar. Ybema and Kamsteeg (2009) also discuss the concept of being a stranger but being familiar with the environment, they explain that this can create a real tension for the researcher when deciding on what to report on and can add an autoethnographic element to the research, as the researcher begins to reflect on their own personal perspectives about what they are observing. The researcher who studies their own familiar environment is different from someone studying an unfamiliar setting. Autoethnography allows the author to write in a highly personalised style, using their experience to extend the reader's understanding about the culture being studied (Wall, 2006).

This paper is a reflection on my positionality as an insider but thinking like an outsider and came about because of my presentation at the Ethnography Symposium in 2023 (Strudwick, 2023), where I delivered an oral presentation on this topic. Other writers have tackled the issue of positionality, using the terms 'emic' and 'etic' perspectives, where the emic perspective is that of the insider and the etic perspective the view of the outsider (Fetterman, 1989). It is the responsibility of the researcher to bring together their own perspectives of the culture being studied and the perspectives of the participants in that culture. In order to do this, they need to reflect on both the emic and etic perspectives (Clifford and Marcus, 1986). However, it is not really that simple to have a clear division when researching a familiar setting. For example; how do you know that what you have seen and the way in which you have interpreted it comes from being in insider or an outsider? Taking an autoethnographic stance means that the author acknowledges the inextricable link between the personal and the cultural (Wall, 2006).

This paper focusses on my positionality as outsider and insider and considers my opinions on the findings from my own autoethnographic perspective. This is not a common approach within radiography research and therefore there is very little known about how researchers feel about their

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research findings. This is particularly interesting when the results may be positive. I will be reflecting on two themes that arose from the data and how I reported the data along with my thoughts and feelings about the data as a diagnostic radiographer. This has the potential to reveal new information about how the radiography researcher feels about their research and their data.

Methods

Positionality

In 2011 I completed my doctoral thesis titled 'An ethnographic study of the culture in a Diagnostic Imaging Department' (Strudwick, 2011). I was interested in studying the culture of my own profession, and therefore considered ethnography to be the obvious methodological choice. I am a diagnostic radiographer with over 20 years' experience. I worked as a radiographer in practice in the United Kingdom (UK) National Health Service (NHS) for eight years, then I moved into radiography education, and I am currently professor at a university in the East of England. I have had a close working relationship with many diagnostic radiographers working in the placement hospitals associated with the university. The hospital where my doctoral research was undertaken is one of those placement hospitals. I continue to hold a 'bank' contract as a diagnostic radiographer and work shifts at my local hospital and so I am still well-integrated into the culture of my profession.

My perspective as a researcher is therefore not detached or objective. I am familiar with the professional culture and working practices of diagnostic radiographers. I am also familiar with the day-to-day working of a DID. As an educator and an active member of the Society and College of Radiographers (SCoR), the professional body in the UK, I am aware of the current issues and challenges within the radiography profession.

Within ethnographic research, the researcher is neither a complete insider nor outsider. It can be argued that researchers take on different roles depending upon the situation they are in and their familiarity with the linguistic, sociocultural norms of the group being studied. These approaches go beyond a dichotomous insider–outsider divide and stress the fluid, intersectional and deeply situational positioning of the researcher (Deodhar, 2022). Snounu (2021) also reflects on the role of the ethnographic research, their positionality and how they are received by different participants depending on the commonalities between the participant and researcher. This has an impact on how the researcher will report their findings and how they feel about the information they receive.

In every ethnographic study, regardless of the topic, subject matter or discipline the ethnographer themself emerges as part of the research. The ethnographer is inseparable from the ethnography (Vine *et al*., 2018). This is because the ethnographic researcher is positioned within the group being studied and they need to be reflexive about their role within the research. This goes against all that we learn about research, that we need to be objective and not influence the outcomes of our research. This is not possible as an ethnographic researcher, as the research not only reveals information about the group being studied, but the research also reveals information about who we are as a researcher. The written product of an ethnographic study reveals the researcher and their integrity. Rigour in qualitative research includes the concept of reflexivity, which is the ability of the researcher to acknowledge and account for their role in the research process and the generation of data (Allen, 2004). Richardson and St. Pierre (2005) suggest that this is particularly important in qualitative research, as it is the researcher that is the research instrument, and not the methods used.

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The issue of role and identity became a major consideration for me as I explored how I fitted into the research field and my influence on the data collection. At times I had to stop and think about who I was; was I an educator, practitioner or researcher? During the observation, as I became a part of the culture of the group, radiographers would ask my opinion about things or discuss their practice with me. It was at times like this that I had to think about my role, why I was there and just how much I should participate. There were a few occasions when radiographers were struggling with techniques or had questions which I was able to answer and when the students were present, I felt the tension between my role as educator and researcher. It is difficult to remove yourself from other roles that you hold and just focus on being a researcher.

Because of my professional experience I have a good understanding of radiography, the terminology used and the cast of characters (Roberts, 2007). Therefore, I was able to make a judgement about my observations based on my previous experiences. This gave me an advantage over a non-radiographer investigating this topic as the participants did not need to provide lengthy explanations to me. However, I am aware that I entered this research study with some pre-conceived ideas which, although I am aware of them may have subconsciously influenced the way I conducted my observations, interviews and the data analysis.

Holland (1993) advocates that undertaking research in one's own field of practice reduces the 'culture shock' and means that the researcher is more sensitive to the participant's behaviour. However, she also says that there is a danger of data being overlooked because of familiarity with the study area. During the whole period of observation, I was aware that my insider status could contribute to me missing out on important information (Styles, 1979), as I would not necessarily see something as strange or unfamiliar and record this in my notes. I needed to fight familiarity when carrying out my observations and look at the environment with a sense of strangeness (Coffey, 1999). I needed to try to see the imaging department as it would be seen through the eye of an outsider - the etic perspective (Fetterman, 1989). I had to try and view the environment from a different perspective (Cudmore and Sondermeyer, 2007). It would be easy not to notice things as I was used to them all and I am already professionally socialised into the culture. I needed to be aware of over familiarisation (Bonner and Tolhurst, 2002), so every day I endeavoured to look around the department for something new that I had not seen before or written about. This way I tried to keep my observations fresh and tried to see the environment in a new light.

There is a tension between becoming part of the group to understand the group and how it works but looking in as an outsider, I needed to build up a rapport with the participants in order to be able to speak to them, but I did not want to become too familiar.

Autoethnography

Moving on from the positionality, there is also consideration of how to represent the voices of the participants which are interpreted by the researcher and how the researcher reflects on these findings. Qualitative researchers should be~~are~~ comfortable with reflexivity in research where the researcher pauses to consider how their presence, standpoint, or characteristics might have influenced the outcome of the research process.

Autoethnography, which comes from postmodernism, challenges the value of tokenism in reflection. This is often included as a paragraph in an otherwise neutral and objectively presented manuscript (Wall, 2006). This appears to be contradictory and not really acknowledging that the researcher is the research instrument. Denzin and Lincoln (1994) refer to this call for more genuine reflexivity as the "crisis of representation" (p. 10), which started in the mid-1980s, with publications which

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questioned the traditional notions of science. They suggest that it has become increasingly apparent that the world that we are studying can only really be captured from the perspective of the researcher (Denzin & Lincoln, 1994). In research which sets out to discover the personal experience of the participants, there is an obvious relationship between the researcher and the participants, and the issue of how the voice of the participants is represented arises (Clandinin & Connelly, 1994). Giving the researcher the freedom to speak about their experiences and thoughts and mingling their experience with the experience of the participants helps to gain a greater understanding. If the researcher's voice is not included, the writing simply ends up being a summary and interpretation of the works of other people and adding nothing new (Clandinin & Connelly, 1994). It can be argued that an individual is the person who is the best situated to describe their own experience more accurately than anyone else is able to (Wall, 2006). Ellis (1991), who is a strong supporter of emotion-based, autobiographical inquiry, suggests that a researcher who has lived through an experience can use introspection as data and study themself and their own perspective on the research situation.

The emergence of autoethnography as a method of inquiry moves researchers' "use of self-observation as part of the situation studied to self-introspection or self-ethnography as a legitimate focus of study in and of itself" (Ellis, 1991, p. 30). Autoethnography can remove the risks inherent in the representation of others and allow for production of new knowledge by a uniquely situated researcher, who is both insider and outsider, and offer knowledge and information about specific situations (Denzin & Lincoln, 1994).

Ethical approval was gained from the University Research Governance and Ethics Committee, the local research ethics committee (LREC) and the research and development committee (R&D) at the Hospital where the study took place. The manager of the DID volunteered to host me and was very interested in my study and so it was relatively easy for me to gain access to the DID. Allott and Robb (1998) cite this as a distinct advantage of doing research in your own area of practice.

However, because of the way in which I gained access to the field I was aware of coercion and made every effort to ensure that participants made an informed decision about taking part in the research and did not feel obliged to do so because the manager had given permission for me to work in the DID and because they might already know me. Roberts (2007) discusses coercion in her paper about carrying out research on her own students. She was aware of the pressure to consent to be involved in the study for students as she was their lecturer. However, she points out that from her experience the students were not easy to coerce into divulging information that they wanted to keep private. I agree with this notion, and I believe that the staff in the DID had the opportunity not to participate in my study and they also had many opportunities to discuss subjects that they did not want me to hear about or be aware of outside of my earshot.

Participants needed to give consent for me to observe them in practice, and only two members of staff declined, so I was able to avoid them.

Data collection consisted of four months participant observation. After the first week of observation, I had a feel for how the DID worked and I decided that I would like to spend some time in each area of the DID, in order to see different staff and working practices. After a few days in the DID it become apparent that the main viewing area, was the 'hub' of the DID. I therefore decided to spend more time observing there than in any other place within the DID. During the observation I took field notes in a small notebook. I documented what had happened and my thoughts and perspectives and these were the basis of the field notes (Strudwick, 2020).

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I took on the role of 'observer as participant' from the four researcher roles in observation outlined by Gold (1958). I considered being a participant observer, the advantages of working as a radiographer and carrying out the research would mean that I would really be a part of the team with my own patients and my own work to discuss. However, I decided to discount this idea for this study as I felt that if I was working as a radiographer I may miss out on interactions between staff as I could be alone in an X-ray room, imaging patients. I could not really say that I was a 'complete observer' or a 'complete participant' due to my professional qualification. In order to obtain information and data, I needed to seek and find common ground with the participants. Creating a rapport can be an uneasy experience, but it is necessary to gain insight into the participants' thoughts and feelings about the culture of the group (Deodhar, 2022).

Interviews were undertaken following the observations to explore issues uncovered by the observation in more depth. I was able to interview a cross-section of ten staff from the DID. The interview participants were identified during the observations, and I selected these people in order to gather meaningful data. This was a purposive sample (Bowling, 2004), as I wanted to have a mixture of background, experience and points of view. When considering who to interview I first asked all the participants for consent to take part in the interviews, this was part of the initial consent form, so I was aware which staff I was able to select from.

The interviews were conducted face-to-face and were semi-structured in nature, they ranged in length from 17-43 minutes. The interviews were audio recorded and transcribed verbatim. Questions were open and exploratory following an interview schedule.

The data gathered from observations and interviews were analysed to look for common themes, patterns of behaviour and actions. Thematic analysis was used to analyse the data from both the observations and interviews all together (Fetterman, 1989).

Examples

In this section I will provide two examples from my ethnographic study which an insider might not find unusual or remarkable, but an outsider could. In presenting this data I will also consider how I felt about it as the researcher, giving an autoethnographic perspective.

1. Dark humour.

Like many professionals working in public services, diagnostic radiographers use dark humour in their conversations about their service users. Dark humour is used as a way to express emotion and to deal with situations within the workplace. It was evident from my study that dark humour was an acceptable part of the culture in the imaging department. However, to an outsider, this might appear to be uncaring or lacking in empathy for patients. An outsider could question why those in a seemingly 'caring' profession joked about what happened to their patients. As a diagnostic radiographer myself, I was aware that dark humour was a part of the culture, and had participated in its use, particularly after stressful or life and death situations.

Dark, black or gallows humour is a genre of humour in which laughter comes from cynicism. Often about peoples' misfortunes or death. Taboo subjects such as death and dying are brought into the open and dealt with in an unusually humorous way, which can be both amusing and uncomfortable. Those new to a culture where dark humour is present might find this difficult to deal with, but it soon becomes a normal part of the culture as they fit in. The catalysts for such behaviour include murder, suicide, death, depression, terminal illness, violence, disease and disability; all of which are experienced by health care professionals including diagnostic radiographers. An insider, i.e. a

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diagnostic radiographer would not see this as unusual, but more a normal part of their working life and way to cope with some the difficult situations they face. However, an outsider might be shocked about this behaviour, seeing those from a so-called caring profession joke about their patients and their misfortunes. This could be seen as uncaring and callous behaviour. From my own personal and professional perspective, the use of dark humour and identification of this as something that happens is embarrassing. I know that it is used and that it is part of the culture of my profession, as a coping strategy, but it is something I am not proud of.

Dark humour in radiography is mentioned by Decker and Iphofen (2005) in their paper about the use of oral history to describe the development of the diagnostic radiography profession, they observe that dark humour is used by radiographers as a coping mechanism. Wolf (1988) in her ethnographic study of an acute hospital ward observed nurses using humour in their interactions with one another, particularly during stressful situations or following an emergency. Dean and Major (2008) suggest that the use of humour helps with teamwork, emotion management and maintaining human connections. From their ethnographic work in critical and palliative care they noted that humour enabled co-operation, relieved tension, developed emotional flexibility and 'humanised' experiences. I saw all of this in my data, diagnostic radiographers used dark humour to cope with stressful and difficult situations and to relieve tension. It was seen to be a normal way of coping, using humour rather than becoming upset and tearful. I have certainly used humour in this way and remember one time after dealing with a major trauma incident, sitting in the staff room with my colleagues and joking with them about what had just happened, it certainly helped me to make sense of it all, and to manage my emotions. After I had done this, I felt ready to return to my shift.

Christopher (2015) when writing about paramedic students, suggests that to the uninitiated, dark humour may appear callous and uncaring and those new to the profession may find this type of humour employed by their new colleagues as something of a culture shock.

This particular use of humour was evident in the imaging department and afforded staff the opportunity to 'let off steam' and bring into the open how they are feeling. The first example I observed followed a particularly stressful situation when a patient had suffered a cardiac arrest in the department.

> *"The radiographers joke about a patient having a cardiac arrest in the imaging department. They laugh about what the patient looked like, what colour his face was and how stressed everyone was." (Observation in staff room).*

This incident had been challenging for all those involved, and the patient had died. Humour was used to diffuse the situation and relieve stress. It was used behind the scenes, and not in front of other patients. The staff involved went into the staff room and shut the door before the humour started. Noone else could hear the interaction.

There was another occasion I observed in the computed tomography (CT) viewing area.

> *"The staff make derogatory comments and joke about the size of an obese patient who was so large that he only just fit through the CT scanner." (Observation, CT).*

This occurred when the radiographers had been having some difficulties scanning the patient, and the humour was used to let out their frustrations. Sullivan (2008) describes the use of dark humour in social work as being used to deal with stress so that social workers can continue to deal with their service users. This could be seen to highly inappropriate by an outsider, making jokes about a patient's size would not be expected behaviour for a healthcare professional.

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Each time, during my observations, the use of humour was in a staff only area, and the discussion could not be heard by patients or relatives. This is an important point, as those outside of the profession and situation may be uncomfortable with this use of humour. It occurred behind the scenes in what could be termed the backstage area. Goffman (1959) theorised about the use of front stage and backstage in a working environment where the front stage was public-facing and the backstage out of the view of the public. The concept of front and backstage was used again by Murphy (2006, 2009) in his work on behaviour of diagnostic radiographers. Perhaps we could question why this might be an issue if it occurs out of sight and earshot of patients. After all, it is only the staff that hear the dark humour. An outsider might question why it occurs at all and if there was a better, more respectful way to deal with the situation.

One of the radiographers in her interview made this suggestion to explain this behaviour.

> *"It's never nice to see patients in pain and I think to an extent we laugh about it to keep it light." (Interview with radiographer).*

This radiographer tried to justify laughing about patients and implied that it was acceptable in private in order to lighten the atmosphere and make things less serious. This is a true insider's point of view, defending the behaviour. However, an outsider might not agree with or understand this perspective.

Other radiographers saw the use of dark humour as a coping strategy and a way to deal with the challenging situations that a radiographer might experience.

> *"I think it's a coping strategy you know … I guess you turn it into humour to keep you going, it's just a coping mechanism… well you can't cry, you can't well you can't show any emotion so the only way you can show it is by joking about it and turning it into something light-hearted." (Interview with radiographer).*

This is a standard and expected response and can be seen in other public services. This radiographer was also reflecting on their own use of dark humour and taking up a subject position saying, "I am not a bad person" and "I can justify my behaviour". It can be seen from this quote that this radiographer felt that they were not able to cry or show any emotion in public, even if the incident was upsetting. Therefore, the next best thing was to show emotion through humour and use laughter to release the tension. Another radiographer expressed this in her interview.

> *"I think it helps you to cope, to make a joke, otherwise you can get quite depressed I suppose. Oh yes, definitely, it is about how we cope. It is you know how you get through it and otherwise you know you'd just get so depressed and so stressed you well you wouldn't cope. You have to not take it into heart too much … but it's good that you can you know well even if something starts off as a joke it brings it to the fore and you can then discuss it you know … there's no point in trying to hide things up and pretend it didn't happen. If you take it on board, it's not healthy." (Interview with radiographer).*

This radiographer suggested that the use of humour gave staff members a way of discussing something that had occurred in a non-threatening way with their colleagues.

The department manager discussed how uncomfortable they felt when working as a radiographer in challenging situations and how they believed colleagues felt about discussing life and death matters.

> *"You're actually dealing with things that are well if they happen to you would be the stuff of your worst nightmares but because you're in a front line hospital, you've got people coming*

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> *well if you've just had a severe road traffic accident or have got the worst forms of cancer, the things that you absolutely dread and it's not actually you know even as I'm sitting here talking to you about it on that level well it almost feels uncomfortable but you'd normally cope with it by saying or by treating it a little bit more lightly." (Interview with Manager)*

They concluded that radiographers like to treat things a little more lightly, using humour, in order to cope with what they might have just dealt with. In my experience this is something I identify with and resonates with my experiences as a diagnostic radiographer.

Another radiographer was keen to emphasise that the alternative to using humour to respond was not good for anyone.

> *"I think it's the way that that we deal with it because I think if we took everything to heart, I think that seriousness um we would never cope… We do see some very horrible, pretty horrendous things and you know then you can see some of the radiographers are shaken up over it and the only way to probably deal with it is make a joke about something you know, and they've sort of used it to see the smiles return to everyone's faces." (Interview with radiographer).*

This radiographer felt that it was important to keep going and to keep smiling, which raises the issue of emotional involvement. Radiographers expressed that they should not be upset in front of patients and that they need to maintain a professional demeanour. This is learnt behaviour termed 'display rules' by Goleman (2004), and it describes how we present ourselves in different situations. Display rules are learnt by newcomers to a group, they learn by observing the behaviours of the other group members and seeing what is and is not accepted.

Compassion fatigue, emotional labour and mental health are all important considerations and have come to the fore following the Covid-19 pandemic and its effect on health care workers. Diagnostic radiographers are there to provide a service and it was felt by those in my study that emotional displays should occur after the event, in private.

In addition, the department manager suggested that dark humour and joking could be used to gauge if a colleague was okay and not too upset after a difficult situation.

> *"there was a patient who was very ill and had a brain tumour, I can't really remember any of the light-hearted remarks that were made …but it was just a way of dealing with it. I can't remember exactly the throwaway line that she used to say, yeah I'm okay about it. I mean what you're actually communicating is … I know that it was horrible, and I've been through it and I'm actually okay and don't worry too much. An awful lot of that kind of emotional stress that people experience is dealt with in that almost subliminal sort of humorous way … that was horrible you know and are you okay? And they will come back with a flippant remark which is actually saying I'm okay you know, and I've dealt with it and if they promote the conversation then you know they want to talk about it. So, it's a coping strategy that often I think is actually a very effective one." (Interview with Manager).*

Goleman (2004) suggests that "being able to pick up on emotional clues is particularly important in situations where people have reason to conceal their true feelings" (p. 135), so in behaving as the manager describes, we are giving our colleagues a non-threatening way of talking about what they have been through and using humour as a means to do this. Being able to support colleagues is an important aspect of teamwork, however, I had never looked at the use of dark humour in this way, the manager has a point here, as this is how I observed it being used after the cardiac arrest that I

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witnessed. The radiographers were using humour to find out how the other person was feeling without asking a direct question.

Dean and Gregory (2005) found that higher levels of stress elicited greater use of humour. This would be different from what an outsider would expect from healthcare professionals.

2. Labelling patients

A variety of patients access the imaging department for different radiographic examinations. As with other professions, diagnostic radiographers tend to label or categorise their patients. This could be based on the patient's age, gender, the examination they have attended for, the nature of the injury or pathology that they are being investigated for and the circumstances of the acquisition of the injury (Reeves and Decker, 2012). Other professionals use labelling, both in healthcare and other public services (Murphy, 2009). These snap judgements assist them in dealing with the variety of people that they encounter. The ethical issues surrounding labelling and categorising patients are sensitive issues particularly when the standard of care is being scrutinised (Francis, 2013). It could be argued that making snap judgements does not allow for person-centred care.

It is generally part of a cultural group's behaviour to have 'types' of people and to be able to categorise them (Agar, 1980; Atkinson and Housley, 2003). When we meet someone for the first time, we have a natural tendency to categorise that person, and this assists us in predicting how that person might behave. Becker *et al*. (1961) in their seminal work about the culture of medicine use the term 'labelling' to describe how society defines people. Davis (1959) in his paper 'the cabdriver and his fare' suggests that cabdrivers develop their own typology of cab users based on their appearance, demeanour and conversation. This also occurs in healthcare, Hollyoake (1999) describes this in nursing.

Diagnostic radiographers encounter many different patients. The role of the diagnostic radiographer is both technical and caring, and is characterised by short patient interactions (Reeves, 1999). The diagnostic radiographer must therefore make quick decisions about their patients and categorising the patient into a typology assists them in their decision-making and planning for the examination that they need to undertake (Murphy, 2009). I can remember doing this myself, as a diagnostic radiographer you call a patient from the waiting room, and the way in which they respond can give you a clue about how the X-ray examination is going to go and what you might need to do to support the patient.

However, reductionist language, where patients are referred to as body parts is endemic in diagnostic radiography (Reeves and Decker, 2012). Patients are referred to as 'a chest', 'a wrist', 'a knee' etc. The diagnostic radiographer scrutinises the X-ray examination request which usually starts with the examination being requested, listed as a body part and then this is used to label the patient (Culmer, 1995). This language is also part of radiography education as students are taught to image different body parts (Reeves and Decker, 2012). Students become socialised into this way of referring to patients which is used by radiographers. Patients are discussed in relation to the body part being imaged. To an insider, this would be seen as a normal part of the process of imaging a patient, and the use of reductionist language would be commonplace in planning the X-ray examination. To an outsider, this labelling of the patient could be seen to be reducing the person to a label indicating why they have come to the department, rather than thinking about and caring in a holistic manner and considering the person which the chest, wrist or knee is part of.

Murphy (2006 and 2009) suggests that diagnostic radiographers categorise their patients in order to decide how best to image them. In my study this was clearly linked to the workload and how it was

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managed, this was done through understanding which patient was next and which examination they had come to the DID for. The radiographers felt that labelling and typifying patients helped them to decide how the examination would go, how to address the patient, and more crucially it gave them some idea of how long the examination might take, so that they could plan. In categorising patients, based on their previous experiences, they were able to have an idea about what to expect.

> *"the radiographers talked about how they categorise people in order to know how long something will take, they tend to build up a picture in their minds of the patient once they have looked at the request card, they look at the name, date of birth, address and the reason they are there, and then they can decide what type of patient they have and what the examination will be like." (Observation, staff room).*

This was all done before the patient was called into the room, a judgment was made purely on the information given on the X-ray examination request.

As well as referring to their patients by the examination for which they have attended the department, for example 'there's a chest outside', 'the next patient is a knee' (Reeves and Decker, 2012), the radiographers also referred to patients who had attended for several radiographs as a 'shopping list' or a 'shipping order'. This was observed in the staff only areas of the department, out of the earshot of patients. One of the radiographers explained it thus;

> *"Well it's our job isn't it, to X-ray their foot and that's what you're doing. Although we are aware that there's a patient attached to the foot, it is the foot really isn't it?" (Interview with radiographer).*

Long *et al*. (2008) in their hospital ethnography call this 'depersonalisation' and suggest that whilst in hospital people's identities are stripped bare, and they take on the name/role of their condition/pathology and are known by this, for example, a hip replacement, and appendectomy.

Labelling of the patient is done to assist the radiographer to build up a picture of the patient and to plan their workload. Diagnostic radiographers need to make a rapid assessment of their patients and their capabilities and by categorising them into patient 'types', they can call on previous experiences with similar people and make decisions about how to proceed with the X-ray examination. I would certainly do this, as it helped me to plan the X-ray examination, how long it might take and what equipment I might need. However, referring to patients by their examination is degrading and goes against all I hold dear in terms of person-centred care and values-based practice (Strudwick *et al*., 2023).

Patients were also categorised into those who were deserving and undeserving of healthcare. This notion of deserving and undeserving patients comes from the Elizabethan period where the 'impotent poor' (the deserving old or sick) where cared for in poorhouses or alms houses, and the able-bodied (undeserving) worked in houses of correction which some people thought were too comfortable or expensive. The Royal Commission of Inquiry and 1834 Act shifted responsibility from the church to the Poor Law Commission, and the Poor Law aimed to put people off applying by sending them to the workhouse. The main principle was that the undeserving poor must be worse off than the worst paid worker so that only those who were in real need would seek relief and support. Many of the public still hold on to this belief of people who are deserving and undeserving of welfare support or healthcare. When the National Health Service (NHS) was created in 1948, it was available ~~in~~ on the basis of healthcare need, free at the point of delivery, and therefore aimed to reduce the notion of the 'deserving' and 'undeserving'.

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Many studies in healthcare talk about the notion of unpopular or undeserving patients; for example, in the emergency department (Dodier and Camus, 1998), in medicine (Becker *et al*., 1961), and in nursing (Cudmore and Sondermeyer, 2007). Other studies suggest that healthcare professionals make judgements about patients and categorise them to decide how best to treat them, in radiotherapy (Brooks, 1989), in the emergency department (Dodier and Camus, 1998; May-Chahal *et al*., 2004) and in health and social care in general (Taylor and White, 2000).

In the imaging department the patients who were considered undeserving were broadly those who had contributed to their own healthcare issues, for example due to alcohol consumption.

> *"I observed two radiographers discussing a patient who had been behaving badly and had been involved in a fight. He had been drinking heavily and he was rude to the radiographers. They commented that he did not deserve to be looked after." (Observation, Emergency department).*

Or due to obesity.

> *"one of the radiographers talks about an overweight patient she had imaged that afternoon and how it was a challenge. Other radiographers comment that obese patients need to lose weight so that they have less chance of having health problems." (Observation, staff room).*

The radiographers made judgements based on the patient's circumstances and this had an influence on the way in which these patients were perceived. An outsider could view this as an uncaring attitude and not upholding the values of the NHS.

In contrast to this, when the radiographers felt that the patient was, in their opinion deserving, then they genuinely cared for them. I did not observe patients being poorly treated and it was not obvious at the time how the radiographers felt about the patient. It was only after the event, in the staff room that the radiographers expressed their feelings. There appeared to be agreement amongst the staff about which patients were deserving and which were not, and this could be considered learnt behaviour. This categorising of patients into deserving and undeserving did not sit well with me. Although I struggle with some of the self-inflicted healthcare issues that patients might face, I do not think it is the role of the healthcare professional to make such a judgement and to treat patients differently based on their circumstances.

It appeared to be normal for radiographers to label and categorise their patients in order to manage their workflow and depersonalising the patients appeared to help them to maintain a professional distance.

Discussion and Conclusion

There are very few ethnographic studies of radiography, and therefore very little reflection on how the professional culture within radiography has an effect on person-centred care and what this means for radiographers and their practice.

In the case of this paper, both examples,; the use of dark humour and labelling patients, resulted in reflection on my part as an insider to the diagnostic radiography profession. Whilst I could see and understand why radiographers used dark humour and labelled their patients, this does not fit with my philosophy which is person-centred.

I am a radiography researcher who has advocated for and written about person-centred care and values-based practice within my profession (Fulford *et al*., 2018; Strudwick *et al*., 2023; Strudwick, 2024). Therefore, I find the use of dark humour within a so-called caring profession a dichotomy,

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how can someone who cares for people in public joke about them and their misfortunes when in private. To an outsider, this could appear to be uncaring and lacking in compassion and empathy. However, to an insider they might perhaps understand that this is how radiographers might cope with some of the nasty things that they see in their day-to-day work, and how they 're-charge' so that they can 'go again'. This is a way to manage empathy distress (Goleman, 2004), and this is key to managing one's own capacity to care. I am aware that I employed dark humour myself as a coping strategy, but at that time I had not reflected on how this could be seen to conflict with person-centred care. I do, however find it reassuring that radiographers use dark humour in the 'back-stage areas' (Murphy, 2009), places such as the staff room where their conversation cannot be heard by patients or their relatives. I think that this shows that radiographers have an awareness of professional behaviour and what the boundaries should be. As an insider I can also understand this distinction which could easily be observed between 'front stage' and 'back-stage', and behaviours which were acceptable in each area of the department (Goffman, 1959; Murphy, 2009).

Labelling of patients could also be seen to be reductionist, rather than holistic. Reducing a patient to their body part, rather than considering the whole person to which the body part to be imaged is attached (Reeves, 1999). Once again, this could be seen to be lacking in person-centred care by only focussing on the part of the patient that needs to be imaged, rather than the whole person. As an insider, I can see why this happens as the radiographer is preparing for the examination that they are about to undertake. Within the department where my research took place, this also occurred in the 'back-stage' areas, where patients and relatives could not hear the conversation. An outsider and indeed patients themselves, could see this labelling of patients to be unprofessional and uncaring.

The ethnographic researcher needs to be aware of both the insider and outsider perspectives in order to notice and report on the culture being studied. As an insider the researcher could potentially miss those behaviours exhibited by the participants that they would consider to be 'normal' behaviour that they are familiar with, this would include the use of dark humour and labelling patients by radiographers. As a diagnostic radiographer, I could have missed these, as I was studying my own profession, but attempting to view the group with a sense of strangeness and thinking like an outsider enabled me to see aspects of the professional culture that would be remarkable to an outsider.

It is important for the ethnographic researcher to have an awareness of both the emic and etic perspectives and to be able to make the familiar strange in order to see the culture from an outsider's perspective. As a diagnostic radiographer myself and reflecting on my own behaviours and knowledge of my profession, I can view these aspects using an autoethnographic approach and relate these experiences to my own thoughts and feelings about this topic.

This paper has added to the methodological debate about studying a familiar culture within healthcare and how easy it can be for the researcher to miss aspects of the culture due to their familiarity with the setting. It has also added autoethnographic reflection on what it means to uncover behaviours that can be uncomfortable and against all that you hold dear. It is important to bring these uncomfortable thoughts and feelings to the surface and to reflect on how there are apparent contradictions between being a caring professional on the 'front stage' in front of patients, but that behaviour differs when 'back-stage' and away from the public view. In view of this work, there are some implications and courses of action for practitioners. It is clearly part of the professional culture of a diagnostic radiographer to utilise dark humour as a coping strategy in challenging situations. However, this needs to be carefully managed to ensure that patients and their relatives do not hear this and that dark humour does not become something that is visible on

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the 'front stage' of the imaging department. Likewise, diagnostic radiographers need to be aware their tendency to label and objectify patients and ensure that this is kept behind the scenes and does not influence the way in which patients are cared for.

Person-centred care should always be at the centre of a diagnostic radiographers' interactions with their patients.

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