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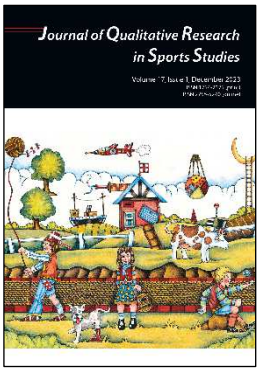

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Baring one's soul in narrative health research: the enculturation of a health care professional in an island population

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Baring one's soul in narrative health research – the enculturation of a health care professional in an island population

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Keywords: *autoethnography, health care, narrative, storytelling, reflection*

Abstract

Autoethnography demands a high degree of self-reflection and openness about one's own life that is both disconcerting and necessary. Therefore, the presentation of self becomes necessary to inform the reader about the author's positionality in research, but without overextending its scope to the extraneous or sensitive. The utility of the narrative form in autoethnography is discussed in this paper revolving around four short stories including: 1. *Starting Points,* 2. *Arrival,* 3. *Transition to Care Work and Nursing,* and 4. *Professional Initiation.* These auto-narratives are part of a wider study into the enculturation of a health care professional in an island population. These progressive and linked accounts are counterpointed with metanarrative as reflexive explanation of how autoethnography has been deployed as research method. Our paper highlights the potential contribution of autoethnography and narrative research to health practitioners working in socio-cultural and clinical settings. The field in this research is the Isle of Wight, off the south coast of the United Kingdom. Key themes related to this location include its geographical position (i.e. its relative isolation to the mainland), and its role as a social-demographic outlier as foretaste of the future population that the National Health Service will serve (i.e. it's high percentage of retired and elderly people). Consequently there is a wide variance in healthcare needs represented in the Island's population, which are placing new demands on the healthcare workforce to meet those needs in the community. Our paper concludes that the narrative turn through this research is yielding positive insights to how health care is received by those whom it is intended to help, and importantly therefore, how health care professionals might alter their practice in the future, to enhance social approaches in clinical care and therefore to maximize the positive impacts of their actions.

NB: The first author is a PhD by Portfolio candidate at the University of Central Lancashire. PhD by Portfolio requires a collation of personal experiences and professional attainments, upon which a 'retrospective' reflective critique of can be made, in order to guide and inform a new 'prospective' phase of research. This article is part of that process.

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Introduction

The presentation of self in narrative is problematic inasmuch as it opens up to accusations of being biased. The subtext of this ethical attack is that there is somehow a morally neutral position from which to assess a research problem. This is clearly a position that can be contested. For example, ask the simple question 'Why ought one take a morally neutral viewpoint?' (Patrick, 2021), and we are left reaching for moral scaffolding to support a morally neutral viewpoint. Despite lacking coherence, this position often leaves the researcher who presents themselves in the narrative, as being under attack.

Autoethnographic process however appreciates that knowledge is partial and situated, and has a viewpoint (Punch, 2012). In contrast to the objectivist, the interpretivist proudly flaunts the colours and hues of their life, that influence and shape their worldview, and epistemological lens. Therefore, embracing these limitations, this account of my culturation into an Island community and health care system is structured as follows:

1. Starting Points

2. Arrival

3. Transition to Care Work and Nursing

4. Professional Initiation

I present each narrative, with questioning about my enculturation into each subculture I visited (Gunaratnam, 2009; Haynes, 2012; Rooney *et al.,* 2016). These questions counterpoint the narrative with my own interpretation of this information. It also demonstrates my commitment to critical thinking about my past, at this moment in time (25 years or more into my career), and not an uncritical and unthinking acceptance of the past, as it was. Critical appreciation of one's own narrative contributes to self-awareness, reflexivity, and empathy for others with shared human experiences (Rosairo, 2023). The colour of the narrative comes, I believe, from presenting the 'situatedness' in such a way as to generate a picture of the journey in the mind of the reader. Times, places and persons are highlighted to situate the derived knowledge in such a way as to make it obvious to a reader the logical and reasonable nature of my own reasoning and conclusions from what I have confronted. I hope that this encourages others to take seriously those touchpoints of their life that informed their own outlook and positionality, and to offer these insights in the knowledge that they help to authenticate their position and view of the world.

Narrative also poses the difficult question of how much one should reveal about oneself (Wolcott, 1983; Gilbourne, 2013). The discomfort of revelation is tempered with the need to present it in such a way to others (eg. Laing, 'The Divided Self'

(1960) and 'The Politics of Experience' 1967) that does not disrespect those being written about, or oneself. Sympathetic disclosure should not however hamper criticality, as this is unhelpful and prevents asking deeper questions that might provide informative insights about oneself and one's worldview.

1. Starting Points

My working life has been on the Isle of Wight, but my life did not start there. My contact with healthcare starts from the age of 5 in the early 1980s, as I recall, having been brought up in Surrey, the width of a field away from the M25. Diagnosed with asthma at the age of 5, I was in and out of hospital for 5 years. This was from my first year in school to middle of middle school. In all, I counted 26 admissions that I can remember. What does this do to one's outlook on life? Well for a start off, it means spending more time in hospital than at school. It becomes part of your life, and to add to that, it normalises it in some respect which I am not sure, had I had less contact with the hospital environment, that it would have done. I have had the opportunity to observe healthcare from the inside for over 40 years. This shapes how you view healthcare in my opinion and how you appreciate it. Not least because the longer you are around healthcare, the farther back you can remember how different it was.

The absence from school is important to highlight too. Unpopular as it was, I spent significant amounts of time on what would now be called colloquially the 'Thickie' table. I was on the same table as people with dyslexia and other learning difficulties as we now understand them. In retrospect largely because of my absences from school, this affected my development or so it appears. I achieved below average in many respects. I didn't know at the time, that I am actually neurodivergent. The label didn't exist to explain my different experience of the world.

You might ask what gives me reason to believe that these prolonged absences caused my suboptimal performance in school to that point? Two things happened close together. The first was my father who was a nuclear test veteran, was diagnosed with inoperable (in those days) lung cancer, and died 6 months later in a hospice. This caused another period of intense contact with healthcare settings. Secondly, my mother and her subsequent partner (who she met whilst my dad was in hospital) went on holiday to Ventnor, on the Isle of Wight and took me out of hospital to go…

As rash as discharging an 8 year old from a hospital ward against medical advice sounds to modern ears, it was probably the best thing that ever happened to me. My symptoms, badly managed in Surrey where the air quality was poor, disappeared in the cool breezy air of Ventnor. Ventnor, the home to the largest

respiratory hospital in Europe at one time, proved my symptoms could be more easily controlled. The die was cast and we moved a year later. What subsequently happened was that when my health improved, so it appears, did my academic achievement. Not once from moving to the Island did I then need hospitalisation for my asthma.

Did 5 years of intense contact with hospital settings for both my and my dad's health conditions lead me to become a nurse? The evidence says otherwise. Look up childhood hospitalisation and career change and little evidence emerges to link the two. (Bryce et al, 2023) Irrespective of the general consensus, events conspired otherwise. At school, post GCSEs I went for a music course but never finished it. The reason was my mother had mental health issues and I wasn't able to leave her without support, so there was no question of me moving off the Island. Secondly, one of the issues with that type of employment on the Island is that music and hospitality industries on the Island are seasonal, and you need a more stable source of income to survive. That, and my previous experience probably explains why, when I left school, that I entered health and social care through the route of a Youth Training Scheme. Ironically, this was the career choice suggested to me when I went for careers advice. I had rejected it then perhaps because I was less self-aware of what would suit me. Little did I know then where that choice would take me.

Starting Points was the name I gave to the first descriptive phase of my life. I elected to include reference to my early personal experiences of healthcare, as I genuinely believe this informed my later career choices. It also highlights my positive experience of moving geographically which coincided with improvements in my health. This is an additional derivation from the narrative, the idea that health or ill health can be influenced by where you are geographically, and decisions that are made around where you live can either help or hinder your overall health state (e.g. Department of Health, 2021; Public Health England, 2021).

The geography of the Isle of Wight at the same time constrains and advantages my narrative. Its constraints are geographical and rural, with the isolation compounding the sense of 'other' in relation to the mainland. Historically the Isle of Wight remains less ethnically diverse than other comparative areas of the UK and has traditionally lagged behind in the adoption of innovation in many areas. However in research its isolation and containment can be exploited to produce and test out hypotheses in the microcosm of the Island, the findings of which can be reasonably extrapolated to the macrocosm of the 'north Island' (the rest of mainland Britain).

I also genuinely believe that early contact with healthcare through illness gives you an empathy towards others that someone who does not have that shared

experience often lacks (Moudatsou *et al.,* 2020; Guidi and Traversa, 2021). Recent developments of roles in NHS organisations that emphasise the 'lived experience' demonstrate the commitment of NHS organisations to integrating this insight into their service development.

2. Arrival

Coming to the Island in the late 80s was interesting for a number of reasons. Many small businesses still prospered at this point and it was easier to gain work in them. The predominant employers on the Island however have been and still are hospitality and the health and social care sector. Hospitality, as I had already noticed, was seasonal, taking advantage of the beautiful location, Victorian history and interest, and the feeling of getting away from it all when you crossed on the ferry. Seasonality meant you work as hard as you can from April to October, and then have a dry five months with a small hiatus for Christmas visitors to the island, or as we called them, the Turkey and Tinsel brigade. Health and social care however are steadier forms of employment and attract people for that reason.

It could be argued that health and social care is such a predominant employer on the Island as a response to the local demographic. Even in the 80s, the Island attracted the retirement population. People year after year would come over for holidays, only to retire when they didn't have to return for their work. (Department of Health, 2021; Public Health England, 2017). Our move to the Island was precipitated and facilitated by my mum's former work colleagues from Surrey. This is a common experience. One of my school friends from Surrey too moved to the Island and so we knew people here. The transition was eased because we knew others. Our family move was almost an analogous experience to enculturating yourself to an ex-pat community in Spain.

It appears also however that there is a transient population here on the IoW. There are extremes of Poverty punctuated by enclaves of affluence, often not only permanent residents but second homes – the 'DFLs' – Down from Londons, who can be observed during the yearly gathering of the yachting fraternity at the world renowned Cowes week, and the summer months, in their droves coming off the ferries to invade the relative quietude of the Island. Over 90% of the Island remains rural, with isolated villages and hamlets hiding pockets of poor health, poorly kept housing, and erratic employment. Health and social care resources are spread wide and thinly, with surprising variation even in such a small geographical area.

Listening to my own language describing these things, I have become enculturated over these 35 years here on the Island. I too was a mainlander, risking being ignored if I didn't fit in. I too was an outsider, fighting to fit in

with the locals. I too experienced the need to be accepted. All of these affect us, affect our ability to function here, and the experience of that process of enculturation geographically and culturally, has its analogies to the ability to enculturate oneself into hospital subcultures. I hadn't really thought of this analogous experience until the exercise of reflecting on my history, but it clearly plays a part.

As I reflect, construct and compose my story, I am becoming aware of the impacts of retelling my story. I note my own language has changed. This is the hand of hindsight at work. Note also I am setting up the themes of enculturation and transitions in this narrative. I purposely wrote this prose to colour in the picture in the mind of the reader, giving them a taste of the environment in which I moved and breathed. This is scene setting for my main research , where I 'reach back in to my autobiographical narrative' to highlight points of learning and scope out potential impacts in the future.

Rural populations differ in many respects from urban ones, the differences being magnified by the geographical isolation of the Island. Urbanised areas attract working populations, but bleed them to the rural idylls on retirement. This attraction of the older retired population against the need for care and hospitality staff creates tension in a population such as the Isle of Wight where need outstrips availability of staff (Public Health England, 2017; Department of Health, 2021).

In contrast to the researcher observing a culture at arms length, the immersion of the researcher in the culture being researched, begs a different reflexive experience. Reflecting upon oneself as the self now reflecting upon the self then, and critiquing one's views then pairs transparency with reflectiveness. Narrative exposition needs to be superimposed with my own criticality to reveal insights that I have derived from these experiences, and how recursive immersion into these recollections reveals more and more of my own views of the subcultures which I immersed myself within (Vryan, 2006).

Offering these insights into my previous experience and work in an Island setting, I hope, underlines how my past work situated on the Island. informs my future work positively. To use understandings derived from the past to inform future hypotheses is in my view intellectually justifiable, provided they are tempered with a willingness to expose them to the crucible of new evidence. This validates these insights, rather than being purely a product of selective memory on my part, unwilling to admit my defects in my approach. To corroborate hypotheses derived from past experience in prospective data collection and research, validates the conclusions that can be drawn. Autobiographical detail is offered in the spirit of transparency to highlight my personal perspective, addressing the criticism that such

methodologies are unbalanced by my own narrative, biases and opinions. Presenting oneself in autoethnographic narrative is treated with perceived inferiority by objectivists, a view I firmly reject. Rather, an appreciation of the intersection of the self with the arena under consideration in an open way, as an 'insider' of the subset of systems practitioners offers the 'Heineken' of ethnographic research, views and research insights that 'other methodologies just cannot reach'.

The theme in this element of the narrative also strongly features transitioning as a means of understanding transit between and immersion in cultures. The reader should feel that they are transported to the Island settings in which I worked through the descriptive analysis presented. Against these elements unique to my working journey, I also trust that the universal experience of transition and change resonates enough with the reader that this requires no explanation, but that the landscape of people, places and events needs unpacking to contextualise and situate this transition in a reality that I observed, experienced and interacted with. Narrative in my analysis assumes a certain amount of universal human experience that requires no explanation. This helps to keep the speed of the narrative and the interest of the reader without descriptive detail that detracts from the points I am trying to draw out from the narrative itself.

3. Transition to Care Work and Nursing

Leaving school, my first career move was into the Youth Training Scheme (YTS) for carers (Department of Employment, 1981), which coincided with my first experience in paid care work. I worked in a care home within walking distance of home in Ryde. Care work on the Island in the early 90s was a popular choice for school leavers. The YTS offered such a road into care work. The care home I started in was typical of the 80s and 90s, buildings which were basically converted houses. These had a homely atmosphere but were nothing like the purpose built environments we have now. The ease with which large houses could be extended or converted to small homes would explain why at its height the Isle of Wight had around 150 of these small homes. This number dwindled as the regulations governing the accommodation standards and the need to adapt home environments for increasingly medically dependent residents made the operation of smaller homes untenable. The demands of the regulations outpaced owners' efforts to maintain viable businesses and many businesses closed. Those that were left expanded and extended their footprint, either assisted by being subsumed by larger mainland chains, or by being brought by individuals with expressly commercial interest seeing profit at the core of the enterprise.

As a male school leaver and young carer, it was no use avoiding the stereotypes. Males entering care work were commonly labelled gay, without any

recourse to finding out about the individuals themselves. This was not helped by care work then being a predominantly female occupation. I was a minority in this group and had to negotiate enculturating myself into this environment. My gender didn't help. Add to that that the whole point of me being there was actually an apprenticeship in care, I had a lot going on. Firstly, having to negotiate a female dominated environment. Secondly having to go from an academic environment to a vocational environment, and thirdly actually being in a workplace where I earned money full time, rather than the Saturday and evening jobs I had had up to that point. I had worked in a care home kitchen around the age of 16, so I was familiar with the environment but not on the care side.

I moved through three different jobs during those early years post school; care home, then nursing home, then back to care home. My first environment was predominantly older persons with few physical or mental health issues, the nursing home had mainly nursing dependent patients and then the third home had mental health issues. It was around this time I started to become more familiar with the work of the community nursing teams coming in to provide wound care, diabetic injections and other community nursing work. I became aware of the interplay and interdependency between care homes and the visiting professionals that relied on the care home teams to implement the care plans they created. These were my first observed examples of the delegation of nursing tasks to unregistered staff, the thin end of a wedge that would affect my professional life and position as a researcher later. I observed two sorts of nurses, those who wished to delegate everything thus upskilling frontline staff, and those who wished to centralise and control everything unwilling to delegate. This tension has increased over the years in my estimation, something that I constantly questioned and has been central to my work with subcultures throughout my career.

Years later I found this early experience inestimably valuable. You are 'stamped' by this process in some intangible way which is communicated invisibly every time you speak to teams in these arena. This awareness informed my approach to care homes and how I approached enlisting them in the projects we undertook. An experienced insider in this game recognises another experienced insider. Experience cannot easily be counterfeited or faked in the presence of experienced colleagues. People try to do this (and I have met many who try to do this) but end up not sounding authentic. The ring of 'actually having been there and done that' shines through when you relate to these teams having been through the wringer of actually working in them. As I look back, my advice to self (and others) is do not underestimate how valuable this experience is even if it feels that little is gained at the time.

During this time I repeatedly applied to enter the nursing profession, and it took three attempts over four years for me to get in. At the time the first two failures were disappointing but in retrospect it was not the right time for me.I reflected on my early applications, and realised they reflected a lack of maturity on my part. There was no magic moment in which I realised this. The transition and development of my thinking only became apparent when I revisited my previous applications in preparing to apply again. Insights borne of experience and exposure were tellingly not present in my earlier applications, but which I was able to put into words in my successful application.

When I eventually got into nursing, the experience of becoming a student nurse added different colours to my life experience. In my case I continued to work in care environments whilst working as a student nurse, as do many others in the same situation. Nursing doesn't always pay enough, so you continue to work at the same time. For me, this tempered an increasingly academic process with a pragmatic temperament about working with real people.

There is a positive appreciation in this narrative that when one's journey does not go as planned, that it is still beneficial or that helpful insights can still be derived from situations which at the time are perceived negatively. Failing to achieve milestones, such as getting a job interview or getting onto a nursing programme, feel wrong at the time but the insights and improvements one makes as a result of these negative experiences justifies the pain one experiences at the time. Additionally providing examples of where the outcome is unexpected or not in accordance with the intentions of the researcher underlines a commitment to honesty, transparency, and authenticity, with the intention of increasing the reader's trust in the candour of the researcher, who is prepared to bare their soul in the pursuit of truths unearthed from their personal narrative (Gerard, 1996; Mockler, 2011).

I also reflect upon this narrative that I like the term 'ticket collector' that I came upon in my professional career, the idea that one 'collects tickets' (certificates) as one goes through certain experiences to trade them in later, to reach a higher level of professional or personal development. This certainly fits in with the worldview that no insight is wasted provided it is employed in one's own betterment later on.

4. Professional Initiation

There is no other way in my mind to describe entering nursing but the initiation into a professional club, a process of enculturation where one assumes the mantle, and language, and technical paraphernalia of the discipline to which you become devoted. My entry into nursing was on the mental health route, not my first choice, but serendipity was at work. Assumption into this discipline felt like contracting a fungus, a slow rising line of 'mental health

nursingness'. Sadly I fought much of it. I didn't realise why at the time I felt so out of place and like the greater fool for questioning basic notions of mental health nursing, such as 'to what archetype does one compare a person's mental health?' or 'if health is relative, who is to define this as healthy and that as unhealthy?' My critique of mental health then reflected my absolutism, and resistance to relativism, in contrast to the process of consensus mental health nursing trusted to inform its views of health and healing, a process I felt was driven by subjectivism Subjectivism, with its lack of commitment to the safe harbour of an anchoring absolute, stalked me and made me feel uncomfortable in the profession I had come in to.

I didn't find a resting place in acute mental health work, and ended up working with people with dementia, at the cross over between mental health and what can be measured objectively with the use of CT scans and mini mental state examinations. It is true to say that my experience of working with people with dementia was fundamental in shaping my view of persons as being persons, not objects, and it shaped my subsequent view of how we should relate to persons. Four years in, and having slogged through a Bachelor of Nursing degree, I pivoted to stroke research, capitalising on my degree with its strong leaning towards research evidence, and started at the hospital, my introduction to the wards.

Stroke research nursing, even before I started Tissue Viability, gave me one key insight that I have held onto ever since. My role followed the entire pathway of a stroke from admission to discharge or sometimes passing away. I observed the interplay between teams, professionals, and patients with their family circles, all in the service of a single pathway. This imprinted upon me the need to enlist all of these subgroups (read subcultures!) in the pursuit of a single goal, and an appreciation of how they need to be coordinated and led for the pathway to work. This insight I drew into my later work in Tissue Viability too.

Moving into Tissue Viability was an obvious transition for me given my previous experience. Older people with dementia and stroke patients often experience leg ulcers from wandering pressure ulcers when they are immobile, and skin tears from their agitation, aggression and from falling, So when the role came up, I was interested in taking my interest in wounds and wound management further. My interview for a post in Tissue Viability was, from my perspective at least, one of those times where you figure you have nothing to lose. I was a complete outsider, as 'mental health nurses don't apply for these positions, don'tchya know??' I also was not attached in some respects to the outcome, I simply was interested in the role and what I could do with it. My three interviewers, a Deputy Director of Nursing, an Education Lead, and a

previous Tissue Viability nurse, laughed from beginning to end, not something that reassured me at the time, but the outcome said otherwise.

There was one memorable phrase in my job winning presentation I still carry with me, and only with my delving into autoethnography did I appreciate its significance. I spoke about the wound as a story. The person, and the wound on them, are a story we must discover. This narrative united my presentation, but more accurately, it unified how I saw the world. It was the scaffolding around which all of my subsequent approaches were based, as the story, with its heroes and villains, the events that lead up to the wound, and the touchpoints of victory and defeat in healing the wound, all played out. The heroic endeavour of sometimes healing the wound, sometimes not, inspired my presentation, as it does even now. It also frames my reference to people. Talk to the people first and the story comes out, an important emphasis when it comes to later consideration of my retrospective analysis.

To say that my appointment caused waves is an understatement. 'Mental health nurses don't become Tissue Viability nurses!' Some wards would not even engage with me because of my professional background. This posed a problem for me to get anything done. How would I win them over? How would I engage with them productively? How would I ever achieve anything when it was me against them? Those questions dogged my early years, and I look back at them now with a degree of humour, not something I experienced when I was in the thick of it. How I resolved those issues, and transcended them in some respects sets the scene for my current research and into experiences in a health care system from an islanders perspective.

The narrative is interposed with quotations selectively presented to summarise the story of others, phrases that become memes or posters that one passes in the journey, presented to offer to the reader a taste of what I experienced in these situations. I also propose in the narrative the questions that I posed to myself and which required resolution to move forward. My underlying attitude and feelings, now with a reflective sense of humour, against the underlying angst and anxiety at the time, are compared to offer an insight into my development and relationship to the memory of these events, hopefully again demonstrating a maturity of insight that is afforded by distance from the events themselves and reflection upon them.

Conclusion

The unfolding narrative of my early career is offered to inform the reader and guide them through experiences to which I was exposed which informed my worldview, and to flesh out the landscape in which my subsequent retrospective analysis and prospective research is situated. I deliberately elected to adopt a story

telling voice in laying out my positionality, as this, I felt, made it more understandable, dare I say it palatable, to a reader. The reconstruction of these events I appreciate is as much based on my memory as it is on the significance which I ascribe to these personal, temporal and geographical touchpoints. Their exposition is coloured by my view of them. I acknowledge this, but without apologies, as to apologise, to feel abashed as it were, for my view suggests that I think my view of the world is somehow inferior. This is not the point. Quite the opposite in fact as I seek to demonstrate that storytelling is in some sense the most important method for making sense of these events and how they inform my future work.

I intend the theme of storytelling to permeate my description of enculturation, as I propose that this seems to be the method with which one enculturates oneself, by weaving oneself into the storytelling of the culture into which one wishes to enter, sit down and coexist with (Frank, 1995; 2000). An appreciation of this seems to be a novel view of the problem of navigating and coordinating subcultures in the pursuit of cross-cultural goal alignment. Being able to provide an original viewpoint on this issue, and also suggest means with which others facing the same challenges might adopt to achieve cross cultural goals, would seem to me to validate the employment of this pedagogical method.

Avoiding meandering narrative and remaining focussed is a constant challenge. It is rarely, if brilliantly, employed to good effect on occasion (e.g. *The Mezzanine* by Nicholson-Baker, 1988). Stories must have a structure, a beginning, middle, end and moral to the story. The moral, if one would call it that, of the story I present is the adoption of storytelling itself, the exchange of and incorporation into the stories of subcultures, can be utilised effectively to weave them together into a new narrative, unifying individual stories in the achievement of a higher cross-cultural purpose.

Stories, the currency which we exchange in forming and reforming our own and others narratives (McAdams, 1993) may grow in the telling, but this growth is nothing to fear in my opinion. In fact this growth should be celebrated, as I propose this signifies their value increases over time. Expounding them over and over reinforces their significance in defining subcultures, a process that can be influenced positively to the benefit of all involved. The practice of exposition both verbally and in writing adds to the development of this skillset, something that makes autoethnographic analysis both essential and valuable (Gerard, 1996).

Personalisation of care in healthcare relies on the ability to recognise and build upon the stories patients carry with them all the time. Positive appreciation of these stories leads to the ability to incorporate oneself into them in a way that is both therapeutic and affirming. This process is also two way as an informed, alert,

reflective practitioner takes as much from these stories as they give to the person to whom they have a duty of care. One need not fear the story telling – one must wield this secret weapon with pride and hone its edge daily.

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Reviewer Comments

Reviewer: Glenn bravely embarks on a disconcerting but necessary journey where we, the readers, are invited to share in the richness of his experience. His message is clear, 'It's all about people' and without knowing ourselves and why we do what we do, how are we to relate to others? He powerfully reflects on his early experiences; his asthma and struggles at school, his father's short battle with lung cancer and his mother's mental health issues which led him, unknowingly at the time, into a life of care work. In doing so, he provides ample support for autoethnographic methods, against the naysayers who cling to absolutism and objectivity as he courageously strives to validate relativism and subjectivity in health care research.

Not only does Glenn enculturate us in the Island, curious about the pockets of poor health and poor housing and sceptical of the 'Down from Londons' and the 'Tinsel and Turkey Brigade', he also neatly plots his journey and crucially, shares what it means to be human. At some time or other we all experience being an 'outsider', having to consistently enculturate ourselves. At times like these it is essential we feel vindicated, and we should not be expected to remain neutral and bias-free. We too can begin to understand the value of our experience, however anxious we may feel at the time, reflection is to be valued and we may look back with humour rather than angst, as Glenn does, for it is these experiences that shape us and the way that we interact and interplay with others. Hopefully, for many, this account can be the Starting Point, Arrival, Transition or maybe even Initiation for the recognition of person-centred care and the value of storytelling in healthcare research.

Author Response:

Strange bedfollows - juxtaposing absolutism and subjectivism in autoethnographical research

In Smith *et al.,* (2023), I set out my positionality as a researcher through storytelling and narrative. This was interpreted by my reviewer as setting out a subjectivist and relativist mindset. This worried me as I would never define myself as that, and I admit that this might be a personal discomfort. However on the basis that I must admit to myself that this reaction may not be just something I experience, but that it is something that would resonate with other qualitative researchers, I want to unpack my discomfort a bit, in an effort to mine the autoethnographic gold at the bottom of this particular seam of self-narrative and reflection.

I struggle with the word subjective because it has associations with the idea that a view that is put forward that is described as subjective is somehow of lesser value. One never hears the term "merely objective". The term "merely subjective" can be used pejoratively and colloquially to invalidate the personal viewpoint, as if somehow the fact that a particular experience is only experienced or lived by a few or even one, that this automatically disqualifies that experience as being of value. This seems, to me at least, to be an imbalance.

The subject, as the person who experiences, the indivisible unit of observation and experience that generates the story and narrative, is to me valuable. In fact, I will go further. I suggest that the person is of supreme value in my interpretation, because whilst I admit to subjectivism where it aligns with the goal of recognising the person as a person, I do not subscribe to the automatic assertion that commonly comes alongside this that this infers that I am also a relativist. And that is an awkward juxtaposition. Because to admit that a person is of supreme value commits me to the premise that there is such a thing as an "absolute person". This on the one hand sets out an absolute standard, but on the other links it with personhood, not objectivity, and that is a weird mindset to many academics.

Reductionism, at its roots, reduces phenomena to objects or pieces, the lowest common denominator that can be experienced by everyone. Hence the test of objectivity being the idea that one can experience something independent of time place and person. Relativism asserts no absolute foundation but that all is relative and can be interpreted and that no one interpretation has more validity or value than another. On the one hand this guards against the dismissiveness that can so easily creep in, dismissing the minority view as of no value. But at another level, if all is valuable, none is valuable as there is no absolute comparator upon which to judge. The yardstick that elevates all voices to be listened to simultaneously disavows their value, because to judge value implies a hierarchy with which to judge, and point to one voice over another as being more or less valuable. The Achilles heal of Relativism is that as a viable concept, it has by definition to be relative to itself, which is an absurdity.

The magic trick, if one can call it that, is to simultaneously value the person as an individual, but with supreme value. Whence however, does that value derive from? The answer perhaps can be made in reverse. If one rejects reductionism, as I do, then the opposite in my perspective is to assert a holistic perspective that integrates, and that in my view is the person, who integrates the times, places, and persons, and their significance into the golden thread of narrative. If one rejects relativism, then one must assert an absolute value system. The nexus of these two is the absolute person. And it is this quantum, this idea of the person and their output

of stories and narratives that define the value of their existence that seems to me to be the most valuable reason for adopting an autoethnographic approach.

But wait. In the minds of some, this echoes of religion and spirituality. Hadn't we done away with this psychological paraphernalia in the modern world? Well perhaps not. Perhaps that which exited quietly like a true gentleman through the back door when reductionism and relativism took hold, has come back in the front door in the form of autoethnography. And that will disturb some, indeed it may turn the world on its head.

Because to assert this cuts to the root of a particular epistemological issue, which is the value of research against the hierarchy of evidence. The fact that it is even constructed as a hierarchy implies a judgement of value. That which is at the top, the systematic review and meta-analysis of randomised controlled trials, is deemed top notch, and the single case narrated by a sole observer is at the bottom. Yet to assert the value of the individual voice must necessarily involve ascribing value to that which is de-valued in the hierarchy of evidence. Evidence, as the output of observation, derives its value in this hierarchy from the ability of every observer to observe the same thing in the same way. Uniformity and conformity is rewarded. However this is not what a person experiences in real life. The cause effect relationship investigated by a randomised controlled trial is observed in an environment sanitised of complexity and idiosyncrasy, all of which are necessary corollaries of personality and personal stories. Similarities between stories breed resonance, disparities breed counterpoints. The bleaching effect of purging all from a population through exclusion criteria divorces that which is investigated from real life.

That will sound unnecessarily harsh to some, but frameworks wittingly or unwittingly influence people's thinking, and to think of the individual story as being devalued because of the hierarchy of evidence will inevitably, in my view, lead to the devaluing of the person behind that story too. Does someone have the moral courage to call this out? To start a social movement that brands such behaviour as 'merely objective'? Sadly I doubt it. And its effects can be reasonably predicted to be deleterious.

Autoethnography with its appreciation of the quanta of individual stories in my estimation rails against such interpretations, raising as it does the mind of the researcher above objective effects to the one effecting the effects. Agency, as John Lennox puts it, is more important, or just as important, as Mechanism, and Agency can only be investigated and made sense of when one understands the agent, not the mechanism. Autoethnography sneaks inside this barricade to unearth the person behind their output.