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The Interactionist Self and Grounded Research: Reflexivity in a Study of Emergency Department Clinicians

Abstract

This paper shows how the theory of symbolic interactionism shaped a grounded investigation of the organizational labor of Australian Emergency Department (ED) clinicians. Further, it shows how symbolic interactionism supports reflexive criteria for validating grounded research. Using ethnographic methods across two metropolitan EDs, interactionism's emphasis on roles applied equally to the relationship between researcher and participants as to the relationships among participants. Specifically, the researcher generated data by positioning interactionism as the mediator of the emergent relationship between researcher and participants. The results of this positioning were: a traceable path from understanding to interpretation and the search for consequentiality rather than truth. Interactionism facilitated the co-production by the researcher and participants of limits on the generalizability of the data. The paper is an argument for symbolic interactionism as a means not merely to generate sociological findings, but to conceptualize the impact of the researcher on the grounded research process.

Keywords

Symbolic interactionism; Reflexivity; Self; Emergency Department; Grounded theory

This paper is an exercise in reflexivity. The central argument of the paper is that the reflexive capacity of symbolic interactionism (hereafter referred to as interactionism) can be engaged to validate qualitative, grounded research. The paper shows how, in a study of Australian emergency cliniciansⁱ, the interactionist self of the researcher constructed the data. The objective of the broader project was to understand the way nurses and doctors in the EDs of two tertiary referral hospitals in Sydney, Australia, carve out a unique domain for their work in their interaction and negotiation with doctors and nurses from other departments within the hospital. This empirical objective is realized by recognizing that the communication of these clinicians sustains shared and often unspoken understandings of their roles within their interactive environments. Furthermore, these interactions create social structures. These are core tenets of interactionism. The present paper is concerned not so much with the project's substantive findings, but with the role played in delivering the substantive findings by the interactionist focus on the way the work

worlds of Emergency clinicians are produced in interaction. The paper shows that interactionism is capable of accounting for differential relationships between researcher and individual participants, even though such differences might appear to show the primacy of differences between people rather than commonalities among people, which is a distinguishing feature of the theory of interactionism. The paper extends literature by showing how interactionism supports the validation of the data-generating process, and conceptualizes those data generated in the emergent and cyclical grounded process. I will outline the central tenets of interactionism and argue that the interactionist perspective on the self was implicated in my relationship with my research participants and show how it shaped the production of the substantive findings.

The paper focuses, then, on the contribution of interactionism to the empirical research. Although the substantive findings of the research have been described elsewhere (Nugus 2007a; 2007b), I will summarize them and some of the literature on which they draw as an orientation to the framing of the research. Emergency nurses and doctors undertake knowledge work and post-bureaucratic work to challenge the bureaucracy of the hospital (Nugus 2007a). “Knowledge” work is work based on communication and organization rather than physical labour, and is a feature of post-industrial society since the late twentieth century (Drucker 1989). It overlaps with “post-bureaucratic” work which means that organizational knowledge, flexible worker identities, creative solutions to problems, informal relationships, social networks and team synergies are more important in solving problems in real time than focusing on the formal, compartmentalized structure of the organization (Heckscher 1994; Heckscher and Donnellon 1994). Specifically, the work of emergency clinicians involves responding to the organizational misfit of having to coordinate the journey through the hospital of the “whole bodies” of patients who are increasingly presenting with multi-organ problems. However, the hospital, as a product of modernity’s emphasis on control, is a specialized, compartmentalized bureaucracy corresponding to biomedicine’s reduction of the human body into fragmented parts (Nugus 2007b).

Despite claims of the conceptual impoverishment of interactionism (e.g. Lofland 1970), these results show the power of interactionism to engage “testable” explanatory models to illuminate data. Indeed its descriptive, abstract nature enables interactionism to generate such models. The project is unique in applying an interactionist perspective on ED work and also in contributing to the sociology of the organization by focusing explicitly on the formal organizational boundary of the relationship between departments. Beyond the substantive findings of the organizational labor of emergency clinicians, interactionism also enabled the study to generate knowledge about general contingencies of communication, interaction and collective identity of workers in bureaucratic organizations.

The methods that delivered the findings of the broader study and were shaped by interactionism were as follows. Field work consisted of unstructured and structured participant-observation and semi-structured interviews. The ethnographic observation was conducted in two metropolitan Australian EDs over 10 months, during which time 130 semi-structured interviews were also conducted. Field interviews were also conducted following observational shifts. My participants included doctors, nurses and allied health professionals from the EDs and nurses and doctors from other departments of the hospital who interacted with emergency clinicians.

I drew on an emergent, cyclical grounded methodology to collect my data and discourse analysis to analyze them. A “grounded” approach to data collection and analysis involves deriving explanations from the data itself rather than starting off with a pre-conceived hypothesis, or prior codes and categories of analysis which are then tested (Punch 1998: 60). The research process is therefore emergent. In other words, grounded “theory”ⁱⁱⁱ prescribes that the research questions and strategy emerge through the research process rather than commencing with an overarching theory to guide the research and it is an inductive rather than deductive process. However, the cyclical nature of the process means that theories are verified throughout the process as well (Punch *ibidem*: 166-7). As a theory-building enterprise, a grounded researcher seeks to provide new knowledge about generic social processes (Neitz 1999: 101) and not merely provide new information (Thomas 2003: 478). Thus interactionism is an appropriate frame for a grounded research project.

Typically, the grounded researcher needs to observe in order to know what to look for and to talk to people to know what to ask them. Coding and analysis move backwards and forwards in a series of cycles rather than in a necessarily linear, sequential and predictable manner. The objective is that the findings will be anchored in detailed, systematic and transparent analyses of the data (Glaser 1992; Glaser and Strauss 1967). The contribution of the paper to grounded research is that it exemplifies Hall and Callery’s (2001) rigour-enhancing notions of “reflexivity” and “relationality” that “grounded theory” has overlooked. Reflexivity is the researcher’s critique of their influence on the research process, and which I take to include relationality, which is recognition of and accounting for power and trust relationships between researcher and participants (Hall and Callery *ibidem*: 258). Hall and Callery (*ibidem*) argue that these notions have been overlooked because of “grounded theory’s” assumptions that procedures for verifying data are inherent and thus unproblematic in the grounded process, and that data unproblematically reproduces participants’ realities. They attribute these assumptions to the overly mechanistic prescriptions of Strauss and Corbin (1998) for the conduct of grounded research, despite their claims that it is an inductive process. Yet, ethnography is an intersubjective process and the researcher’s meanings influence choices and judgements (Hall and Callery *ibidem*: 258, 260). The remainder of the paper shows how interactionism enables the grounded research process to sidestep this contradiction by mediating the data-generating capacity of relationships between researchers and participants.

Symbolic interactionism

I argue that an interactionist perspective on the relationship between the researcher and participants accounts for the researcher’s journey from information gathering to interpretation, the sociological, that is transferable, significance of findings, and a project’s validity or generalizability. Qualitative research must confront traditional questions of reliability and validity. “Reliability” has been cast in the qualitative context as “dependability” and concerns the internal stability of data over time and across different observers and coders of the same data (Lincoln and Guba 1985). “Generalizability” or “external validity” (often called “transferability” in an ethnographic context) depends on theoretical diversity, “thick description” of the

context to allow the reader to determine wider applicability, and a sufficiently high level of abstraction to allow applicability to other social settings (Punch *ibidem*: 261).

Interactionism has established its empirical credentials as a framework for analyzing the patient experience of illness and in non-hospital healthcare settings. However, interactionism has had a limited presence in hospital research, and virtually absent from hospital organizational research. Through interactionism, social theory can reach deeply through theory and practice and across disciplinary boundaries by striving to locate “intelligible common objects”, the meanings of which are shared by diverse people (Forte 2002). The centrality of the production of findings in the present case study lies in the fact that the philosophical indissolubility of mind, self and society connects the individual self with social worlds. Symbolic interactionism holds that selves are at the same time products and creators of social structure (Vryan, Adler and Adler 2003: 378). Individuals exercise agency by choosing from a range of sayable or doable items in particular situations. Such purposive action generates social structure. However, individuals are also constrained by the limits of what they perceive their community considers to be sayable or doable in particular situations. We enter a world of pre-existing symbols formed by those whose communities we enter. We exercise agency within and to expand those sets of symbolizations.

The interactionist “self” is realized through assuming the roles of others with whom one takes on shared activities (Blumer 1969: 21). Mead (1934) argued that, through playing games, a child learns to see oneself as an object to oneself and to a generalized “Other”. They come to see themselves as a potential “Other” to another person. Language and gesture mediate the self and society by facilitating role-play which allows the child to learn the significance of roles in society (Mead *ibidem*: 7, 34-6). As such the discovery of the “self” is the same moment as the discovery of society (Mead *ibidem*). Specifically, “it is impossible to conceive of a self outside of social experience” (Mead *ibidem*: 26). Mead summarized the role of the individual in society by suggesting that social interaction can only occur when the individual uses as a reference point the attitude of the rest of the society. In the words of Joas (2001):

(Interactionism is) about understanding and anticipating the meaning of others’ words and actions within a shared definition of the situation. The individual makes his own behaviour (like his partner’s behaviour) the object of perception. One sees oneself from another point of view ... The ‘me’ refers to the internalisation of what I perceive others to expect of me. (pp. 91-2)

For interactionism, the “social” is located in the concept of the *self* as a “cognitive object generated in acts of reflexive knowing” that joins in a single act the self that is the knower (the “I”) and the self that is known (the “me”; Weigert and Gecas 2003: 267). Interactionism shows us that researchers do not need a “macro” perspective on social life to engage social structures. Interactionism emphasizes the universal tendency of human and possibly non-human beings to classify (Konecki 2005). They use this symbolic ability to learn from their community “vocabularies of motive” (Burke 1935) from which to choose in exercising agency, or free will. To this extent, interactionism aligns with Snow, Morrill and Anderson’s (2003) elaboration of Lofland’s (1995) concept of “analytical ethnography”. Specifically, interactionism eschews positivism’s assumption of the existence of a real world that can be represented objectively (Halfpenny 2001: 372-5). Neither does it assume the validity

of subjective experience. Instead it focuses on illuminating generic social processes, that is “formal” theory, rather than the “substantive” theory of specific spatio-temporal settings (Snow et al. *ibidem*: 185-6). Identities are both structurally imposed through interaction and also collectively created. Gibson, Gregory and Robinson (2005) applied Luhmann’s systems theory to conceptualize grounded research and thus to render the grounded research process sociological, that is “for” the social world. In a hierarchy of concepts, interactionism assigns grounded “theory” as a research strategy rather than a theory because interactionism’s theoretical umbrella focuses on the way selves engage in social action rather than the social action that is generated. This dynamism renders interactionism an inherently descriptive, empirically practical sociological theory because it makes the most sociologically minimalist assumption that human beings are interdependent.

Aligning definitions of the situation

Not surprisingly, in the current case study, I spent the majority of the observational phase of the project observing my participants interacting with each other. They were usually not interacting with me. In interactionist terms, they were “fitting together lines of action” (Katovich and Maines 2003: 202-3) to “shore up fractured sociation” (Scott and Lyman 1968: 46) or “aligning” meanings with other clinicians and with patients (Albas and Albas 2003: 364), rather than engaging with me. However, I came into the shared symbolic world of my respective participants when either I or they interrupted an event to create a new interaction. On these occasions the same interactional processes that were observable by me also applied to my relationships with my participants.

My interaction to derive observational data depended on my participant/s and I sharing a common “definition of the situation”, as for all interaction (Goffman 1959: 231-2). As human beings my participants and I had the “categorical attitude” in common which meant that we were able and yielded to the social pressure to align meanings within a shared definition of the situation (Hewitt 2003: 313-4). I was initially concerned that I was not clinically trained and this appeared to be the prevailing feature which distinguished me as an outsider in the field. I initially conceptualized the “insider-outsider” dualism, known in anthropology as the “emic-etic” distinction (Tedlock 2000), as defined by my participants’ clinical knowledge and my lack of clinical knowledge in not being clinically trained. However, my ability to interpret the events I observed went beyond emic-etic, as we will see, because my lack of clinical training did not impede my ability to generate sociological information. From a symbolic interactionist perspective, as a human being I had more in common with my participants than I had different.

Dramaturgy defining the researcher as an instrument

As a member of a shared symbolic community I understood when my respective participants whom I was observing in the field were happy, unhappy, surprised, shocked, distressed, anxious, embarrassed, amused or elated. Agency, or “will” is clear in “abnormal” or “deviant” conduct (Herman-Kinney and Verschaeve, 2003: 213-4). As an observer, then, I was particularly attuned therefore to less common events such as anger. For instance, I attended a ward round during which an administrator from the hospital visited and informed the emergency doctors present about a new protocol and form for drug ordering. A staff specialistⁱⁱⁱ

appeared furious, demanding to know why emergency doctors had to do the task and not the medical or surgical team who would admit the patient as an inpatient in the hospital. The emergency doctor asked the administrator to leave the ward round. This gave me the opportunity subsequently to approach the emergency doctor to ask about the interaction and also to approach the hospital administrator to tell me how they perceived the interaction and for me to learn what underlying organizational issues they thought underpinned the interaction (Fieldnote B4: 9). My ability to derive data from this event stemmed from the fact that, from an interactionist perspective, meaning does not reside in the intention or in the announcement but in the way the receiver responds to it (Mead *ibidem*: 75-82). The fact that I understood the responses of participants to each other's interactions showed that our common symbolic character was more prevalent than my outsider status as a non-clinician or social scientist.

Sometimes I did not understand the context of a conversation but recognizing the function of the response, I knew what to follow up in "field interviews". I relied on field interviews that I conducted with my participants following observational shifts and in addition to formal semi-structured interviews. Prior to conducting the structured observations, comprising the observation of 12 individual clinicians over 24 shifts, my respective participants generously agreed to answer any questions I had after the shift. Not including other opportunistic field interviews, I spent, on average, 26 minutes and on four occasions between one and two hours. During observations I wrote a vertical line down the left hand side of my note pad to indicate points that I wanted to follow up after the shift. After the shift, I started at the beginning of the notes and addressed these issues. My research focus was the relationships between emergency clinicians and clinicians from other departments as an indicator of their organizational labor within the hospital. The relative clarity of this focus meant that the field interviews, combining the "best" of observation and interviews, yielded more data than unstructured observations because I had concrete events, stories and interactions on which to explore their organizing roles. For instance, one emergency staff specialist asked the emergency staff specialist I was observing: "Are you the gatekeeper of hell tonight?" In my field interview after the shift I asked him what the phrase meant. He told me the other emergency doctor was implicitly asking whether they were responsible that night for determining which patients were to be placed in the overnight "emergency medical unit (EMU)" – otherwise known as the "observation ward" or "short-stay unit" (Counselman, Schafermeyer and Garcia, et al. 2000). I asked why they used the phrase "gatekeeper of hell". My participant said they believed it was because it was a very difficult task to determine which patients were to be allocated to that unit and which were to be diagnosed, treated and discharged, or for another medical or surgical team to be consulted with a view to admitting them to the hospital. They explained that it was tempting to place patients in the EMU because patients were allowed to remain in the EMU for up to 24 hours, and this would alleviate the pressure to fulfill measurable targets of patient "flow" through the department. However, it was unclear how many patients might need to be allocated to the unit that night, given its limited number of beds. This made the decision "a delicate balancing act" (Fieldnote senior doctor B2: 24).

Interactionism assumes that shared meanings or shared definitions of the situation make interaction possible (Goffman *ibidem*: 83, 90, 231-2, 255). That is to say, although we do not make it explicit, interaction assumes a shared answer to the questions: "who are we and what are we doing?" (McCall 2003: 329). One initiates

interaction on a hypothesis, announcing a definition of the situation. The action is based on the expected action of the other/s and the assumption that categorical or symbolic knowledge is shared with others (Hewitt *ibidem*: 313-4). A shared definition of the situation does not mean that people respond in an identical fashion under the same circumstances. People exercise choice or agency in their responses. If the hypothesized definition of the situation turns out not to be shared by the other, the announcer seeks actively to re-align their behavior with the definition they perceive the other/s to have of the situation (Stokes and Hewitt 1976; Blumer *ibidem*: 47). Interactants adjusting or providing an explicit account of their behavior (Blumer, 1990: 47) has its roots in the interactionist assumption that we seek, in general, to behave as others would expect us behave (Turner 1962). What this means is that the meaning lies in the response of the other, not in the mind or action of the announcer (Mead *ibidem*: 75-82). Meaning therefore changes moment to moment in interaction. This gives interactionism its dynamic, emergent, situational, uncertain, unpredictable, improvisational, event-based flavour. Placing meaning in the response rather than the announcement diminishes the relevance of cognitive questions of whether, for instance, one is telling the “truth” or whether interactants do indeed share the same mental definition of the situation (Mills 1940: 900). For interactionism the point is less that the hypothesis is correct and more that people act on the basis of hypothesis. This is the “categorical attitude” (Hewitt *ibidem*: 313-4). So, moment to moment we improvise based on our perceptions of behaviours which we have learned are appropriate in particular situations. We adjust our presentation of self on the basis of the response of the Other.

Goffman (*ibidem*) introduced the notion of “dramaturgy” which focuses on the embodied gestures that communicate what words cannot. Dramatic presentation of self involves using the body to control “expressions given” (deliberately) and limit negative “expressions given off” (involuntary) (Goffman *ibidem*). Importantly, Goffman (1963: 31) proposed that people have a vested interest in and act to allow the other opportunities for “face-saving”. For instance, people use “tact” to rescue the other in order to preserve the definition of the situation (Goffman 1963: 30-1). During our interactions, my participants announced a definition of the situation which I was eager to uphold. I believe that I needed to maintain the definition of the situation, that is, to try to manage, as Goffman suggested, that the impressions deliberately “given” were more influential in presenting my idealized self than the impressions unconsciously “given off”. I needed them for my work; they did not need me to do their work. The dramaturgy, that is gesturing to communicate more than words can say (Goffman, *ibidem*), involved “fitting together the lines of communication” or “shoring up fractured sociation”, through their unprompted accounts and disclaimers, and my reflexivity in my notes taught me to impression manage to get better data. I believe that my anxiety about the way I presented self centered on ensuring that my participants kept volunteering to speak to me in an unprompted fashion. I did not lie to my participants but my field notes remind me that I invested enormous emotional labor to appear non-judgmental and supportive, fascinated rather than merely interested when I was tired, nonchalant when I was so unoccupied that I wished the ground would swallow me up, and to feign distraction or disinterest if a participant appeared to be embarrassed or compromised in interaction with another, or simply appeared uncomfortable with my presence.

The foundation of my education was provided by the open questions in the interviews and observing my clinicians without engaging with them. These two forms of data collection took place during the same 10-month period, weaving in and out of

each other as the busy timetables of my participants permitted. The quality of the relationships affected the type of information acquired, how often and what my participants volunteered to share with me, and importantly, my confidence in asking questions.

Re-defining emic-etic in the grounded process

As conceptualized by the grounded approach, the research focus took firmer shape as the research progressed. The combination of interactionism and a grounded approach accounts for the emergent process of aligning definitions of the situation. As my understanding of the cultures of the EDs – that is, their tacitly shared but observable practices, norms, rules and metaphors (Alvesson 2002; Schein 2004) – increased, I engaged with participants on more sophisticated and specific topics. This section accounts for the influence of interactionism on the way my emerging relationships with my participants generated data. Table one represents the differences between commencing as an outsider to interpreting the work of emergency clinicians. The differences are summarized as corresponding dualities.

Table 1: The interpretative journey

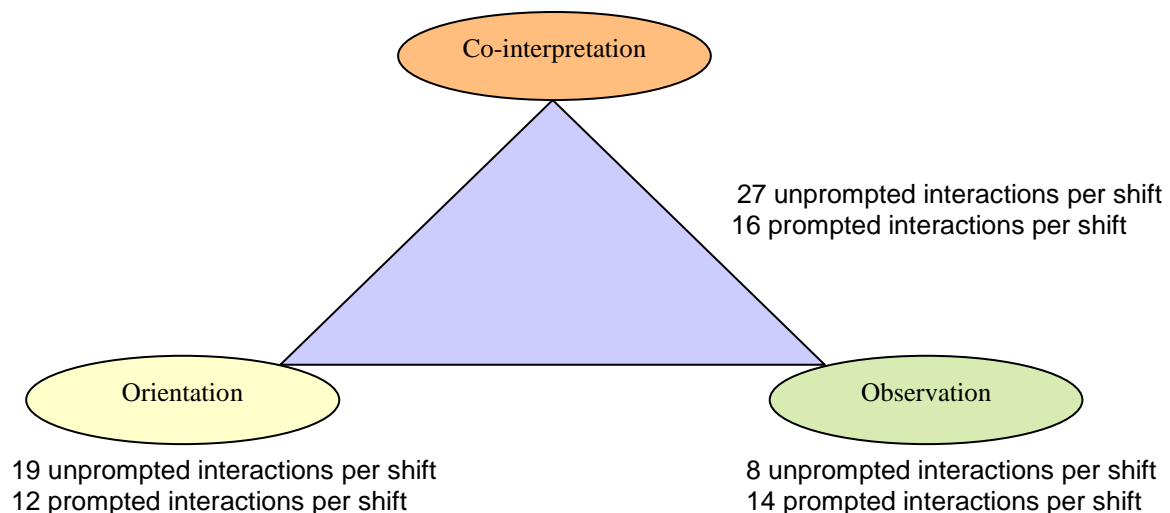
	Commencement	Conclusion
Status of researcher	Outsider/ Etic	Insider/ Emic
Research approach	General	Specific
	Looking for consistency (patterns) (‘What’s happening here?’)	Looking for variation/ deviance (‘Is this what’s happening?’)
Data collection	Unstructured observation	Structured observation
	Observation/ No interaction	Participation/ Field Interviews
	Open questions to generate themes	Closed (hypothesis-testing) questions to validate themes
	Qualitative methods	Qualitative and quantitative methods
Data analysis	Collating instances to build the story	Cross-referencing instances to account for variation
	Voice of the participant/ Researcher gaining knowledge	Voice of the researcher/ Researcher making interpretations

Table one summarizes, albeit in an over-simplifying and abstract way, my perception of the grounded research journey. The diagram shows that the research process was not merely emergent, but directional in terms of interpreting the inter-departmental work of emergency clinicians.

The research process presented a potential challenge to interactionism’s focus on what human beings have in common rather than what distinguishes them. I derived different types of data depending on my perception of the quality of my relationships with core participants. This might appear to demonstrate the

preeminence of personality characteristics and individual differences over interactionism's emphasis on what people have in common. However, my differential relationships with my participants are explicable not solely by personality and other inter-personal characteristics, but in terms of the relationship between inter-personal characteristics and differing degrees of success in aligning definitions of the situation. Specifically, I came to realign my conception of the emic-etic distinction along the lines of gender, age and personality. Analyzing my interactions retrospectively through my field notes, I learned that I interacted more frequently with participants who shared my gender, general age range and personality style as I perceived it. My detailed fieldnotes enabled me subsequently to count the number of times I interacted with my core participants, that is the emergency nurses and doctors whom I accompanied and observed over various shifts. I recorded when they initiated interaction ("unprompted") and when I initiated interaction ("prompted"). On the basis of my quantitative account of engagement, and my subjective account of my relationships with these core participants, I divided them into the following three groups which are summarized in figure one below. The classifying groups transcended occupation, role and rank. The interaction with some participants was enjoyable, jovial and very relaxed and comfortable, helping to facilitate "co-interpretation". As shown in figure one these participants initiated interaction the most of the three groups. Those with whom the relationship was relaxed, friendly and comfortable "oriented" me to their work by explaining their tasks and activities. Most of the information they provided was from questions I asked, although I felt relatively comfortable asking. With some participants, I perceived that my relationship was characterized by observation, passivity and disengagement. In these cases the relationship was usually cordial and courteous but not warm on their part, and on two occasions I perceived at least mild irritation at being accompanied. These participants usually answered questions I had, but briefly, and I was less comfortable asking them questions than participants with whom I had what I perceived to have a more friendly relationship.

Figure 1: Quantity and quality of interactions with core observational participants



There were, of course points of co-interpretation with participants with whom my interaction was less comfortable, especially when they were less busy and had time

to talk with me, and points of mere observation with participants with whom my interaction was enjoyable, especially for participants who appeared busier and more mobile. The point is, however, that the degree of comfort I experienced in being able to align with my participants the definition of the situation correlated generally with the frequency of our interactions. Such differences do not subsume interactionism as a frame for the research process because the degree of information yielded overtly by those whom I merely “observed” was limited by my relationship not by my categorical ability to pursue themes which appeared relevant to my research.

I came to realize when analyzing my interviews transcripts that my interviews shifted from being semi-structured to structured, and were accompanied by more closed than open questions. For instance, an emergency nurse told me in an interview that she believed that nurses from other wards sometimes say they are not ready to receive a particular patient whereas the emergency nurses believe they are in fact ready and they do not wish to receive the patient. Other emergency nurses told me in interviews that this frustrated them because the ED cannot control when and how many patients come into the ED. From my observations, and acknowledgement of this from nurses from other wards, I also believe that this was sometimes the case. However, drawing on an interview with a nurse from an inpatient ward, I asked the abovementioned nurse: “What if I was to tell you that a nurse from another ward said to me that, despite the apparent urgency, sometimes patients are transferred from the ED up to two hours after being told that a bed on the ward is available?” This is an example of a more closed question that I felt comfortable asking when our relationship developed, showing my confidence in our shared definition of the situation, and satisfying my desire to verify my emerging interpretations (Interview A1: 19).

Another closed question I put to an emergency staff specialist in an interview was to wonder whether it is easier for emergency clinicians to transfer patients to a non-organ specific specialty like aged care than an organ specific medical team who were in a stronger position to deflect the patient by referring to the specific features of a certain organ. In this case, the interviewee agreed with me. In most cases my participants either agreed with my emerging interpretation or found my perspective interesting. Sometimes they disagreed. For instance, I confronted a senior emergency staff specialist with my perception of the link between the relatively recent emergence of the College of Emergency Medicine, and hence formal recognition of the specialty status of emergency medicine, and the relative lack of respect for emergency doctors within the hospital. They told me that I was trying to push “hard core sociology” onto something that was not part of the everyday experience of emergency doctors (Interview B2: 3). I now believe that they were at least partially right. However, I formed my own view that there is a clearer association of context than they acknowledged or realized, but that it indeed could not explain the day-to-day dynamics of interdepartmental interaction. In other words, there was romantic appeal in the association but it did not fit together as neatly as I thought. The real world is not neat, and neither is systematic research.

Such closed questions within structured interviews produced two further limits on the generalizability of the data. First, I realized that my interviews and questions were becoming more focused and I deliberately asked hypothesis-testing and sometimes provocative questions, the result of which was that in every one of my final 23 interviews, the interviewee, at least once, made a comment such as: “I’m not qualified to answer that”, “I can’t say”, or “you’ll have to ask x”.

Second, if we needed any more evidence against the limited perspective of talking about “sacred” versus “profane” accounts (Wolf 1988), that is the difference between what is performed at the “front” and what really *is* at the “back” of the dramatic scene (Goffman *ibidem*), interviewees spoke against what I would have perceived to be their interests. An emergency staff specialist claimed in an interview that doctors from other medical or surgical teams tended to resist becoming involved in the care of ED patients and persuade emergency clinicians to approach another medical or surgical team if they can. I asked them whether they sometimes also “market” or “market” the patient in a particular way to persuade other teams, as I believed happened, if they are unable to persuade another medical or surgical team to accept care of the patient. He said:

Ooh yes. If I’m having trouble getting anyone interested in a patient, I might ring a nice, friendly rheumatologist. I mean if they need to stay in the hospital they need to stay in the hospital. They like patients because they don’t get many. (Interview A2: 11)

Similarly, a doctor from an organ-specific specialty^{iv} acknowledged that, in the context of extreme busyness, a function of the decision to become involved in the care of an ED patient depended on their perception that the patient was or was not diagnostically “interesting” (a term they used without my prompting; Interview A4: 7). I perceive such closed questions as giving the participant an explicit opportunity to stop me from over-generalizing from my data. Such questions served a hypothesis-testing function. They served validating and ethical functions by giving participants the opportunity to respond to my emerging findings.

The shift from semi-structured to structured interviews attests to another dimension of the emic-etic distinction: that throughout the research process I turned from absorbing knowledge to making interpretations. This was aided by conducting interviews and undertaking observations at around the same time, so each was informing the other in a cyclical, grounded fashion. In the fashion of a grounded approach, I sought to use the interviews to derive subjectively produced themes and to compare and contrast these with participant-observation. True to constructionism, I was also reserving the right to make my own judgement for which I will be held responsible. The responses of my participants to my closed questions and field interviews represented our attempt to maintain a shared definition of the situation.

In essence, differences in the types of data generated from my participants evinced our common symbolic humanity because they depended not on our shared points of view, but on our ability to co-generate data and interpretations. I did not need a close relationship with my participants to yield data from my interviews and observations. What we did need was a shared definition of the situation. However, participants with whom I shared a closer relationship volunteered more information and I felt more comfortable drawing on our relationship to sharpen my emergent analysis, for instance through asking questions. Specifically, the substantive findings of the study were derived disproportionately from “hypothesis-testing interview questions” and “field interviews”, more so than open-ended interview questions and field observations closer to the “observer” than the “participant” end of the participant-observer ethnographic spectrum. However, in support of interactionism’s emphasis on commonality rather than difference, these latter two forms of data accounted for the vast majority of the time spent collecting data, and produced the foundational patterns without which I would not have known what to ask about and what particular questions to ask.

External validity of a sociological view on the organization

Interactionism goes beyond subject specific content to produce sociological or social psychological analytic content (Charmaz and Olesen 2003: 648). Interactionist ethnography is not about ethnographies of settings; it is about ethnographies of concepts (Manning 2005: 172). Clinicians, like all people, interact in the here-and-now and are not aware of the precise character of the social structures influencing their actions and their contribution to social structures in their ward or organization (Katovich and Maines *ibidem*: 292). They seek to exercise agency in the here-and-now. The current claim to external validity, that is generalizability, is made not only through the inductive methods of a “grounded” approach but through interactionism’s ability to facilitate examination of generalized contingencies of human interaction. Rejecting structurally causative theory helps avoid the charge sometimes level against medical sociology that it is “doctor bashing” (Anspach and Mizrachi 2006). Because interactionism focuses on individuals’ responses to the expectations of roles they play, the focus is less on moral questions, such as which departments or clinicians are “good” and “bad, and more on the situations in which any person could, under particular circumstances, find themselves. For instance, after claiming that Emergency doctors treated psychiatric patients as “creatures from another planet” and not treating their presenting medical problems in the same way as they would others, a psychiatric registrar I interviewed then said: “But then again when I was an intern in emergency I hated dealing with psych patients too” (Interview A4: 11). Similarly, I spoke with an inpatient registrar who was rotating as the after-hours medical registrar (AMR) and whom I knew as having rotated through the ED at an earlier point in time. He said: “We have to put up barriers. The onus is on (emergency doctors) to convince us (to accept care of the patient). We can’t survive if we don’t manage our workload”. I asked the AMR how it was then for him when he was in the ED. He said: “Well, we had to manage our workload too. That meant getting the patients out.” (Fieldnote B6: 13) Therefore, by directing research attention to the roles that any person could find themselves in, rather than the fundamental moral categories of clinicians, empirical research is able to generate findings about the contingencies of human interaction that apply to social settings beyond the time and place of a particular investigation. Therefore, an interactionist focus demands attention to the roles that people play according to their circumstances.

Conclusion

This study has shown how the interactionist self of the researcher constructed the data. In doing so, it contributed to reliability and validity in an empirical study in the Emergency Departments of two metropolitan hospitals. Focus on the interactionist character of the relationship between my participants and me showed the dynamics of our attempts to align the definition of the situation. These attempts did not centre on my status as a non-clinician or social scientist as the defining characteristic of my etic status. Instead, the focus was on the categorical nature of human beings, more so than whether or not we shared the same opinion. This focus revealed how I attributed meaning to my participants’ responses to my announcements in aligning the definition of the situation. It further showed how I sought to manage the impressions “given off” to ensure that my participants

continued to volunteer information. The interactive dynamics of our defining of the situation also governed my preparedness to ask closed interview questions and to conduct focused observations based on my emerging interpretations of the social action occurring in the EDs. These enabled my participants to disagree with me, enhancing the reliability of the research. It also rendered the research more ethical, by disciplining the transition from evidence to findings.

The unique contribution of the paper is to show how interactionism and grounded research can be combined to enhance the trustworthiness of ethnographic research. They allow greater participant engagement in the findings and interpretations. Interactionism illuminates the dynamics of the researcher's potency as a research instrument that needs to be accounted for reflexively. The categorical attitude has greater explanatory power than the genuine personality differences and qualities of interaction one encounters in the field. The categorical attitude allows participant worlds to present themselves to the researcher as the foundation of the researcher's testing of their interpretations among those participants who facilitate "observation", "orientation", and "co-interpretation" in particular. Interactionism eschews a focus on the fundamental moral categories of clinicians. By directing research attention to the roles that any person could find themselves in, interactionism shows itself to be a descriptive, social theory that is sufficiently abstract to account for the universal interdependence, or the inherent socialness, of human beings. Thus interactionism enhances research validity by generating findings about the contingencies of human interaction. These apply to social settings beyond the time and place of a particular investigation.

Endnotes

- i I will refer to the nurses and doctors working in the ED as "emergency" clinicians.
- ii Although "grounded theory" is the label commonly used I will refer to a "grounded approach". The grounded approach is a "methodology" (research strategy) which I do not want to confuse with the more conceptually abstract "theory" of symbolic interactionism that informs it and which it is intended to operationalize.
- iii A staff specialist equates with a hospital-employed physician in the United States.
- iv The term "organ-specific" is applied as an adjective to specialty medical or surgical teams, or doctors of an inpatient specialty subdiscipline, based on specialised knowledge of a particular organ of the body, such as cardiology, respiratory medicine and neurology.

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