LIVED EXPERIENCE IN REALIZATION OF PARTICIPANT OBSERVATION IN AN INTENSIVE CARE UNIT

EXPERIÊNCIA VIVIDA NA REALIZAÇÃO DA OBSERVAÇÃO PARTICIPANTE EM UMA UNIDADE DE TERAPIA INTENSIVA

EXPERIENCIA VIVIDA EN LA REALIZACIÓN DE LA OBSERVACIÓN PARTICIPANTE EN UNA UNIDAD DE CUIDADOS INTENSIVOS

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ABSTRACT

Objective: to share the experience of the authors in the use of participant observation as a key technique in data collection in the context of an intensive care unit. Method: experience report conducted during a qualitative study on the construction process of symbolic violence in the area of decisions and care relations. Results: centered in the approach related to the entry into the study context, the approach strategies to the participants, the different stages of participant observation and records of observations. Conclusion: we believe that the experience can bring valuable contributions to improve the knowledge and the application of this technique in new qualitative research. Descriptors: Qualitative Research; Participant Observation; Intensive Care Unit.

RESUMO

Objetivo: compartilhar a experiência das autoras na utilização da observação participante como técnica fundamental na coleta de dados no contexto de uma unidade de terapia intensiva. Método: relato de experiência realizado durante um estudo qualitativo sobre o processo de construção da violência simbólica no campo das decisões e relações de cuidado. Resultados: centrado na abordagem de aspectos relacionados com a entrada no contexto de estudo, as estratégias de aproximação aos participantes, as diferentes etapas da observação participante e os registros das observações. Conclusão: consideramos que a experiência adquirida poderá trazer contribuições valiosas para aprimorar o conhecimento e a aplicação desta técnica em novas investigações qualitativas. Descritores: Investigação Qualitativa; Observação Participante; Unidade de Terapia Intensiva.

RESUMEN

Objetivo: compartir la experiencia de las autoras en la utilización de la observación participante como técnica fundamental en la recolección de datos en el contexto de una unidad de cuidados intensivos. Método: relato de experiencia realizado durante un estudio cualitativo sobre el proceso de construcción de la violencia simbólica en el área de las decisiones y relaciones de cuidado. Resultados: centrado en el enfoque de aspectos relacionados con la entrada en el contexto de estudio, las estrategias de aproximación a los participantes, las diferentes etapas de la observación participante y los registros de las observaciones. Conclusión: consideramos que la experiencia adquirida podrá traer contribuciones valiosas para aprimorar el conocimiento y la aplicación de esta técnica en nuevas investigaciones cualitativas. Descriptores: Investigación Cualitativa; Observación Participante; Unidad de Cuidados Intensivos.

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This article follows the development of a doctoral thesis with the research objective of the construction process of symbolic violence in the area of decisions and care relations between older people, families and health professionals in the context of a intensive Care Unit (ICU).

This problem presumes the choice of a careful and appropriate methodology to help analyze how the process of construction of symbolic violence permeates the area of decisions and care relations. In this perspective, the qualitative approach seemed to correspond to our interest, since its incorporates the issue of meaning and intentionality as inherent to acts, relations and social structures, taken both in their advent and in their transformation as significant human constructions.¹

With this approach, we intend to interpret and understand the social reality of a ICU as it is experienced by health professionals, elderly and family, from what they think, how they feel and how they act. Their values, representations, beliefs, opinions, attitudes and habits correspond to a deeper space of relationships, processes and phenomena that cannot be simply quantified and reduced to the operationalization of variables.¹

In this sense, the universe of qualitative research privileges the daily lives and experiences of common sense, interpreted and reinterpreted by the subjects that live them.¹ Despite the plurality of interpretations of thought on the qualitative level, all have in common the recognition of subjectivity and symbolic as integral parts of social reality.¹ However, our choice focused on the area of research, method that privileges usually extended presence of the researcher in the social context investigated and the direct contact with people and situations studied. Characterized by flexibility and absence of legal constraints type, the area investigation is no mere use of uniform technical framed in a linear model of steps or stages.² It depends on a complex interaction between the problem to investigate, the investigator and the investigated ones.²

The area research is a way we can bring about a real and deep understanding of the broader dimensions of structural and organic nature featuring an ICU, as well as a careful and systematic view at the dimensions of relational and symbolic nature. However, for the area research being carried out effectively, there must be a link between the theoretical foundation of the object under study and the area that seeks to explore. In order to facilitate its implementation, it is necessary to meet various steps including the selection of data collection procedures.² In this perspective, participant observation was considered the investigation technique indicated to seize rich and detailed data on actions, human interactions among different actors, situations and events that occur in the context of an ICU. Given the above, this article aims to share the experience of the authors in the use of participant observation as a key technique in data collection in the context of an intensive care unit.

METHOD

Descriptive study, in the form of experience report on participant observation conducted in the ICU of a public hospital in the Central Region of Portugal. To undertake this sharing, it was essential to get access to this context study. This is because, participant observation takes place through direct, frequent and prolonged researcher contact with the phenomenon studied, in order to get information about the situation of people in their own context and not artificially.² In this sense, it was requested by formal letter, the appreciation of the Thesis Project to the Joint Commission University of Aveiro/Public Hospital of Central Region of Portugal (HPRCP). As result of favorable approval, the request for data collection was submitted to the Board of HPRCP Administration. Later, the study design was submitted to the Commission of ethics, along with the request for consent of the ICU director, and respective Terms of Consent to the elderly, relatives and professionals.

Participant observation is conceived as a collection technique of dynamic and engaging data, where the researcher participates in people’s daily lives, observing and questioning what happens, listening to what is said, to clarify the facts in the investigation.² However, it is not possible to study all the people and all the events in a given social situation.² In these circumstances, the selection is inevitable to define the area of study and reduce the scope of work. In this perspective, the non-probabilistic intentional sample was used for convenience. Besides the specific knowledge that participants had about the subject matter, it was considered equally important to diversify in order to grasp similarities and differences. The sample consisted of health professionals, elderly and family members. Its size was not defined, since the guiding principle was the quality of...
the data, that is, the accuracy and depth with which the context is portrayed as a whole.5

The following eligibility criteria for inclusion in the sample were defined. Health professionals should have a professional experience in ICU up to two years and an active participation in care for the elderly in the ICU. The criteria for the elderly should need two different situations. The moment where they may be subjected to mechanical ventilation, unconscious or under the influence of drugs that can alter the level of consciousness. And the moment where they are awake, oriented in time and space, and able to verbalize their wishes and needs. Concerning the family, they should have a close relationship with the elderly and follow their hospitalization (minimum of four visits). It was tried to respect the four principles established for research with human beings:6 each participant acted in complete freedom, free from any kind of institutional or psychological coercion (autonomy); they have been clarified and felt good to collaborate in order to contribute to improving the quality of care developed at ICU (beneficence); in all phases of the study it was assured a duty not to harm the participants (non-maleficence); and respect their right to anonymity and confidentiality of data without distinction or inferences (justice).

It was easily apprehended that the researcher is part of the context under observation at the same time modifying and being modified by this context.1 Face to this intersubjectivity in every moment, the observation situation allows and facilitates the apprehension of the real, once they are essential aspects assembled in the area.4 In this study, participant observation embraces the subjective aspects of social life in ICU, providing an approach to their daily lives and their social representations, rescuing their historical and socio-cultural dimension. It integrates the various moments of the interaction process and reveals convergences and contradictions that are implicit in social relations that develop in different areas of this context. In this sense, below there are the results of lived experience in which one approaches the entrance in the context of the study, focusing the strategies used to observe the different stages of participant observation and finally some examples of records of the observations that were made.

**RESULTS OF THE LIVED EXPERIENCES**

♦ **Entrance in the contexto of the study**

Entering into the area predicted the details of the first impact of the research.1 The establishment of the first contacts deserve special care, given that enables start a network of relationships and understand the rules, regulations and routines that govern the daily lives of the ICU, not for interfering with the dynamics of this space. In this sense, it was facilitating the meeting with the leaders of the ICU, the service director and the head nurse. It was tried to establish an empathetic and trusting relationship with the social study groups, avoiding constraints and misunderstandings. In each contact, it was clarified identity as researchers, the study objectives, the aspects that wanted to clarify and the people who it was intended to work more closely.2

For that to happen, strategic, identity and temporal factors were determinants.2 It began to negotiate with honesty and patience the proximity ways with the different actors to the research route to carry out with their participation, as protagonists and not as simple objects.2 The interaction with the different members of the team took place in a progressive and timely manner, preventing some mistrust and the uncomfortable feeling of strangeness. It was decided that we would use a uniform similar to the ICU team, to be “natural scenery” and can freely go to all spaces.

♦ **Strategies to observe**

Every participant observation takes place in social situations and every social situation can be identified by three primary elements: local (physical space), actors (people involved) and activities (set of activities that people do).4 In this study, observation participant was held at the ICU in which four social situations were closely related by physical proximity: (1) the inpatient unit which develops the care to the elderly in critical condition; (2) the waiting room where family await preparation for entry into the unit; (3) the corridor that connects between the different rooms and offices; (4) the pantry, place to eat and professionals’ interaction in moments of pause.

The complexity of social life in ICU requires that the participant observer becomes explicitly conscious, aware and attuned to things that are usually blocked. Thus, the selection of these four interrelated social situations corresponded to our interests for two main reasons. Because the possibility of a
more comprehensive perspective of service and participation of different actors and because all these social situations allowed the observation of activities, people and the physical aspects as well as our involvement in some activities.4

As such, the observations were not limited to a particular shift or time. On the contrary, they favored all shifts, morning, afternoon and evening, since the number of actors in the research stage and the type of activities carried out was pretty much the same, except with regard to the family. It was tried to observe at every shift the events causing the least interference possible in the social situation: the care environment and the dynamics of the ICU regarding the elderly in critical condition; the interactions between the different agents of the area and the diversity of meaning of messages exchanged; the postures, the silences, the verbal and non-verbal language that accompanies all agents; activities that particularize each professional mode of action; the diversity of situations and the pace of events that occur in the same space-time context.

We cannot ignore that the data obtained through this collection technique depends on the time that the investigator has to make observations.5 Thus, time is a prerequisite, given that a single moment is insufficient for understanding behaviors and actions of people. Consequently, it was determined the period from 10 January 2012 to 10 January 2013 for data collection. Initially, the residence time in service was more regular, varying from 3 days per week for 7 hours per day. This plan was carried out with some flexibility, considering the possibility of some constraints to the context and the study participants or we as research resource.3

Later, when there seemed to emerge new data, the incursions into the area became more sporadic. The return took place whenever needed to validate and refine some observation data that had been overlooked at first. The observation led the process of gathering information. However, when the observation was revealed insufficient, informal interviews addressed to participants appeared. The questions were not just to know what was happening or had happened. They were carried out in order to validate the information gathered6, and the possibility that they may later integrate the interview script.

Steps of participant observation

To achieve this purpose, the level of involvement with people and activities that were observed was different and acquired varying intensities of participation in the course of the investigation. Thus, participant observation can be classified into passive, moderate, active and complete4, exposing it as a lived experience support.

Observations with passive participation

At other moments, we had a moderate participation, seeking to maintain a balance between belonging and not belonging to the group, seeing the “inside” and “outside” situations counterbalancing the observation participation. Participating in some activities helped us to create favorable conditions for a closer relationship with the various actors and learn more about some details that go unnoticed in the previous phase. For example, the ways of doing, living and speaking, the different rhythms of work and understanding of situations and events. During this phase, it was also evident our concern for the development of the ability to make the data set. We realized we had no difficulty in remembering the facts in detail using a few keywords. The problem was that the time spent in the process of writing notes was much higher than time spent in the area.

Observation with active participation

At a later stage, we had an active participation as nurses, engaged in various activities, doing what other people were doing. In this way, grasping the cultural rules of behavior, we have adopted supportive forms of action and monitor social situations considered important from the perspective of the participants. Some moments were privileged, such as the admission of the...
elderly in the unit, care of hygiene and comfort, invasive procedures, prioritization and organization of care to be developed, the shift change, the familiar host at ICU, and interaction of health professionals among themselves and with the family. These moments were essential because they allow an interpretation from the knowledge and experience. Finally, familiarity with certain situations as common participants expanded our involvement in the research. In this case, we have developed a complete participation to do systematic and detailed observations during the course of daily activities. Insignificant events were recorded as a source of data that could prove important when examined together at the end of the study.

During the fieldwork, participant observation evolved in stages not always planned and sequential: descriptive observation, focused observation and selective observation. In order to data obtained be more substantial, at each stage, specific questions were built in due to the context and observed situations. In this perspective, the descriptive observation, began a “big round” to the social situation under study, seeking an overview of social aspects, interactions and what happens in the area. Therefore, we systematically raise the broad links in the study of an ICU considering the nine major dimensions:

- **The physical space**, resulting from the identification of the structure and organization of ICU: reception area and secretary support area, inpatient unit, visit room, kitchen, different offices;
- **The actors**, as people involved in the situation: professionals, elderly and family members;
- **The activities**, as different set of interrelated acts, carried out by the different actors in the ICU: professionals, elderly and family members;
- **The objects**, as physical elements present in the observation space: materials and equipment, furniture and their position;
- **The acts**, as individual actions, individual, performed by professionals, elderly and family.
- **The events**, as sequences of particular activities that involve and are enthralled by the actors: shift change, hosting a family, admission of an elderly in critical condition;
- **The time**, as time sequence in which events occur: work shifts, breaks for food, visiting hours, time management in carrying out different activities.

- **The goals**, as all the actors intend to carry out in particular situations.
- **The feelings**, such as emotions felt and expressed by them in a particular context.

These dimensions helped formulate the initial issues of the “big round” and to make observations that guided the study: What are the actors involved? What kinds of activities do they develop? What spaces do they occupy? What are the main events? What distinguishes the work of different professionals? How to communicate with the elderly and how they value their feelings, intimacy and privacy? What standards of service are there? Are they reflected the way of being, living and do in ICU? How are they completed or implemented? Are there meetings between professional groups? Who are the people involved in these meetings and how to process? How do professionals react to disruptions of these meetings? Does support for the elderly and the monitoring of their family take up space in the concerns of different professionals? How are decisions made regarding the care to be developed? What problems are identified in the decision process? What are the moments of tension and conflict? Who are the protagonists? How do each professional group transmit and record the information on the interventions with the elderly? How are streamlined changes in service? Who leads the various initiatives in the ICU?

The descriptions of “big round” offered opportunities to investigate much smaller experiences units called “mini-rounds” of a situation. In this stage of research, we focus on the interrelations between its various dimensions, answering questions such as: What types of relationships are observed between actors in different types of events on the ICU environment? How to build the links between health professionals in the care of the everyday practice in the ICU? How do events change relationships between actors? Which roles the different actors play in the different activities at ICU: professionals, elderly and family? How do the different actors interact in the spaces they occupy and how do they develop care for the elderly in ICU? How to change the events with the participation of the actors? Could the care environment characteristics in ICU influence on interpersonal relations and the decision-making process? What complicities are established in moments of pause? In what space does this sharing take place? How do...
different actors exchange ideas with each other and solve problems they encounter?

Descriptive observations served as a basic guide to build a detailed picture of the social situation under study and were used for further observations and more detailed issues in a particular context. Thus, it can be stated that the participant observation objectives will beyond the detailed description of the components of a situation, allowing the identification of meaning, guidance and the dynamics of each moment. Describing a cultural scene in a comprehensive manner it is quite difficult given the cultural complexity. Even the simplest social situation is imbued with a large number of cultural meanings. Consequently, some aspects were studied in a more comprehensive and profound way than others. Thus, some structural issues were prepared that allowed move from a detailed description of a particular context for a series of observations focused. For example: To what extent the structure and organization of the ICU influence care developed by health professionals for the elderly? What types of situations or events influence the decision-making process in ICU? What strategies, negotiations and agreements are used or occur among health professionals in the development of care for the elderly? What are the reasons that professionals have to their opinions are divergent? How do the problems/conflicts/differences of opinion show power relations between different professional groups? How the differences of opinion and action among health care providers are managed? What are the ICU environmental characteristics that may influence the decision making process? What are the ways to accomplish the various activities?

After the understanding of what is happening in a given social situation through descriptive observation, there was the observation focused, limiting and clarifying the area of study. Then it was the time to find the differences between specific cultural categories already identified. To realize it, it was necessary to return to the area and resort to selective observation that allowed the definition of situations and specific elements to watch. This type of observation requires careful planning and the development of specific contrast issues before approaching the social situation under study.

Observations record
The area research simultaneously involves collecting and analyzing data. In this regard, regular recording information after each observation period containing details of the date, time, places, events, activities, people and conversations is essential. There were times when we retired for a while, because we considered inappropriate to perform the records in the presence of the participants, although in most situations we had made naturally. This helped to understand what we wanted and contributed to greater openness, complementing and justifying some ideas which in turn led to new data and new reinterpretations. This exercise positively influenced both participants and researchers, favoring a process of discovery, exchange and joint reflexivity.

The area work notes form a condensed textual of verbal formulations of the study participants, “word by word”, drafted as soon as possible after each observation session in the place. To this end, we used a field diary, the audio recording and photography. In the diary all personal reflections on the daily conduct of the research were recorded, social integration in the observed area, the experiences and impressions, fears, doubts and hesitations, positive or negative reactions regarding the participants in social situations. These records constituted in a valuable information source for the interpretation and discussion of results and simultaneously a self-analysis. For a better systematization of area notes, we used the model described above.

Substantive area notes
They consisted of a continuous and predominantly descriptive record in order to provide a detailed picture of the various situations, particular events of each day and conversations we were involved. We retained the words and phrases that had been used, the used terminology and the issues addressed in order to provide an almost literal record of what had been said. In some situations, schemes have been used to account for certain aspects of the particular contexts, such as the distribution of different professional groups in a business meeting or in moments of break in the pantry. Similar to what happens with the selection of the comments made, the substantive area notes were subjected to a selection process and were coded according to the themes developed to facilitate the subsequent data analysis. We showed an example of the substantive area notes on the lonely decision,
misunderstood and not a medical consensus by other ICU health professionals.

“It’s 9.30 a.m. when the doctor enters the unit and approach the bed where Mrs. X. is. His first reaction is to go immediately to the infusion syringe and adjust the infusion rate of the three amines. Without any questioning of the patient to the nurse who is responsible for their care, he said: give another fifteen minutes if there are no changes, you not continue. He left in a hasty manner. After 15 minutes, the doctor returns and fixed his gaze only on the monitor. The situation remains unchanged. Without comment, without sharing their intention with these elements, he requests a connection to the outside to communicate the worsening of the clinical condition of the patient to a family. Later, he transmits to their colleagues his decision. Their attitude was of obedience and acceptance. This impetuous decision-making, sudden and not shared in its entirety with the team of professionals comes to the knowledge of all. There are looks of surprise and puzzle faces, a difficult murmur to disguise begins to take over the unit’s environment. Medical outbursts like, “I’m getting more confused, it seems that there is a wall, we do not dialogue.” The difficulty in believing, by the nursing elements, are also evidenced by comments such as “so many patients who invested when the irreversibility of the clinical picture was more than confirmed, and this lady was soon ... deserved another chance.” Quickly grasps it is understood that this is no consensus in the medical team, is not understood by nursing professionals.”

♦ Methodological notes

These notes consisted of personal reflections about the activity in the area. Some of them approached problems, impressions, feelings and intuitions as well as some of the processes and procedures associated with the area research. In this notes, we used methods and speculate how they may be adopted, adapted and developed in particular contexts. When reflecting on how the role of researchers was understood by the different actors, we see how it could facilitate or impede the relationship with people, data collection and the subsequent development of the fieldwork. This reflective process helped to understand why a refusal of a mistake or a silence. In fact, this reflection represented a learning opportunity, becoming aware of the limitations and weaknesses, but also discovering the strengths and potentials inherent in the role of researchers. Here, there is an example of methodological area notes regarding a notice of communication between practitioner/family during the visit.

Lived experience in realization of participant...

“We felt a little uncomfortable when we witnessed the nurse’s response to elderly visitors. It seemed appropriate that the nurse clarifies the standard of service that directs to the fact that the information on the clinical condition of patients being given in the doctor’s office, out of the hospital room. However, the way it was done, it has shown a distant attitude and indifference with regard to the request for information from that family that was fragile and worried about the medical condition of his wife. Despite being the standard of service, would not it be more correct to approach him, reassure him with a few words and show readiness to receive when you leave? This attitude also showed us that pre-notion that we take to the area concerning the influence of our presence as researchers in the expression of the opinion of the participants was not confirmed. We do not think that our presence in the health professionals would inhibit their expressions of disapproval or disagreement. On the contrary, they spoke naturally, revealing their arguments.”

♦ Analysis notes

These notes are a preparation of the preliminary analysis carried out on the place. They may include preliminary questions and hypotheses to discuss and test. Therefore, at the end of the working day in the area, we did a summary in which we indicated the emerging issues and concepts that could be developed along with preliminary reflections on the analytical framework. We exemplified these notes with the observation of a situation that ignores the perception and decision-making capacity of an elderly person in care to be developed.

“In the complexity of the care process in ICU, the symbolic violence can be expressed when the decisions of professionals are verbalized without considering the state of consciousness of the elderly. This violence lies in conserving the dominant patterns, ensuring the domination by professionals who hold an established position in that space. We can learn that the decision was made without the involvement of the elderly, without the recognition of his jurisdiction, without regard for the experience of a situation that involved the extension of his hospitalization. Thus, health workers are the dominant players and the elderly is the agent dominated undergoing transmitted decision. Although his expression revealed strangeness, he did not dare stop or question what was going on. For these reasons, this interaction was somehow lived as a natural course, imbued with legitimacy that needs no defense. Thus, health professionals in ICU assist in health maintenance processes and life, but
also crystallize hierarchies at the same time, confirm the deletion and heteronomy of those subject to their practices. In this sense, it is expected that the elderly person does not confront the legitimate know and accept with passivity medical decision. Knowledge of the dominant discourse and the complicity that exists for him is a form of invisible, silent violence that imposes a subjugation-submission relationship type."

Given the above, we conclude that the participant observation as a means of in-depth knowledge of the behavior and perceptions of the actors under study, validates with them coherence between what they say and what they do; allowing access through dialogue, what they believe, their frustrations and successes, interpreting them "in loco" and the subject of the action, which constitutes a fundamental wealth for area notes that the investigator will perform over the investigation. During this process, it was essential a permanent epistemological vigilance so that as researchers we kept us in tune with the reality that emerged from the speeches, silences, gestures, attitudes and omissions. In this sense, we lose objectivity while formulating questions that were answered based on the theoretical foundation.

CONCLUSION

Participant observation can be considered an essential part of research in the qualitative fieldwork. The experience gained in its implementation allowed to understand and interpret the social reality of an ICU, the events, the specific situations and relationships experienced by participants in this context. It allowed to interact for a long time with health professionals, older people and family sharing their everyday lives to grasp what means to be in that situation.

Its application required dedication, commitment, discipline, attention, sensitivity, interest in listening and learning from each other without making value judgments. The answers to the questions depended on the relationships developed with the participants studied and the initial fears have been overcome with the clarification, limitation and precise definition of the objectives to be achieved. Progressively, it was possible to develop a systematic and standardized plan that enabled capture of the reality studied and analyze the object of study. Participant observation constituted a privileged moment of exchange between researchers and participants. All were participants in a process of discovery, growth and mutual learning. We believe that the experience can bring valuable contributions to improve the knowledge and application of this technique in new qualitative research involving human care in an intensive care unit.

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