Short essay: The risks of choosing practice theory for ethnographic research: experiences of epistemological and methodological failures

Introduction

Reading Verbuyst and Galazka's (2023) call to arms to write about navigating failure in ethnographical research reminded me of a participant in my study, Ram, describing a formal, mandatory procedure he goes through: the surgical safety checklist introduced by the World Health Organisation. At three points, before, during, and on completion of an operation, the surgical team use a physical checklist prescribed by the hospital to record (non-)compliance. The aim is to ensure that the right person is having the correct operation, and the team has everything it needs. The team should subsequently reflect on whether everything went as planned, or whether there are issues that need to be addressed. The checklist is intended to draw team-members together, foster familiarity amongst them to facilitate an atmosphere where people felt able to speak openly if they were worried about what was happening during surgery, and to carry out team-based constructive reflection. However, amongst many practitioners the relational aspects of the checklist are unachievable as the reality is that, along with time pressures, not all the team are present at the three stages to participate. In many instances it has become a tick-box exercise, completed to show compliance rather than really engaging with its wider relational potential. Ram's experience is that it has "*a complete and utter lack of humanity, which essentially stops it from functioning*" [Ram: surgeon]. This was a surprising description for a process that is intended to safeguard patients' lives and well-being. Ram then detailed a separate lengthy social, relational routine he has adopted. An excerpt of his routine below illustrates how he creates an atmosphere to encourage his colleagues to speak up about matters that are worrying them. Consequently, his routine also supports patient safety.

> You go in and you say hello, you ask, as I'm normally going out to the coffee room, "*You want me to make you anything?*" They always say no, but they appreciate it being offered . . . You overtly start [the operation] by saying the things that would be particularly good for anyone who's getting familiar with a speciality, the nature of that, it seems to take a lot of pressure off their shoulders. to . . . Try and recognise when things have been done well. "*There, that's fantastic delivery of an instrument*", or "*It's always lovely operating here because everything's so well planned out in advance*".

He commented that the difference was that the informal routine, the laughing together, admitting problems with the processes, and so forth, demonstrated "humanity" – showing understanding and kindness towards other people (The Cambridge Dictionary, 2010).

What is the relevance of this observation here? As Jemielniak and Kostera (2010) remarked, accounts of research blunders and failures are rarely published. What is published is often a polished, highly-honed article, that lacks the warts and all elements, the humanity,

from which we can learn. In this article I describe my experiences of imperfection, to offset the imbalance of knowledge about the messiness of research. This glimpse of humanity, and lack of it, aims to contribute to our understanding of the intersection of contemporary theory and practice: that is how we may use, or are constrained in the use of, ethnography for organisational research. To achieve this, I offer an example of what did not work for me in my ethnographic endeavour and the emotions produced, based around two themes: epistemological oppression and withdrawal of access in an extreme context. Epistemological oppression occurs if people by virtue of their epistemic agency, lead and control understanding of the world – to the exclusion of others, whose engagement in knowledge construction is consequently limited (Dotson, 2012). This issue is implicated in the matter of access to a research field. Coelho *et al.* promote observance and criticality in ethnographic accounts' reflection on the problems and errors in field research, including emotions during research, and experiences of closeness and distance from the environment studied (2021). Within the academic environment these emotions may also be instigated by power dynamics and financial pressures at play as the researcher grapples with the issue of access and gaining knowledge. Yet the problem of access to the field has lacked discussion and the processes that researchers must go through to gain access tend to be skimmed over. This could be for a number of reasons, that "may include, but are not limited to, the limited length of journal articles, self-censoring and simplification of complex processes" (Karjalainen *et al.*, 2015). Delays and restrictions in access can influence our research questions and understandings of the research subject, particularly relating to crises, and organisational change due to the exclusion of researchers from the field (Frandsen, 2015).

In the following five sections, first I present the theoretical foundations of this article with an explanation of practice theory and the original empirical research plan. Second, a summary of the messy research outcome due to the impact of the Covid-19 pandemic and the ethics approval process is provided. Subsequently, I present the concept of epistemological oppression. The fourth section provides a vignette containing two contrasting events that describe my experiences of what may be considered "epistemological oppression". Finally, I conclude with a comparison of those experiences and suggest variations in the epistemological oppression and the potential for exclusion from becoming a "knower".

The focus of my empirical research and the theoretical basis

Put succinctly, my study's aim was to explore what changes in leadership, since the 1980s, members of NHS surgical teams have experienced. I posed the enquiry in the context of research that portrays movement away from the "heroic" form of individual leaders. This shift is towards the development of relational, collective leadership exercised by more than one person.

I was interested to discover what the effects on leadership experiences have been over time, as the teams transitioned from the previously well-documented dominant hierarchical leadership (Baggaley *et al.*, 2019; Gokani *et al.*, 2016; Rivett, 1998; Sinclair, 1997) to contrasting contemporary NHS policy objectives for widespread use of collective leadership. Leadership-as-practice (L-A-P) methodology is recommended (Raelin, 2020) for studying such emergent leadership practices. Practices are the "reoccurring pattern of influence tactic or decision-making behaviour that was critical for the unfolding dynamics" of leadership (Endrissat and von Arx, 2013, p. 284). This methodology encompasses the study of the human actors, physical workspace, and "materiality", the latter being the interaction of people with tools, buildings, and other objects. Additionally, it requires examination of "subjectively felt space" where teams construct and perform leadership (Ropo *et al.*, 2013, p. 381). This includes the less visible aspects of work, such as emotions and culture (Dale, 2005). Interview questions were devised based on a conceptual framework related to these elements, to explore not only

relational aspects, but also the spaces and processes that give rise to leadership. Observations of the surgical team-members before, during, and after surgery were planned with the aim of confirming, or providing additional or alternative evidence of, the practice of leadership in the working environment. Subsequent review interviews with participants were to be carried out to discuss the observations, the findings, and to confirm or reassess the data.

In practice methodology it is considered that we can only observe phenomena if we are in the process of experiencing them, trying to see events from the participants' perspective (Harding *et al.*, 2017). However, what is seen by those in a role may not be the same as what an observer sees.

> Teachers, students and parents are like fishes regarding the school [of fishes]: it is taken for granted and therefore poorly understood. An outsider is needed to remedy this lack of understanding (Czarniawska, 2007, p. 32).

Thus, observation provides the opportunity for the researcher to add value, by the addition of a novel account from someone who is "not socialized into the same system of meaning, but is familiar enough with it to recognize its object" (Czarniawska, 2007, p.81). My planned observation was intended to witness the drawing together of the different components of practice and to counter concerns about the effectiveness of interviewing: in particular, a concern that interviewing does not necessarily enable the researcher to learn about leadership, but rather how the participants "account for" leadership. Observation develops understanding of phenomena in their wider social context:

> Much of the social infrastructure, such as tools, technologies and discourses, through which micro-actions are constructed has macro, institutionalized properties that enable its transmission within and between contexts, whilst being adopted and adapted differently within micro-contexts (Jarzabkowski *et al.* 2007).

The actual messy research outcome

The research process started in October 2018, with the final formal sign off with the NHS, for completion of data collection, happening in July 2022. The first stage of the project was to gain ethical approval from the University and the NHS. This process had four main stages and took about 16 months. The first stage was to identify the appropriate contact in, then gain sponsorship from the University Research Governance Team (a separate department to the business school I was a PhD student in). This is essential as the Research Governance Team confirm the University indemnity insurance will cover you as a researcher in the NHS. Overlapping with this was completion of the University's ethical approval process through the business school, which included completing a similar but separate set of application forms. The ethics application forms were submitted in February 2019 and after answering additional questions from the research committee, approval was granted in April 2019. Next, having identified sponsors within NHS hospitals, I started the formal national NHS ethics process. This starts with an online application which requires a detailed form to be filled in and numerous documents uploaded, comprising proforma information sheets, consent forms, a detailed research plan, and so forth. This application must be approved by each of the PhD student's academic supervisors and the University Research Governance sponsor before it is submitted to the NHS officials to consider. If there are any amendments made, again all the supervisors and the sponsor have to approve them: the organisation of this can be very time-consuming. There was an added complication in the process, requiring some weeks of negotiations, which is detailed in the vignette below.

Once the national NHS ethics approval was granted in October 2019, the process moves to a local level. The hosting hospitals' research and development department has to consider

and approve the study then issue a "research passport" and an honorary contract. This finally happened in January 2020. After these 16 months of ethics form completion and negotiations, I was keen to start data collection. Data were to be gathered from the staff employed at hospitals geographically located in urban areas, who worked in surgical teams or interacted with those teams by virtue of their role, for example, in a managerial or ancillary clinical capacity. The research plan originally envisaged a multi-method approach: in-person interviews, shadowing participants during their work, both in day and night-time shifts, then individual and group meetings to discuss my initial findings. However, as the health crisis we came to know as the Covid-19 pandemic unfolded my well-laid plans unravelled. The barrier that the drawn out ethics approval process had presented to starting my data collection was a precursor to my exclusion from constructing knowledge in my chosen field of research.

Epistemological oppression

In encouraging researchers to contribute to the section in this journal specifically dedicated to failure and ethnography, Verbuyst and Galazka, suggest that our reflection might "make us more alert and resistant to existing power relations in academia". In this vein, this article describes what may be considered "epistemological oppression". This is a concept rooted in epistemological injustice, whereby a person "is wronged specifically in their capacity as a knower, wronged therefore in a capacity essential to human value" (Fricker, 2007, p. 1). In pursuing a philosophical enquiry to seek to advance what knowledge and truth are, and how we may acquire that understanding (Sewell, 2016), we may experience oppression by virtue of belonging to an out-group dominated by an in-group (Nzira and Williams, 2009). This is the notion that some people (the in-group) have epistemic agency, and others (the out-group) experience epistemic exclusion. Those possessing agency may structure, lead, and control understanding of the world by virtue of their role, whilst those excluded are restricted in taking part in knowledge construction (Dotson, 2012).

Epistemological oppression in academia is a subject that has attracted much interest (Burns *et al.*, 2018; Jackson, 2021). Burns and her colleagues belonged to a group that established "The Epistemological Boot Camp" which aimed to engage and "awaken" the qualitative research community to issues and challenges related to epistemological oppression. That awakening appears to be in progress with the recent development of an interdisciplinary body of work which includes studies of oppression related to education, indigenous studies, recognition of voices, community psychology, and medical self-advocacy (Carnevale, 2020; Eichler, 2022; Kay, 2019; van der Merwe *et al.*, 2023; Sonn and Stevens, 2021).

Burns *et al.* argued that it was time replace divisions in the research community due to a "paradigm war" and to proactively try to educate "the other side" (Burns *et al.*, 2018). This was not an avenue that was realistically available to me as a PhD student working in the "academic milieu". Academia is generally renowned for its hierarchical nature, and as I became familiar with the pressure to publish in this milieu, I was very aware that challenging respected members of the academic community could damage my future career prospects (Levecque *et al.*, 2017). This was in tandem with the continuous pressure, common to many PhD students, to complete their studies in the shortest time-period possible, usually within four years, a pressure exacerbated by the knowledge that my research funding would end then (Polkinghorne *et al.*, 2023).

However, although during the PhD process I did not feel it was prudent to challenge "the other side" I am offered the opportunity here to at least highlight epistemological oppression as a stumbling block in ethnographic research, and so I reflect on why my experiences may be considered as oppression. We see two types of oppressors: first, role-holders wielding institutional influence to block access to knowledge and, second, epistemological adherents who prevent adaptation of their preferred methodological practices by the out-group. This

article employs pseudonyms in the recounting of my experience of failure in my ethnographic research.

A vignette of the lived experience of ethnographic research failure
Knowing in jeopardy: (no) access due to ethical application process
There was no indication of the forthcoming extreme context that was about to hit society at the time that the research plan for this study was designed: the Covid-19 pandemic. Although I did not intend to include patients as participants, the fact that they may be in a room when I was observing NHS staff posed a problem, from the point of view of the NHS Research Ethics Committee (REC) which considered my application. Wanting to safeguard patients was understandable, so I found it surprising that my proposal seemed to be a novel one for the REC. There are different levels of complexity in NHS applications and unfortunately this novel issue resulted in the REC allocating my application to the most rigorous, protracted level. This prevented me from following the timetable I had agreed with my supervisor, the University, and the hospitals. It was an unexpected delay, one that I had not envisaged based on the advice I had received from experienced researchers in the healthcare field, and the senior staff granting me access to their hospitals. I felt disappointed, frustrated, and as if I had failed in this early step in carrying out my research plan. In thinking through whether there was a way of preventing the delay, I deliberated with myself whether I was prepared to relinquish one aspect of my plan, the study of emergency surgery, which was the most problematic in terms of the presence of vulnerable patients whilst observing staff. Whilst this was the easier route, I talked myself out of this as the other half of me felt there could be real value in comparing emergency and routine surgical leadership.

I was an outsider to the group of clinicians [1]; and lay-people who constitute the REC, the in-group which controls the decision-making process for the grant or refusal of access to knowledge. Their decision blocked the less rigorous, quicker route to conduct research in the NHS, even though the management at two hospitals had already made it clear they were happy to host my study, in full knowledge of my research plan. After some months I was invited to attend a full NHS REC meeting at which I pleaded my case for access. Amongst the REC I could sense that some members were cautious about granting me access to the research field. A question was raised about my lack of clinical experience and also whether I would be able to cope with seeing "bodily fluids and naked bodies on a table". I was surprised by this, as I had already gone through the thought process of whether I would be able to cope with watching surgery, people in distress, and features of surgery that might present as "gory" to a non-clinical person. I had imagined it would go without saying that someone who had got this far in the process would already have given similar thought to this, and withdrawn if they did not think they could cope. In the end, even though I was a non-clinician, other committee-members were ready to grant me entry to the in-group which already possessed knowledge of the day-to-day workings of healthcare. After more correspondence and undertakings concerning interactions with patients, clearance finally was granted in January 2020 to begin data collection.

Withdrawal of access in an extreme context
Knowledge of the extent of the Covid-19 pandemic was starting to unfold at that time. On 18 March 2020 the NHS Trust sent out notification that all non-Covid-19 related research was suspended until further notice.

> Please accept this email as formal notification that we will be suspending recruitment to your research study at [Hospital A Trust]. We will endeavour to collect follow up data remotely. However, please be aware this may not always be possible due to prioritisation of COVID-19 studies and

clinical need. Thank you for your understanding at this time [Research and Development Team at Hospital A].

There was no indication of how long this suspension would last and, it transpired, no collection of data remotely by them. When I followed up with a question about the extent of the closure, it became clear that I was to have no contact at all with NHS staff: telephone and virtual video interviews were not an option. Whilst, of course, I understood that the pandemic had created much more fundamental priorities, this formed the first piece of devastating news that I know many other researchers can empathise with: at this point it felt that I would not be able to carry out my study, and consequently my PhD. Due to the unexpected nature of my PhD study seemingly being brought to a complete halt, I was unprepared for the weight of the disappointment this caused.

I had managed to conduct three initial interviews with members of the surgical teams by then. This enabled me, as planned, to analyse the data from these initial interviews, and to identify if the interview question schedule needed to be adjusted to focus on any emerging themes. At this stage more information about Covid-19 started to be known, and it had become apparent that the inability to carry out data collection at the hospital sites may continue for some months.

Finally, in September 2020, access was reopened by Hospital A, in that I was allowed to speak to staff. However, going into the hospital was not permitted. This was a distinctly better outcome than I had with Hospital B, who did not reopen my research project in any form until the Spring of 2022. Nonetheless, life seemed to have been breathed back into the research plan and I felt a sense of relief.

I took several steps to continue to collect data and to enhance triangulation and validity of the data in the absence of the planned observations of surgical teams during surgery and other aspects of their work. I considered asking participants to complete diaries to triangulate information provided during interviews. However, I felt, ethically, that this could not be justified. This would be placing an additional burden on people at a time that they were already facing - and struggling with in many cases - new personal and professional challenges. The diaries would have provided a second type of self-reporting of experiences but would still not be an independent perspective of leadership, as diaries were still reliant on other people's accounts of leadership. Therefore, in the unique circumstances of the Covid pandemic in the NHS, this alternative method did not appear justified.

However, I did undertake observation through virtual media, which had not originally been planned. This provided the opportunity for triangulation of interview data and provided the opportunity to test the validity of participants' interview accounts of the impact of virtualisation. I attended hybrid team meetings where patients' care plans were discussed by different types of clinicians: some were present in a meeting room and the rest of us attended via Microsoft Teams. How I could record what was said, and the material I could use from those meetings, was restricted though. As everyone was discussing patients, I was not permitted to audio-record the sessions and was restricted as to what I could say in my accounts. This rather hampered my effort to follow Bell *et al.*'s (2022, p. 416) advice that field notes should be "copious" and "vivid".

There were other problems too. As I was not physically located on site, it proved difficult to obtain individuals' signed consent to their data from group virtual meetings being included in the study. Data collection tended to be sporadic, dependent on when staff were able to participate between the peaks of the pandemic and the subsequent catching up on waiting lists once elective surgery was allowed to take place again. Recruitment was challenging. As a researcher and being married to someone who works in the NHS, I was mindful of the constraints and burdens that staff were under during this particularly challenging time. I took a carefully balanced approach between pursuing my research project and being

sensitive to the incredibly difficult professional and personal position that my participants found themselves in. An example of this was my attempts to gain direct, or indirect, knowledge of discussions between senior leaders and members of surgical teams which may have given a richer view of the relationship between them. Also, access to meetings or meeting notes may have enhanced triangulation of interview and virtual field observations. However, consent was not forthcoming following my request to attend virtually: the door to seeing what was happening behind the scenes about leadership for the deployment of resources (people and materials), rather than individual patients' care plans, was kept shut. Furthermore, one of the requirements of the University ethics approval, amended in response to the Covid-19 pandemic, was that I should only make a request for participation or interviews once. Unable to pursue matters further, my attempt to gain access that way failed too.

All these unexpected changes in the research plan resulted in an "messy" approach to the research project, taking opportunities to gather data, then analyse it in a relatively opportunistic fashion: that is rather than adhering to the timescales and systematic approach envisaged in the original research design. This seemed to have a positive impact on the research though. Empirically, the main benefit was the opportunity to research the unique operation of the command leadership being used, unusually, for an extended period and the sudden upturn in virtual communications. Also, to study leadership more generally within an extreme context which has not been experienced before, at least during the working lifetime of the participants.

Theoretical and methodological disparity
However, this positive feeling soon dissipated when I realised that I had an epistemological problem too and would be unable to continue the study underpinned with practice theory as originally intended. In developing my understanding of practice theory, I had become aware that not having in-person observations could be problematic. Certain practice theorists consider that practice theory bridges (1) what researchers are told and interpret from that, with (2) what they can see and feel in the field. As such "practice theory should be mainly conceived as a theoretical orientation towards the study of the social where the methodological element remains central" (Carroll, 2016; Nicolini, 2017, p. 20). The practice research community strongly advocates the need for practice studies to include data collection through observations in the field (Gherardi, 2019; Jarzabkowski *et al.*, 2015; La Rocca *et al.*, 2017). I had hoped that the virtual fieldwork might overcome this problem, particularly in light of most researchers, including external PhD examiners and journal reviewers all being "in the same boat", looking for ways to adapt their methodology (Tremblay *et al.*, 2021). Also, I held out hope for as long as possible, that hospitals may be opened up again to researchers and I might manage to carry out observations. As the deadline for my funding loomed, and also for submission of my PhD, I had to face the fact that observations were an impossibility within the lifespan of this project due to restrictions on access imposed by the Government and the NHS. My frustration at not being able to get into my chosen field of research was made all the more acute as the pandemic progressed. Other organisations were allowing ethnographers onto their premises, but healthcare was still a forbidden territory, understandably. I was unable to fulfil the epistemological requirement of practice theory: to participate in the process of experiencing the participants' practices, and to add an independent perspective of leadership in its wider social context, that was not reliant on how other people accounted for it.

Concerned by my growing understanding of the necessity for in-person fieldwork to satisfy the epistemological requirements of practice theory I sought counsel. Academic colleagues, including experienced researchers, suggested that in the light of the restrictions

researchers were facing due to the Covid pandemic that PhD examiners and journal reviewers may be more flexible now than before the pandemic. Their suggestion was that a more relaxed approach taken as to whether the methods the researcher ended up having to use matched the epistemological view set out in the original research plan. This seemed a reasonable view in light of advice being given at online training events and within the wider academic community about how ethnographical fieldwork could be adapted due to access being impossible for many researchers during the pandemic. There was a call for field work to be reconceptualised, for researchers to rethink their research methods where in-person methods could not be conducted (Lupton, 2021).

However, my hesitancy to change my original plan was not purely due to "pending access" to the hospitals which held out the tantalising possibility that I could be back on track if access to them suddenly reopened. As a PhD student a key message from my supervisors and other academics delivering training was that my thesis had to deliver a theoretical contribution. I had identified an area in practice theory where I could deliver a contribution, and that was one reason for my reticence to move away from the original plan unless really necessary. Senior academics' advice to adopt other methods felt like "permission" to me as a novice researcher to continue with my plan. Another key reason was what appeared to be the continued confidence of my academic supervisors that I could use practice theory. My PhD journey took place within the usual master-apprentice supervision model, and with hindsight I realised that unknowingly one aspect of my reticence to change my plan was because I was moving from being a total novice towards expertise in a theoretical area. Based on my supervisors' expertise and experience it took time for me to feel confident enough to exercise sufficient influence to persuade them of such a major decision (Gunnarsson *et al.*, 2013; Polkinghorne *et al.*, 2023).

Despite the counsel that it was possible to adapt fieldwork, there was still that little voice, usually in the middle of the night, chipping away at my confidence about my epistemological endeavour's credibility in the eyes of practice theorists. The well-meaning advice so far had come from researchers who did not use practice theory in their own studies. So, when I attended online conference, I seized the opportunity to ask established practice theory researchers, who happened to be attending, what their opinion was of my quandary. A senior academic who had gained familiarity with my research, methods, and concerns, said:

> Yes, not having observations may be problematic with purist reviewers e.g. Smith and Jones. Reviewers are different though . . . It [the lack of observations] does have to be addressed, but I would not label this as a fatal flaw! You may find a few arguments in terms of approach in Smith and Jones, which you briefly cite.

This was not comforting: my PhD supervisor had said he thought that Professor Smith could be a good choice of external examiner, a view which, despite my epistemological quandary, I agreed with. A few months later, after I had finished what data collection was possible – which did not include in-person observations in the field – I attended another online workshop. Who should be there but two other practice theory ethnographers, including Professor Smith. In response to my question *is there any "forgiveness in the Practice community, are virtual observations a good enough second best?"* their advice felt devastating:

> If you study work and most of the work goes online, there's no reason why you can't study that online if all the work is all online. The problem is if the work is in the hospital, you can't go in the hospital. I know this is not good news for you Tracey . . . There is second best but if second best isn't good enough the reviewers are going to tell you, so this is not good news, you have to raise your hands at some point, we have to wait until we have better situations. And this is the thrust of access. We tell students that if you don't have access, you don't have a study. So first you try for access but if you don't have access, you change your research questions . . . . . .so if you can't go in the place but you cannot change your research question because you are too much down your research, which is the

real difficult place where lots of colleagues had found themselves, they have started something one way and they had already invested so much energy. Then the second best can be probably less than just, instead of doing observations or doing interviews, because the interviews will not tell them [Professor Smith].

The Professor did kindly offer to send me a copy of the document in which qualitative sociologists had listed different research "tools" that could be used in place of in-person access to a research site, and apologised that this was all they were able to offer. I took on board the advice, knowing to continue as I had planned was likely to cause not only problems with the examination of my thesis, but also barriers to the practice theorists' review of article submissions to journals, and consequently my future academic career. I took the difficult decision that my ethnographic failure made it unfeasible to continue to analyse and present the research based on practice theory.

Conclusion
Verbuyst and Galazka (2023) counsel us not "to wallow in their regrets and disappointments" for the sake of it. Did I experience epistemological oppression with the capacity to make me feel regret and disappointment? The first experience of *potential* oppression was in the NHS ethics application process. I did eventually overcome the barriers to access but not before it became clear that my non-clinical background placed me in the out-group in the eyes of some of the NHS REC. The second experience was my gradual awakening to oppression of my research endeavour by virtue of the existence of an in-group of "purist" practice theorists. I, along with other academics, was aware that as members of the out-group there was little chance of the acceptance of articles submitted to certain academic journals if we did not adhere to the in-group's methodological stipulations. This was so, even in the face of a global crisis when many ethnographers were adapting to the consequent constraints on research projects. The in-group's oppression is understandable though, given their strong epistemological values. As a researcher situated in the social sciences using qualitative research methods, I appreciate each of us has a different world view and values, which, in my opinion, we should respect, even if we do not agree with them. Similarly, I understood why some members of the NHS REC were reticent to allow me access to the in-group, in their endeavour to safeguard patients. Likewise, it would be incorrect of me to suggest that we could objectively, and definitively, identify what happens as (perceived) failure or (perceived) oppression. How previous scholars have defined oppression, what you or I consider to be oppression, to another person may be a frustrating delay – the first researcher may have several other opportunities to pursue, but for the second researcher this could be their only chance at carrying out this research and to pursue the subsequent career that hinges on successful completion of the research project. This provides us with an example of how socially constructed perceptions, such as emotions, may differ between groups and individuals, depending on their knowledge and experiences: indeed a "negative" emotion may produce positive or negative outcomes for different people (Hadley, 2014). My (internal) response to the REC members' question about my ability to cope with "bodily fluids and naked bodies on a table" reflects the subjective nature of the feeling of oppression and failure. As we all sit in our "own shifting historical context of the present" (Simpson, 2007, p. 78), what appears a just and justified use of agency by one person does not necessarily detract from the perceived oppression felt by the other. So, assuming a single agreed description of emotions or oppression for everyone could misrepresent what I or someone else feels.

There was a variation in the two instances of (potential) epistemological oppression. The difference was that in handling my plea for forgiveness by the practice theory in-group, humanity was evident, by virtue of the inclusion of an apology in the response that there was nothing that could be done to absolve my ethnographic failure. The NHS REC process was far

more akin to the formal enforced non-relational process that my participant, Ram, describes in the quotation in this article's introduction. This variation speaks to epistemological oppression presenting as a spectrum rather than a binary phenomenon. At the one end of the spectrum, at the no or low level of oppression, I felt *potential* epistemological oppression related to my NHS application. Although there were initial indications of oppression – oppression I could have felt had I received at a different decision from the REC than I did – the conclusion of the process was the grant of my access to the field of knowledge and so no oppression. In the mid-range of the epistemological oppression spectrum, the practice theory in-group make a "conscious deontological choice" between loyalty to their epistemological values and acknowledgement of the need for humanity (Robinson *et al.*, 2022): my plea is rejected, I am oppressed, but the exclusion from the in-group is handled with humanity. Finally, at the far, severe end of the spectrum there is the potential during a process, not necessarily the NHS process, for those in the in-group to choose to use their epistemic agency to exclude others' knowledge of the world. The exercise of such agency under the auspices of formal, bureaucratic processes may show a complete and utter lack of humanity. Those seeking to be the "knower" (Fricker, 2007) may feel wronged in their capacity to gain knowledge and their ability to feel they are valued if their application for access is rejected.

Whilst there was a certain amount of wallowing during my PhD study, particularly at the point of closure of access to the field, I reflect on key learning points that I, and I hope the readers, can take away from the causes of that wallowing. I did not suffer from the sever version of epistemological oppression. Consequently, it was possible, admittedly after a great deal of thought, re-analysis and almost a complete re-write of my work, to emerge from the ethnographic failures narrated above, and to conclude with my successful presentation and defence of my thesis. Achieving this was no doubt made feasible by the emergence of a *relational* "pot of gold" during my PhD journey: a team of family, friends, and academic colleagues, including two very patient, experienced, and supportive academic supervisors. Verbuyst and Galazka suggest that laying bare our failings could enable other researchers to "mine" some *methodological* "gold" too (Verbuyst and Galazka, 2023) for their own ethnographical pursuits, or failure in them, and I hope my offering here contributes to that aim. Finally, it occurs to me that I have mined my own methodological gold in writing this piece as well. By voicing my personal experiences, emotions, research practices, relationships with others, reflexivity, thought processes, ways of finding pragmatic solutions, and efforts at methodological rigour, I realise that my ethnographic failings have enabled me to learn a new skill: autoethnography (Adams *et al.*, 2015; Bunde-Birouste *et al.*, 2019). A silver-lining to accompany that methodological gold.

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Note

1. "Clinician" denotes a health care professional who is involved in the treatment and care of patients. Members of the surgical team are clinical professionals.

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