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Ethical and Epistemological Implications of Conducting Ethnographic Fieldwork as a Researcher-cum-Clinician in Brussels, Belgium

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ABSTRACT

We draw on ethnographic fieldwork conducted in Brussels (Belgium) on the health care experiences of undocumented migrants. We explore the implications of the double position of the ethnographer, who is both a researcher and a practicing doctor. We describe how the intimate knowledge the ethnographer-cum-clinician holds about the health care system influenced and shaped the data collection, analysis and subsequent policy recommendations. We examine the ethical dilemmas in conducting research from an engaged position about care practices toward vulnerable populations in one's own professional field. We conclude with recommendations on how to challenge and interrupt complexities faced by multi-positioned ethnographers.

KEYWORDS

Belgium; clinician; medicine; positionality; reflexivity; undocumented migrants

I also have a question for the doctor: “We often have researchers here, but afterwards. . . We do not hear anything from them. Is it to publish in academic newspapers? What is it used for?”
(Jean)

Jean had lived on the streets of Brussels for several years. When he raised this question, he led a relatively stable life as an undocumented migrant. He had secured accommodation and volunteered in a reception center for fellow *sans papiers* (literally: “without papers”) – the term undocumented migrants often use to refer to themselves in Belgium. Although, in recent years, the Belgian government has taken a firmer approach toward hunger-striking undocumented migrants asking for regularization, the local policy in Brussels largely resembles a *laissez-faire* approach (Swerts 2017). A large informal economy and a wide network of formal and less formal civil society and nonprofit organizations currently provide a space for undocumented migrants, where some undocumented migrants manage to build a relatively steady life.

The doctor Jean addressed in the quote is Dirk Lafaut, who carried out the fieldwork on which this article is based. Before entering academia Lafaut worked in the international medical humanitarian sector, and later as a general practitioner (family doctor) in a Belgian community health center. It was a job where he achieved something tangible, something that seemed clear: he was a doctor and provided health care. As a result of coincidences, life-events and some vague academic aspirations he embarked upon doctoral research. Lafaut kept thinking about Jean's question and started wondering the very same thing as Jean. Why had he ever decided to leave his job as a doctor to undertake research? And why focus on undocumented migration in Belgium?

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Media teaser: We argue that conducting ethnographic fieldwork as a researcher-cum-clinician among undocumented migrants influences and shapes their research findings, and has both ethical and epistemological implications.

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Precisely these questions became the topic of a dialectic between us, Lafaut and Dikomitis, a medical anthropologist working with migrants and refugees. Dikomitis took on a role that oscillated between that of Lafaut's doctoral supervisor and that of a *compagnon de route*. We are both Belgian, speak West-Flemish (a local dialect) and we both conduct ethnographic research in medical contexts among vulnerable populations. We found a joint interest in looking for answers to Jean's question. This article is the result of a collaboration between Lafaut and Dikomitis. We switch between first- and third-person perspectives, as we use the first person in those sections related to the fieldwork conducted by Lafaut.

Here, we aim to contribute to a long tradition of reflexive critiques of methodology within anthropology. These methodological debates are particularly relevant in medical anthropology, where increasingly ethnographers with different professional backgrounds – beyond anthropologists – conduct fieldwork. Our main contention is that the level of medical knowledge and the researcher's clinical training impact on the research process.

Reflexivity, positionality, ethnography

Reflexivity implies being critical of objectivity, by actively recognizing the epistemological frameworks and the structural power imbalances that precede, determine and shape knowledge production. This implies we need to think carefully about ethical relationships between the researcher and the community researched and be explicit about our own social position as researchers, and how this position shapes knowledge production (Cancelliere and Ursula Probst 2021; Harding 1991; Schott 2003). This positionality can be conceptualized as a “researcher identity or ethnographic identity, shaped by political alignments; the ethnic, social, and biographical background of a researcher; his or her social or personal status; and his or her religious and/or moral convictions” (Dilger et al. 2015:5).

The notion of reflexivity has been prominent in anthropology at least since the 1970s and 1980s, when anthropologists began to incorporate and openly discuss their own biases, dilemmas, and personal experiences during fieldwork. This so-called “reflexive turn in anthropology” (Behar and Gordon 1996; Clifford and Marcus 1986), emerged as anthropologists began to grapple with the power dynamics that were intertwined with their research practices, especially given anthropology's long-standing complicity in imperial and colonial projects.

However, Boyer (2015) claims that reflexivity about the contingency of knowledge has been a central feature from the onset of the discipline. He refers to *Primitive Man as Philosopher*, in which Paul Radin argues that anthropological knowledge relies (too) heavily upon local intellectuals, as an early example of “anthropological reflexivity” (Boyer 2015:101). Furthermore, he contends that, besides issues of social power, concerns about the validity of anthropological knowledge played an equally important role in the (re)invention of reflexive anthropology that emerged in the 1970s. He also discerns a recent, third generation of reflexive anthropology in which anthropologists establish collaborative epistemic partnerships with research partners from other fields and non-academic spaces.

In recent decades, reflection on the position of the ethnographer also gained further traction as a result of developments in feminist and postcolonial studies. Feminist scholars argued that all knowledge production is “situated” and expanded anthropological analysis to encompass questions previously conceived as private (Behar and Gordon 1996; Harding 1991). These scholars called upon researchers who study marginalized groups to critically reflect on their privileged position. Advocating a decolonial anthropology, they urged anthropologists to go beyond acknowledging past harms, instead proposing collaborative authorship with ethnographic interlocutors and an anthropology in service of recentering indigenous knowledges and peoples (Tuhiwai Smith 2012; JRAI 2021).

Specifically, feminist scholars in refugee studies demonstrated that ethical research, including developing relationships with one's interlocutors, is not limited to obtaining informed consent and avoiding harm (Mackenzie et al. 2007). Similarly, in medical anthropology criticism was uttered to the narrow focus on issues of informed consent in research (Dilger et al. 2015). The application of principles of medical research ethics in ethnographic research, and specifically the anticipatory review process of institutional review boards (IRBs) and the individualized approach to research ethics are

considered to be unachievable and largely inadequate during ethnographic fieldwork (Fassin 2006; Murphy and Dingwall 2007; Okyere 2018). These lead to ethical discomfort and problems in relation to confidentiality (Murphy and Dingwall 2007; Musso 2008; Staples and Marsland 2023).

Mackenzie et al. (2007) argue that research with refugees should aim to bring about reciprocal benefits for migrant participants and/or communities. In line with the emergence of critical medical anthropology, Willen et al. (2011), for example, have urged fellow medical anthropologists to contribute more actively to reframing the scholarly and public debate about access to health care of undocumented migrants. However, this call for political engagement of medical anthropologists has also been met with criticism. Huschke (2015) showed that, during her fieldwork on the illness experiences of undocumented migrants in Berlin, her work as an activist and her involvement in the therapy networks of her participants impacted on both data collection and analytical framework. Practices of giving voice also necessitate reflection about the strategic ownership of the produced knowledge (Mackenzie et al. 2007). In this vein, several scholars warned of the overly simplistic attitudes of anthropologists when they made “claim to listen to the voices of the poor” (Butt 2002:3; Dilger et al. 2015). Reflective accounts by medical anthropologists addressed the existence of different epistemologies of health held by IRBs, researchers and interlocutors (Biehl 2016; Fainzang 2007; Johannessen and Lázár 2005). Fainzang (2015) also pointed to the ethical difficulties in dealing with two very different social groups when studying the doctor–patient relationship between West-African migrants and health care professionals.

Several ethnographers, who were trained as clinicians, wrote about the impact of their double position on the data collection and analysis in qualitative research in health care settings (Dubal 2018; Holmes 2013; Stonington 2020; Wendland 2010). In *Fresh Fruit, Broken Bodies* Holmes (2013) described how he was being perceived as an “incompetent, useless, yet interested doctor” by interlocutors when studying the social suffering and illnesses of migrant labor workers in North-America (Holmes 2013:32). In *The Spirit Ambulance*, Stonington (2020) reflects extensively on how his medical training in the US initially framed his observations about end-of-life care through the bio-ethical lens of autonomy and how these conceptions later were unsettled through his fieldwork experiences. Wendland (2010), who conducted fieldwork alongside medical students in Malawi, used the metaphor of soap – bringing water and oil together – to demonstrate how anthropologists who first trained as clinicians assemble epistemologically incommensurate frameworks. Even so, Wendland (2019) also raised a note of caution about the moral authority of such anthropologists, since, just like in clinical settings, their authority has its dangers as potentially useful observations by other professionals or scholars can go unnoticed. Moreover, she worried about “the sometimes alarmingly little handwringing over positionality” in their work (Wendland 2019:199).

Methodology

This article is part of a study on access to health care for undocumented migrants in Belgium, building on medical anthropology and public health research evincing that undocumented migrants in Europe face particular problems in utilizing health care services (Suess et al. 2015; Ticktin 2011; Willen 2012; Winters et al. 2018; Woodward et al. 2014). We explored how health care professionals and undocumented migrants deal with ethical dilemmas related to restrictions in access to health care. The study was conducted in Belgium which has a public health care system funded through compulsory health insurance and which achieves a near universal coverage for Belgian nationals and residents. The Act on Urgent Medical Aid (UMA) requires undocumented migrants to complete a complex parallel administrative procedure via a physician and the Public Social Welfare Office (PSWO) in their local municipal district to access the public health care system (Roberfroid et al. 2015). In practice, this means that undocumented migrants must apply for a *carte medicale*. This is a one or three month permit to access both preventive and curative care and treatment within the regular public health care system, delivered in both hospital and ambulatory settings. Urgency is not legally defined, rather, it is assessed by the consulting health care professional.

Between September 2015 and October 2018, Lafaut conducted multi-sited ethnographic fieldwork, which included 25 semi-structured interviews with undocumented migrants and 45 interviews with health care professionals in Belgium. The three fieldwork sites included a public hospital, a civil society organization (CSO) and a community of undocumented migrants (a so-called *collectif*) in Brussels.

After conducting exploratory research, Lafaut conducted participant observation for seven months in a *collectif* (site 1) that had just moved to a new municipality in Brussels. He followed the trajectories of undocumented migrants through health care services. Lafaut tried to negotiate access to health care for individuals of the *collectif*, who requested a new *carte medicale* at the local public welfare institute. He also conducted participant observation in a reception center of an organization that provides a space for legal advice, day-shelter and assistance to undocumented migrants on a walk-in basis (site 2). Lafaut volunteered at the reception center on a weekly basis for over a year, assisted undocumented migrants by providing information about the *carte medicale*, listened to their experiences with health care services and facilitated when they faced barriers in their health care access. Throughout this process he was clear that he was simultaneously working as a volunteer and conducting research. Lafaut also conducted non-participant observation in an Accidents and Emergency (A&E) department (site 3) of a public hospital in Brussels for two days a week for over a year. There he observed the interactions between the health care staff and undocumented migrants.

The ethnographic vignettes and excerpts we use in this article are drawn from Lafaut's fieldnotes. We translated these from Dutch or French, the two languages used in Brussels' health care system. The excerpts mainly refer to moments where Lafaut wrote about his own presence, role and practices during the fieldwork. Berliner et al. (2016) argues that, for researchers, it is important to capture such moments of self-awareness. These constitute moments where researchers acquire knowledge about themselves, their own position in relation to others, and the context of unequal power structures within which knowledge is produced.

Epistemological implications as a medically trained ethnographer

The inability to un-become a doctor

During my fieldwork I studied the interactions between health care professionals and undocumented migrants. Not only by training, but also by other social markers such as class, nationality and often ethnicity, I belonged to the same social category as one of the groups I was observing, the health care professionals, holding the dominant position (Fainzang 2015). This obviously impacted on the ways I established rapport with my interlocutors. My Belgian citizenship, and having grown up in Belgium, profoundly shaped my relationships with undocumented migrants during fieldwork. I have not and I will never be able to experience what it means to be undocumented in Belgium. My access to undocumented migrants and my initial relationships with them were often importantly shaped by my "activist credentials" (Pulido 2008), my presence during public manifestations, my political position in debates about migrant justice and my role in the *sans papiers* movement.

Early on during fieldwork, I observed that taking a political stance made many study participants who worked in the public health care system weary. This is illustrated by the following quote from an interview with a 60-years-old male GP, who did consultations in a *collectif* for several years as a volunteer. He commented on other volunteers from a medical NGO who once visited the same *collectif*:

Doctor: You never saw me on television, in the newspaper. You understand? I have so much work. And there were a lot of [other] people coming. . . Suitcase open, photo, hup, this and that. I hated that.

Researcher: What do you mean?

Doctor: There were people. . . They are coming and: "I will do something" and "It is incredible" and "The State" and "We must fight." I was completely against it. [. . .] The less noise, the better the work.

The fear for mediatization of the existing care-practices, the focus on working, getting the work done and avoiding polarization, were recurrent themes in conversations with health care professionals in the public sector. The fact that I was a GP often seemed to reassure health care professionals that I was not one of “those activists,” and not a troublemaker, which facilitated my access to actors in the health care system. Oscillating back and forth between different research sites, put me in an ambiguous position. Sometimes I felt the tendency, or the expectation, to inflate my engagement, sometimes I had to minimize it. In other words, different aspects of both my professional and personal identity mattered in different relationships.

In conversations with undocumented migrants, I usually mentioned my medical degree early on. Similar to the experiences of Holmes (2013), simply introducing myself as a researcher without making it specific proved a real challenge. However, introducing myself as a doctor created other challenges, as it immediately put me in a position bestowed with a certain authority. After 8 months of volunteering in a migrant support organization, Jean greeted me in the following way:

Jean: Bonjour docteur.

Researcher: You can just call me Dirk by now.

[Laughter]

Jean: In Africa you don't even know the name of a doctor.

Jean kept calling me “doctor,” even when our relationship had developed in such a way that we were on first-name terms. Jean explained this is almost impossible, from his socio-cultural background, to call me by my first name. He cannot “unknow” that I am a doctor. And I cannot un-be a doctor in this context. I probably never got rid of my “doctor” identity in my contacts with undocumented migrants. In comparison to the undocumented migrants, I was in a situation of incredible privilege. Moreover, as the excerpt illustrates, my medical training, and the symbolic status that comes with it, did not diminish this privilege, to say the least. Moreover, as I will argue in more detail below, volunteering during participant observation put me in a position similar to that of health care professionals vis-à-vis undocumented migrants as patients, thus bestowing me with the power inherent in a care-giving position.

An (un)invited GP

My medical training played a role throughout each stage of the research process. The impact of my GP-identity on the data collection is illustrated by the following excerpt from my fieldnotes where I describe how I was welcomed at a roundtable organized by a civil society organization working with undocumented migrants:

X [one of the co-organizers] came to address me personally. I was apparently expected as an important guest.

X said: “I had heard that someone, a GP, from [name university] is coming.” Y [main organizer] apparently also has already talked about me to another doctoral researcher. Many interesting questions about my research.

My arrival was anticipated, both in my role as a GP and in my role as a researcher. Although anthropologists are usually “uninvited guests” – arriving in a community without an explicit invitation, even when they developed some connections with community members prior to the start of fieldwork. I was probably a little bit more welcomed than others because of my social status as a researcher, but especially because of the symbolic status I had as a doctor.

However, this needs some nuancing. The medical world is one characterized by profoundly hierarchically structured social relations (Tronto 2009). Firstly, there is an inherent asymmetry and power imbalance between health care professionals and patients. Secondly, within health care institutions power is distributed in such a way that professionals take precedence over nonprofessionals and that, among the professionals, secondary care doctors take the highest position of all (Tronto 2009).

Although there were large individual differences, my position as a GP generally helped me, as a researcher, to get access to social workers, nurses and GPs. Only social workers in the Public Social Welfare Office were, overall, more reluctant to speak to me. This reluctance can be explained by the existence of strict institutional policies for civil servants.

In the hospital, I noticed that my position became a topic of negotiation during the first week of my fieldwork, as is clear from the following extract from my fieldnotes:

It's busy. The doctor asks the nurse to give a patient a painkiller and do an ECG. The nurse asks me if I can do the ECG. I hesitate for a second. I am perfectly capable of doing it, but I did not expect the question.

I say: Yes, I can. [I was allowed to assist with basic logistical tasks, such as sending blood samples or transferring patients when it was busy on the ward]

He is a researcher, you are not going to ask him to do your work, are you? He is observing.

I say to the nurse: Well, if you are busy, I could help you a bit.

The nurse ignores me and leaves without a word.

After the nurse left the doctor turns to me and says: You can do it, but you risk being used for everything.

This is an illustration of the role division and power imbalance between doctors and nurses, who all knew I was a GP. The doctor thought I should not do the nurse's work and stick to my researcher role – observing. Most likely, neither the doctor nor the nurse would have made this remark if I was an ethnographer without medical training. In my role as an ethnographer, it was interesting to connect to health care professionals from different disciplinary backgrounds, allied health care professionals versus clinicians. Yet, the doctor perceived that a GP who is doing the work of nurse is being “used.” Being a qualified clinician, but not performing the full range of clinical duties, impacted on how seriously I was taken by other health care professionals. For instance, when not performing the ECG, I really felt I was letting down a nurse who was working under time pressure. Afterwards, I sensed they perceived me as a burden, not worthy of much of their attention. This, in turn, impacted on which information I had access to. Throughout my ethnographic fieldwork I found it particularly difficult to connect to *specialists*, as secondary care doctors are referred to in Belgium. An excerpt from my fieldnotes during my observation at the separate doctor desk at the emergencies illustrates this:

It is quiet today. I notice that I no longer really feel at ease when there are few patients on [name specialist desk]. I soon feel redundant. [...] Usually, when the conversation shifts to my research, I get the answer: “*Sans papiers*. There are plenty of them here . . . These people, mostly we send them to the social worker.”

I was repeatedly told that the impact of an individual's undocumented status on their medical care was something for which they were referred to social workers. The specialists said it was not something to be dealt with by them. The fact that such secondary care doctors did not feel responsible to take into account their patients' residence status was in itself an interesting finding. By referring repeatedly to the role of social worker, they also implied – without saying it explicitly – that I should focus on the social workers. I felt less comfortable among secondary care doctors. The interviews I conducted with secondary care doctors were markedly shorter than those with other health care professionals. Although GPs nowadays are recognized and trained as specialists in primary care, the perception of GPs as *just ordinary doctors* is still very much alive in Belgium. My position as a GP made it more difficult to establish rapport with specialists.

In other words, my position in relation to health care professionals played out differently depending on the institutional setting and the professional background of my participants. My medical training facilitated accessing and establishing rapport in nonprofit organizations, medical humanitarian organizations and in public hospitals. My position as a GP facilitated access to health care professionals who had an equal or lower position in the so-called medical hierarchy. The services that were accessible for me were also those that are most frequently accessed by undocumented migrants. This influenced the data I collected and, in turn, my interpretations. I shifted my focus to those services that are most easily accessible, and to those persons in the weakest position in the medical hierarchy, notably those carrying out the hands-on and face-to-face care work. In hindsight, I could have paid more attention to those shaping the way health care professionals can take up their responsibility. By primarily observing these services, the structural mechanisms directing undocumented migrants specifically there were possibly obscured.

The inability to un-know medical knowledge

My medical training inevitably also influenced the data I collected – what I wrote in my field notes and the questions I asked during interviews. As a practicing doctor, I was already intimately familiar with the health care system I was researching: the jargon, the triaging criteria, the referral practices. Here is one excerpt from my fieldnotes after I observed the care an Algerian undocumented migrant received:

He consulted A&E with a big wound in the face two weeks ago. Sutured with wide, coarse stitches. An ugly, thick and lumpy scar on the cheek. If the patient had been a Belgian, it would definitely have been stitched by a plastic surgeon.

In a similar vein, an ophthalmologist mentioned during an interview how an undocumented patient with retinal detachment only received the surgery 6 days after the initial diagnosis because priority was given to meet the administrative prerequisites first. The patient, a 48-years-old Tunisian undocumented man, now has a permanent visual impairment, which could have easily been avoided. We have never heard of such delay in getting an urgent surgery happening to a Belgian resident, even if there were problems with the health insurance.

Knowing the standard medical practices and guidelines enabled me to observe differences in the treatment given to undocumented migrants as compared to Belgian residents. It is well documented that cultural attributes (such as accent, clothing style and body language) and social markers (such as ethnicity, gender, social class) impact on the clinical assessments of clinicians and social service providers (Farmer et al. 2013), amongst others in A&E (Lopez et al. 2010). Anthropologists have analyzed the role of normative categorizations and moral judgments about health-related deservingness in practices of selectivity by health care professionals toward undocumented migrants (Fassin 2012; Willen 2012).

During my fieldwork, I also repeatedly observed practices of prioritization and triaging in the provision of the *carte medicale*, by nurses and other health care staff such as administrators and social workers. Some of these practices I found problematic. One instance I recorded in my fieldnotes:

The last person who is prioritized does not know why he is referred. He has diabetes on metformin 500 mg 1dd, last lab relatively recently. He seems a bit bored, did not instantly want to see a doctor, but “diabetes” is equal to “seeing doctor” according to. [name social worker]

This excerpt illustrates implicitly that I thought this patient should not have been prioritized. I regularly observed similar situations. Respiratory or musculoskeletal complaints (even serious arthritis, tendon injuries) were considered as trivial and non-urgent, while kidney problems, a history of oncology (even when cured 5 years ago, for example), planned elective surgery (for instance, fibroid extirpation) were considered urgent, even if there were no symptoms of illness. I soon became skeptical about the criteria health and social care professionals used to prioritize undocumented patients. Given my own medical training, it struck me how inadequate this triaging

was when done by non-clinicians. This was an interesting finding – at least from my perspective. This also raised ethical dilemmas, as we will show below.

I could not avoid thinking about the problem-solving strategies of the health care professionals. My insider-status as a clinician was both a weakness and a strength. Without a doubt it made me inattentive to cultural and epistemological assumptions I share with health care professionals through my socialization in the profession (Brosnan and Turner 2009; Dikomitis 2021; Dikomitis et al. 2022). On the other hand, it enabled me to interpret encounters between undocumented migrants and health care professionals in a way that would not have been possible without medical knowledge. This included, for instance, the way assessments about appeal and “charitability” of an illness, interfered with the willingness of social workers to implement existing formalized procedures to receive health care.

My experience of working as a clinician in the Belgian context also facilitated a rapid understanding of the observed practices toward undocumented migrants within the health care *system* as a whole. When I observed a GP, who referred a previously unknown, undocumented migrant consulting with multiple, chronic dental problems to the Welfare Office to apply for a *carte medicale*, I wrote in my fieldnotes:

The whole trajectory. Pfff, probably something will go wrong in the whole process anyway. Once the *carte medicale* is granted, they are still nowhere. Make an appointment, first assessment, probably technical investigations, return. . . It seems so hopeless, especially with dental problems. Anyway, she [the GP] has no choice but to start with that first step, applying for that UMA. So, in many cases she limits herself to that.

The GP does what seems the only possible choice, referring the patient for a *carte medicale*, instead of referring to a stomatologist, since the patient will not receive treatment without the paperwork. Nevertheless, as an ethnographer-cum-clinician I felt such despair when I observed these situations. I was almost certain that somewhere in the referral chain the patient would get stuck, and, as a consequence, would not receive timely and effective treatment. Some of the knowledge to come to that conclusion was not based on fieldwork, but on previous experience in the health care system. When taken at face-value, the observed referral can be seen as an ordinary, everyday act, or even an example of good care. However, when considering the fragmentation, the waiting lists and the bureaucracy in the Belgian health care system, the referral rather becomes a way to give a patient the runaround, a way of formally taking responsibility, without feeling accountable, or even a way to get rid of the patient.

Similarly, when writing up policy recommendations I put forward a rationale against expanding the available safety net programs, open door services and free clinics; things that are advocated by many scholars (Hacker et al. 2015; Roberfroid et al. 2015). The guidance of a lot of patients with considerable extra administrative requirements toward a few extra facilities results in increased workload, increased need of free care work, and eventually frustrations amongst health care professionals. This leads to burnout of health care professionals, as well as financial challenges for the institutions where they work. This knowledge was not based on my observations per se, but on my knowledge of the Belgian health care system and my experience of working in a community health center offering care free at the point of access. Therefore, I argued to remedy the current uneven distribution of responsibilities in the health care system and to eliminate all kinds of gatekeeping systems channeling undocumented migrants toward a few overwhelmed health care professionals and health facilities.

Ethical implications of being a researcher-cum-clinician

Being an “incompetent, useless, yet interested doctor”

Being a GP, who was clinically active during fieldwork, sometimes lead to confusion among undocumented migrants, especially during my non-participant observation in the hospital. In a similar vein, Stonington (2020:3) mentioned that “although initially determined to remain an observer, I was often shunted into a combined practitioner-observer role.” After undocumented patients had a consultation

with a health care professional, I approached them about the study, and recruiting them for an interview. Although I made it explicit that they did not have to take part in the interview to receive medical care, my questions still lead to confusion, as is illustrated from my fieldnotes about a participant who declined being interviewed:

After the short conversation, I ask her if she is prepared to do an interview. When she hears that it will not just be about her (current) health (problem), she opts out. She repeats the vertigo complaints [that she had just explained to her doctor]. I refer her to her physician. I doubt, because I have the impression that she feels like she will not be followed up properly. She notices my hesitation, and now begins to slightly aggravate her complaints. She leans back and says: "I'm really very dizzy." I feel helpless. I cannot help. Eventually, I guide her to the waiting room and promise that her doctor will come back soon to discuss her diagnosis and treatment.

After introducing myself as a doctor-researcher, the patient was initially willing to talk. Yet, it was insufficiently clear that I was not enquiring about individual symptoms, nor prescribing treatments. This confusion was exacerbated as the hospital manager asked me to wear a white coat during the observation and recruitment in the hospital. As the excerpt illustrates, this raised difficult ethical questions about my role and approach. The question emerged whether undocumented migrants who seek medical assistance should be bothered by researchers at all. My questions about her undocumented status could make her feel "flagged" and potentially undermine the patient's trust in her health care professional. Moreover, undocumented migrants might have expected that participation would improve their future health care access, which sometimes indeed was the case.

Giving back

Huschke (2015) noted that doing ethnographic research "at home" holds important advantages, compared to the important body of medical anthropological work overseas. It provides more opportunities to reciprocate research participation of undocumented migrants, for example by using one's social and professional networks and medical experience to inform participants on "how to get things done" in the medical world. As with Jean's question we quoted at above, the unexpected question of a participant contributed significantly to my awareness of this need for reciprocity. After the interviews, participants and I would often informally discuss how to deal with specific situations of impaired health care access. This felt right, as a way to reciprocate the efforts of the undocumented migrants to participate. Equally, during participant observation I attempted to facilitate access to health care services for the participants. However, these attempts did not always yield results, as I with an excerpt from my fieldnotes how I tried to help an undocumented man:

Made appointment at gastro-entero department [3 months ago]. All possible complications: language barrier (poor French), confusion about his name in the hospital, needed an extra request form from the PSWO, eventually appointment after 2 months. Then first exploratory consultation at gastro-entero, but referred for investigations that required new admin. Gave up. Still not rid of his complaints.

In other words, facilitating access to health care turned out to be much more difficult and complex than expected. Firstly, there were many situations where these efforts became prioritized over my research activities. Secondly, despite these efforts, the outcomes were often not satisfactory. As the excerpt shows, the participant gave up further health-seeking after encountering several well-known structural barriers, such as language barriers and administrative obstacles (Woodward et al. 2014). Informing undocumented migrants about which steps it required to access the *carte medicale* did not include support to overcome the future obstacles. In the excerpt, my presence de facto resulted in raising false hope and expectations on effective health care access, ensuing disappointment and disengagement, and a lot of wasted energy for the participant. Moreover, I became an extra threshold in the whole procedure myself. During one of my visits to the *collectif* of undocumented migrants I experienced the following:

I hear a conflict in the corridor. People are shouting. I ask what the dispute is about.

[Name] says: Conflicts are not that uncommon here.

I ask again: But what is this conflict about?

[Name]: It is about who will get to talk to you first.

I visited the *collectif* twice per week. Although people expressed their appreciation for my attempts to facilitate it also created a new bottleneck. Providing information to the community of undocumented migrants resulted in several people simultaneously trying to access health care services. This led to tensions and competition. Reflecting on this in my field journal I wrote:

Somehow, I feel like I have failed. I have not sufficiently been able to provide people access to care in that short period. (. . .) I have learned a lot from it myself. Actually, with some bad will, one could say I used this situation as a laboratory where I used myself as a catalyst to provoke interactions between PSWO and UM and register them at the same time. The intention was of course to facilitate access to health care at the same time, but this goal was definitely not always achieved. Yet, the research goal was. That is nothing to be proud of.

At the end of my fieldwork in the community of undocumented migrants, I struggled and asked myself: Did I put undocumented migrants in distressing situations through my (sometimes) failing attempts to organize health care for them? And if so, was the benefit to my understanding of health care access of undocumented migrants, the policy recommendations I made and the academic publications worth this distress, even if well-intended? These questions show similarities with those raised by Holmes (2013) when reflecting on his attempts to join border crossers to the US.

The complicit ethnographer

When Dubal studied the relationship between the medical-humanitarian apparatus and former members of the Lord's Resistance Army (in Northern Uganda he positioned himself "squarely on the side of the combatants" (Dubal 2018:25). However, when studying the doctor-patient relationship, Fainzang (2010) argues it is better not to take sides, an approach she coins as a methodological "dual empathy." Being judgmental or being too transparent about my own values, would present participants from expressing (Dilger et al. 2015). From this perspective, I was supposed to stay quiet and merely observe, even when I was observing suboptimal care practices or witnessing obstructive health care professionals. As mentioned above, I repeatedly witnessed practices of triaging in the provision of the *carte medicale*. This gave rise to an ethical dilemma on whether to intervene or not. From a researcher's perspective, it was interesting to witness which categorizations were used to prioritize some undocumented migrants' health care access over others.' Interfering would obviously alter my research findings. Moreover, interfering openly risked impacting on my rapport with participants. They might feel belittled by my criticism of their work. On the other hand, agreeing with sub-optimal care practices toward undocumented migrants felt deceitful in many ways. It felt deceitful toward health care professionals, for hiding my own moral values or convictions. It felt like tricking my participants – I am not even talking about informed consent – gaining their trust just to expose objectionable practices from a supposedly superior moral position. The unease I felt, was even stronger because of my understanding that health care professionals (especially those doing the hands-on care work) are also not always in a position of power themselves, and that their care practices are shaped by complex institutional and societal factors. Moreover, being a health care professional myself, I wondered if I would do, or be able to do, things differently if I were in their position (and if so, if that was really better). Simultaneously, not questioning sub-optimal care practices toward undocumented migrants felt deceitful toward those are the receiving end of such care. My silence made me feel like I agreed and legitimized such practices, a position that has been described by several medical anthropologists as complicity in a context of structural violence that requires us to take a stand and take the side of those who suffer most (Farmer 2005; Scheper-Hughes 1995; Singer et al. 2019; Willen et al. 2011).

The conundrum about how to act became even more tangible when also undocumented migrants, those I perceived to be in the weakest position, took stances which I deemed to be problematic. Having found out that it improved their chances of getting swift access to health care, I observed undocumented migrants using words such as “diabetes” or “unwell” in order to quickly get routine prescriptions. Could I interfere toward PSWO-staff about which patients, according to my medical assessment, had to be given priority when witnessing practices of triaging and prioritization that I thought could be improved? Interfering in a roundabout way, for instance by facilitating the health care access more for those I deemed to have priority, felt even more problematic.

I had even greater doubts when I observed how representatives of different undocumented migrant *collectifs* instrumentalized the distribution of *carte medicale* to mobilize (large enough numbers of) undocumented migrants for political manifestations (Lafaut *forthcoming*). As I supported the undocumented migrants’ political struggle, and provided them with assurances of my support, I did not want to generate information damaging their case. However, obstructing the delivery of the *carte medicale* to undocumented migrants who did not participate in protests conflicted with my personal values about equal access to health care for all. This posed difficult questions about the ownership of the research findings: Could I freely decide to publish them? If not, with whom to discuss them? Some undocumented migrants approved of the instrumentalization of health care, others did not. To whom was I responsible as an engaged researcher? To the individual participants with whom I had established rapport or to the wider social group to which they belong? Did I have to prioritize the political struggle or my “truth” as a clinician about the value of health as an individual right which I had assumed to be universal? Moreover, by an ill twist of fate the findings also coincided with my own interests as a researcher, as the instrumentalization of health care by undocumented migrants was a new and interesting research finding. For a long time, I doubted whether I should publish my findings. Eventually, I did publish, but I am still not sure if, from my position of privilege, this was the right thing to do.

Epistemological implications of moral positions

In this self-reflective account epistemological and ethical implications of being a researcher-cum-clinician were discussed separately. This distinction should be nuanced. Meloni (2020) described how emotional challenges in her research on health care access for undocumented migrants in Canada triggered her to shift the focus of the research toward access to education, thus showing the impact of the researchers’ anxieties, doubts, but also ethical tensions on an epistemological level. Similarly, the ethical challenges related to Lafaut’s medical professional identity probably had an impact on the ethnographic trajectory he made. During his fieldwork in different sites, he evolved from participant observer in a community of undocumented migrants toward non-participant observer in a hospital. This shift was not (necessarily) the consequence of conscious choices but might well have been an unwitting way to avoid some thorny ethical issues during the fieldwork, an unpremeditated move toward what is familiar and feels safe.

Fainzang argued that ethics and epistemology are strongly connected. She explained why, in her research on the use of deception in health care setting, she avoided taking normative positions for epistemological reasons (Fainzang 2015). As mentioned above, Lafaut took a more targeted approach for epistemological reasons. In relation to undocumented migrants he sometimes felt the tendency to take a strong normative position. In relation with health care professionals he sometimes played down his conviction that everybody in Belgium, whether documented or not, should have access to health care. Some health care professionals he encountered disliked activism. Nevertheless, many health care professionals assumed his research was morally and politically committed. They assumed that he wanted to observe dismissive behavior toward undocumented migrants, that he was there to “monitor” them. Similar to what other anthropologists have described, his presence was considered akin to that of a spy (Loizos 1994). Possibly his openness about his medical professional identity was enough reason to assume that he would also advocate for a right to access health care. Alternatively, they had

other reasons to assume his moral position. Literature suggests that most researchers in social sciences, and especially those using immersive methods, conduct research from an engaged position. Anthropologists in particular, very often take an activist position wanting to fix the injustice experienced by those without perceived power (Jobson 2020).

It is not only clinicians-cum-ethnographers who have to deal with the complexities of ethnographically studying “malpractices” toward vulnerable populations in one’s own field. In several disciplines, professionals-cum-ethnographer (such as a teacher-cum-ethnographer or lawyer-cum-ethnographer) were interested in unveiling bad practices or barriers toward marginalized groups in their own field. It is possible to draw parallels with existing literature in other fields such as legal anthropology. Lawyers-cum-ethnographer researching human rights (violations), for example, have described how they had doubts whether to intervene or remain silent when they observed that social justice principles were not being applied.

Conclusion

We showed how an ethnographer’s intimate knowledge of medicine impacts on different stages of the research process. A fieldworker’s medical knowledge and clinical training attributes them a certain position in the medical world. The position in the medical hierarchy the ethnographer is accustomed to, because of their clinical training, can be reproduced in medical ethnographic practice, by affecting which doors open and which ones remain closed. Our analysis also shows the impact of being trained as a clinician on the interpretation of medical decisions, referrals and treatment management.

We also highlighted the challenges to define and give substance to the researcher’s responsibility when studying interactions between health care professionals and patients, while by training, profession, and medical knowledge, belonging to the supposedly dominant group, the health care professionals (Appell 1978; Fainzang 2015). It causes dilemmas on how to act – and more specifically whether or not to interfere – when observing suboptimal care practices, or when observing instrumentalization of care practices by those who are perceived to be in the weakest position. These conflicting loyalties generate well-known questions about how open one has to be about one’s normative position and on how to deal with how these intentions are being perceived (Lederman 2020). The American Anthropological Association (1997) states that ethnographers have a responsibility toward those they study, and to avoid becoming spies pretending to be engaged in anthropological research while pursuing intelligence operations (Lederman 2020). However, this advice becomes highly complex when conducting ethnography with two social groups with different positions of power. Taking the side of those in the weaker position almost inadvertently turns the ethnographer into a spy.

Both in interaction with health care professionals and undocumented migrants, ethnographers with medical training end up in a position where they are confronted with a “fractured habitus” being split between clinical duties and social science critique (Schlesinger et al. 2021). Such clinicians-cum-ethnographers siding with undocumented migrants when following them along their health trajectories, implicitly presuppose that these patients need and would benefit from access to health care professionals; in other words, to people like themselves. Even when clinicians-cum-ethnographers are on “their” side, you are still located in the “us” of the people helping “them” (Pitkänen 2014). On the other hand, during their presence alongside consulting health care professionals, such ethnographers are perceived by patients as somebody who’s taking the side of the health professionals. A clinician-cum-ethnographer amongst health care professionals inevitably remains an insider. Simultaneously, clinicians-cum-ethnographers also become outsiders by their clinically inactivity and the unclarity about their role, but also by the research objectives and their implicit normative and political position.

We invite our fellow researchers in medical anthropology to reflect on such hierarchies and privileged access during fieldwork. Therefore, we suggest some practical recommendations to actively interrupt, and challenge, assumed roles and hierarchies in the medical world before entering the field. Firstly, this involves making decisions around how much detail will be provided about one’s clinical identity and

medical training during participant-observation. Secondly, we invite ethnographers to reflect on which clinical and professional spaces they want to access during participant observation, and how the researcher's position in the medical world might facilitate or obstruct this. This goes beyond a merely instrumental assessment of which doors will be opened by emphasizing the researcher's training; it also involves acknowledging and questioning the different ways clinical identities are valued within the research settings. Thirdly, therefore, it is paramount that such preparation is not an exclusively academic exercise, confined within university walls, but it should, ideally, involve all stakeholders (communities being researched, those conducting the research and those working in the research settings). This has become routine practice for medical anthropologists working in health research (Dikomitis and Wenning 2023; Polidano et al. 2022). Medical anthropologists could embed a robust community engagement and involvement model in their research studies, to ensure that community members are engaged with and are involved in each phase of the project (Polidano et al. 2022). This includes the co-production of the project design, data collection, methods of analysis, and the dissemination strategy. Setting up a community advisory board before the start of each project will redress power imbalances and avoid a "parachute" model where medical anthropologists enter and exit communities at a time and in a manner of their choosing, collecting data without consultation or input from those studied (Polidano et al. 2022). Indeed, co-designing ethnographic studies with study participants (both those who provide care and those at the receiving end) counterbalances – to some extent- the disproportionate valorization of role of the ethnographer (and by extension that of the researcher-cum-clinician). Such epistemic partnerships might well provide other and better kind of arguments for negotiating access to clinical and professional spaces, and resonate with what Boyer (2015:101) called "third generation reflexive anthropology." Building an epistemic partnership is also closely intertwined with building ethical research relationships, especially when conducting research with disadvantaged communities, such as undocumented migrants. As argued elsewhere, and emphasized in the special issue of the *Journal of the Royal Anthropological Institute* on decolonizing anthropology, this involves recognizing that participatory methods of conducting research and collaborative methods of writing (including authorship agreements) are integral to this approach (Dikomitis et al. 2022, JRAI 2021; Mackenzie et al. 2007).

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