



THE FAKE PATIENT: A RESEARCH EXPERIMENT IN A GHANAIAN HOSPITAL

SJAAK VAN DER GEEST^{1*} and SAMUEL SARKODIE²

¹Anthropological–Sociological Center, University of Amsterdam, Oudezijds Achterburgwal 185, 1012 DK Amsterdam, The Netherlands and ²Department of Sociology, University of Ghana, Legon, Ghana

Abstract—The authors report on a research experiment involving the admission of one of them as a pseudo-patient in a rural Ghanaian hospital. The experiment was meant to assess the feasibility of carrying out unobtrusive participant observation in a hospital setting. Practical, methodological and ethical implications are discussed. © 1998 Elsevier Science Ltd. All rights reserved

Key words—anthropology, research methodology, participant observation, unobtrusive observation, hospital, Ghana

INTRODUCTION

The term “participant observation” is often used rather frivolously by anthropologists. They claim it as the hallmark of their profession, even if their research entailed little more than having been there and having seen the place.

The prime reason for regarding participant observation as the distinct approach in anthropological research is of course that it produces insight. Sharing experiences is the beginning of understanding. That thought is tersely put in Solzhenitsyn’s (1968) first novel about a man in a Siberian prison camp: “How can you expect a man who is warm to understand a man who is cold?”. The church father Hieronymus said the same thing when he remarked that it was “easy” for someone with a full stomach to discuss the advantages of fasting (*Plenus venter facile de ieiuniis disputat*. Epist. 58,2). Krumeich (1994), who did research among women with young children in Dominica, was able to move much closer to them when she became pregnant herself and had a child. Rätch (1992, p. 29) is of the opinion that students of drug use should themselves use drugs. Others have expressed similar ideas about topics as different as being disabled, having AIDS, being old, and losing a partner.

To the defense of those anthropologists who don’t live up to these expectations, it should be said that participant observation is not an easy thing to do, or, to be more precise, it is impossible. Participant observation is a dream, an ideal, and a *contradictio in terminis*. Favret-Saada (1990) and Ellen (1984) call it an oxymoron. True participation precludes the type of observation which is required of an anthropologist.

Apart from the schizophrenic demands of participant observation, participation alone is hard enough. Stanley Diamond (1974), a fervent advocate of equity in anthropological fieldwork, admitted that during his research in Nigeria, he was not able to participate as he had wanted: “In a year’s time I could not learn to live and work as an Anaguta and anything short of that would have been a waste of my energy and an outrage on their privacy”. We should forgive him the rationalization at the end; most of his colleagues did not even have the courage to admit their failures in participant observation.

A Dutch writer with anthropological training wrote the novel *Allemaal projectie* (All projection) (Zwier, 1980) about an anthropologist who is sent to do research among Berbers in Morocco. He is terrified to go and tries to fake the research while hiding in his home in The Netherlands. When that fails, he settles in a hotel in Marrakech and employs an assistant to do the work for him. He hardly leaves the hotel. Later on he discovers that much of the “excellent data” has been made up by the assistant. The autobiographical calibre of the story is not known, but it can be taken as a — malicious — parable about the anthropologist’s fear of participation. Barley (1986) ironic tale of his fieldwork in Cameroon may be a more true-to-the-facts report of the hardships of participation.

There are situations where participation in the ordinary sense of the term is not possible because the people concerned do not allow “intruders”. Examples may be drug users, criminals, religious believers, political activists, prostitutes, employers, salesmen and medical doctors. In such cases the field-worker may opt for “unobtrusive” or “covered” or “secret participation” or as Schatzman

*Author for correspondence.

and Strauss (1973) call it, "participation with hidden identity"; those who are being studied are not aware of the field-worker's presence because the latter pretends he is one of them. The Dutch islamologist Snouck Hurgronje (1875–1936) spent six months in Mecca, disguised as a pilgrim and wrote his dissertation on the basis of his observations there. Leonard (1990) posed as a street prostitute in order to interview clients of prostitutes. A renowned case in Dutch anthropology is the hidden participation of some researchers in the meetings of a religious sect (Bayer and Köbben, 1959). Among journalists it has become a well established practice to infiltrate the group they want to write about. One of the best known is the German journalist Wallraff (1985), who described the situation of Turkish workers in German factories by posing as a "guest laborer". Wallraff put on a black wig and used dark contact lenses. Even the people who knew him did not recognize him in this disguise.

Another reason to carry out hidden participation may be that the researcher expects that his presence would influence the answers or behavior of the informants. Research into racist behavior, for example, will only succeed if the informants are unaware of the fact that they are being studied (Bovenkerk, 1977). The same applies to research about the sales activities of people working in pharmacies (Tomson and Sterky, 1986; Wolffers, 1987; Igun, 1994). Researchers posed as customers and were thus able to observe the ordinary practices taking place in the pharmacy.

Classic examples of such secret participant observation are the study by Sullivan *et al.* (1952) on the training of soldiers in the USA army and by Caudill (1958) of a mental hospital. Bulmer (1982), who discusses these two cases also cites Bettelheim's stay as a prisoner in a German concentration camp in 1938/1939. Bettelheim (1943) made a "virtue out of necessity" and observed the behavior of guards and fellow inmates without telling them. Like Wallraff, the researcher who infiltrated the American army took drastic measures to disguise his identity. He underwent minor plastic surgery and got rid of more than 15 kg to look seven years younger (Sullivan *et al.*, 1952).

Both reasons for doing covert research may also apply to the anthropologist who intends to study life in a hospital ward. In the first place he may find it difficult to get permission to visit the ward. Doctors and nurses are often reluctant to allow non-medical observers to their work. Their motive can be to protect the patients' privacy in accordance with the Hippocratic oath they have taken. Another, not always revealed motive can be that they dislike being watched by outsiders who will later put their observations on paper (cf. Van Staa, 1993). In fact, anthropological research by outsiders in hospitals is not common. Most medical anthropology is practiced outside biomedical institutions,

in people's houses, in public places and among non-biomedical healers.

Several cases are known of research which did take place in a biomedical setting and resulted in a conflict when the data were published. A notorious case in The Netherlands was a book about life in a cancer hospital which was banned and destroyed by order of the court. The hospital authorities had requested its destruction because they felt misrepresented in the study (Van der Geest, 1989). Another conflict about the publication of research results from a hospital occurred in Denmark (Hansen, 1991). Unknown is the number of researchers who were denied entrance to a medical institution or gave up because of the numerous barriers.

There are, of course, also examples which ended well. Fox (1959) studied terminal patients who were subjected to medical experiments in an American hospital. The book (her dissertation) was reprinted in 1974 and 1998. Fox was allowed in as a participant observer and so were Cole (1962), Goffman (1968), and Roth (1963), all of whom did fieldwork in a medical institution in "the West". But there are more recent examples. Nichter (1986) wrote an intriguing article about hierarchical conflicts among the staff in an Indian Primary Health Care center. Kirkpatrick (1980) did research in the ward of an Indian hospital and described the important role of relatives and friends there. Sciortino (1992) published research on nurses in a rural health center on the Indonesian island of Java. Two studies of medical work in American neonatology units were carried out with the approval of the authorities (Frohock, 1986; Guillemin and Holmstrom, 1986) and the same applies to two anthropological studies of euthanasia in Dutch hospitals (Pool, 1996; The, 1997).

The second reason for doing covert research in a medical setting is to improve its reliability and validity. Caudill (1958), who was allowed to conduct research in a psychiatric hospital, would not have been able to collect the type of data which he did collect if the staff who treated him had known his true identity (Caudill *et al.*, 1952). During the two months he spent as a psychiatric patient only two senior staff members were aware of his double role. In another research study, Rosenhan (1973) wanted to find out how "insanity" was established. He and seven colleagues were admitted as psychiatric patients to twelve different hospitals. As soon as they entered the ward, they behaved normally, but their "sanity" was never discovered by the staff. In the context of psychiatric care in the ward, normal behavior continued to be declared "insane". It is obvious that this research experiment would not have been possible if their identity as researchers had been known.

Semi-concealment was applied by a British student who was also a tutor in a nursing school. He spent three weeks in a unit for drug abusers, pre-

tending he was updating his clinical skills. In reality he was collecting material for his thesis. The staff knew he was a visitor and observer, but in another sense than he actually was. Some were apprehensive about his presence and asked whether he was going to write a report which he — with a lie — denied in order to make them “more forthcoming”. A similar strategy was adopted by Greenhalgh (1987), who attended doctors’ consults in India. The doctors saw her as a medical student (which she was) learning professional skills, while she was actually observing their prescribing habits.

Anthropologists doing research in a hospital or clinic find themselves out of place. Not being a doctor, nurse or other type of health worker and not being a patient either makes their position somewhat awkward. It limits their room for anthropological research. Their role could perhaps be likened to that of visitors, but visitors usually spend just a few hours in the ward and see only a fraction of what takes place. For the anthropologist who wants to grasp a fuller understanding of hospital life, a continuous stay in the ward, as a patient for example, would be preferable. After all, the presence of the researcher should be inconspicuous in order not to disturb the daily routine of activities and conversations.

A PERSONAL EXPERIENCE

A few years ago, the first author was admitted to a Ghanaian public hospital because of cholera. It was an instructive experience. Four aspects struck him in particular. The first was the continuous visits of praying people. The ward was not merely a place for practicing medicine, it was also a “place of worship”. Physical illness was not — as in most Western hospitals — divorced from its religious meaning. Bodily and spiritual problems were treated together as it were.

The second — somewhat startling — observation was the poor hygiene found in the hospital. The toilet was reached through a door leading to an area which could in every respect be called a “backstage” in Goffman’s sense of the term. The place was filthy. The floor was flooded, the drain did not work properly and used toilet paper was disposed of in an open bucket where flies had easy access to it. The contrast between ward and toilet, front and backstage, was indeed enormous. The ward was relatively clean and the same applied to the people in it, doctors, nurses, visitors and patients. On Sunday the doctor on duty even wore a festive traditional *kente* cloth. The striking aspect was of course that this lack of hygiene occurred in a place which is supposed to function on the principle of strict hygiene. Those in charge of the ward — and of the hospital in general — must have found ways to accommodate these contradicting phenomena. Most likely, they never entered the backstage and

managed to reduce their “cognitive dissonance” between biomedical theory and hospital reality by ignoring the latter.

The third observation was the importance of cash money while being a patient. Most materials needed for treatment had to be paid for promptly. The purse had to be within arm’s reach continuously. When the materials were not available in the hospital, one had to go and buy them outside. A relative attending the patient was therefore indispensable, which was the fourth observation.

Pondering over his impressions, Van der Geest realized again the importance of being a patient in order to understand what takes place in a hospital ward. For many patients, their stay in a hospital is an entirely new experience. Little is known about how they cope with this new environment and its strange rules, customs and objects. The few studies which have been carried out on Ghanaian hospitals (e.g. Tijssen, 1978; Osei, 1994) provide hardly any insights into the patient’s experience. Such insights are however indispensable for improving care and cure conditions in the hospital.

In addition, there is a general idea in Ghana that many hospitals, particularly those under government administration, don’t function well. Basic facilities are said to be missing and — partly as a consequence — doctors, nurses and other personnel are poorly motivated. Newspaper articles and letters to the editor lamenting the hospitals are common. The following pathetic lines were written in *The Mirror* of 14 May 1994 by a concerned reader:

Sir, the wailing, mourning and gnashing of teeth in our hospitals are increasing by leaps and bounds. Children are crying for attention, women in labor are groaning, relatives of sick people are desperate while dealers in coffins are having a field day.

We began to plan the experiment which is discussed in this paper.

THE RESEARCH EXPERIMENT

During his fieldwork in a rural community in Ghana, Van der Geest contacted the second author, Sarkodie, who was an M.A. sociology student at the University of Ghana. They discussed the possibility of Sarkodie spending a few days in a nearby hospital as a would-be patient to see whether it was possible to study the daily proceedings in the ward from within. Several methodological and ethical problems presented themselves, but it seemed that the best way to solve them was just to try. They selected the nearest hospital and Van der Geest wrote a letter from which the following quotation is taken:

“I am supervising a young Ghanaian sociologist from Legon who is training to become a medical sociologist.... I want him to do a brief pilot research in a hospital, to study how patients in the ward react to the treatment they are given, how they

adapt to the different lifestyle which exists in the hospital (e.g. eating, sleeping, toilet, rules), how they understand the instructions of doctors and nurses, et cetera.

I wonder if you would allow him to do this brief pilot study in your hospital. The manner in which he will do the research is a bit unusual, perhaps. I would like him to be "admitted" in one of your wards for the period of about three days. Being himself a "patient" he will be in the best position to observe and understand what the patients are doing and experiencing. The falseness of his illness should be revealed to the medical staff, but not to the patients".

Van der Geest delivered the letter personally to the hospital secretary who immediately took a great interest in the idea. He gave the impression of regarding the request as an honor to the hospital and promised to put the question before the other staff during their weekly meeting. When he returned a few days later, Van der Geest received a positive reply. The secretary suggested that the student be admitted to the general male ward and be subjected to all procedures which precede admittance. The staff seemed to enjoy playing the game with us. It was decided that the diagnosis would be malaria. Two days later, Sarkodie went to the hospital and passed through all the procedures without any problem:

"I was asked to go through the usual admission procedures which include going to the records department for my personal data to be taken. I then moved to the history room where the nurse in charge examined me, took my temperature, blood pressure, weight and my health condition of the past four days.

I was sent to a doctor's room where the doctor prepared a report on me for admission. On my arrival at the male ward, I was received by the nurse in charge who introduced me to the other nurses of the ward and I was given a well laid bed".

Since his identity was known to the nurses, Sarkodie probably got special treatment. Upon arrival, the nurse took him around the ward to show him all the facilities, including the lavatory. In the evening, another nurse took over. She had not been informed about Sarkodie's status and got ready to give him the prescribed medicines against malaria. He then had to explain the situation without the other patients hearing it. She complied immediately and withdrew the medicines.

SANITARY CONDITIONS

Sarkodie wrote an extensive report for the hospital. We quote a few paragraphs of his remarks on the sanitary condition:

"The ward has a sluice which has one water closet and an open bathroom which also serves as the urinal. All the patients in the ward use these facilities. The treatment room is meant for dressing wounds. The sterilization room has been abandoned because the main sterilizer in the room has not functioned for about five years. However, the ward has a portable sterilizer sitting on the cabinet at the nurses' office which is used to sterilize forceps, pans, needles, etc. Nurses were using this portable sterilizer also to boil water for patients' baths and to make coffee or tea for them*. The nurses told me that all the needles and syringes are disposable and used only once. Every patient is required to buy the syringes and needles needed for treatment.

At the time of the research, the sewage system in the male ward had broken down. The toilets which are water closets had not been functioning for some months. Formerly, the patients were using the only water closet available in the ward, but one patient used a corn cob which clogged the closet. Patients now had to walk about 200 m to reach a toilet. Patients who cannot walk this distance are provided with a bedpan in a room at the sluice. The bedpan is later emptied into the toilet by their relatives or the ward orderly.

The toilet now used by the patients is a bucket latrine which is actually emptied by the conservancy laborer when it becomes full. There are three holes, that is, three bucket latrines for the entire male ward (23 beds).

In the ward, patients are stratified. Some are put in the main ward and others on the porch. Those who are put in the porch have infectious diseases such as hepatitis, HIV, etc. However, this arrangement in the ward is not reflected in the lavatory. All patients use the same toilet.

According to the nurses, most of the patients prefer using the bucket latrine to the water closet, because they also use the bucket latrine in their houses. Many patients find it therefore difficult to use the water closet. The patients often soil the place with faeces and urine and the ward orderlies always fight with them because they make their work difficult.

The ward has three porters who have been assigned to sweep, wash and scrub the ward. These porters run shifts in such a way that, every morning and afternoon, there is a porter on duty in the ward".

Relatives

Relatives have become an integral part of hospital life due to certain developments that have evolved over the years in Ghanaian hospitals (Cf.

*Cf. The Goffman (1968, p. 187) remark: "In every social establishment participants use available artifacts in a manner and for an end not officially intended, thereby modifying the conditions of life programmed for these individuals".

Osei, 1994). The most salient ones are the non-feeding of patients by the hospital, the non-availability of certain drugs in the hospital dispensary and the cash and carry system. Patients who cannot pay their bills after they have been discharged, have to inform relatives who are with them to go and bring money from the house while the patients are detained in the hospital.

A patient was admitted on one of the days of the research and a relative who came with him, was sent by a nurse to go to town and buy a medicine from a pharmacy shop which was not available in the hospital.

Nurses in the ward always tell patients' relatives to come and stay in the hospital to look after the patient. Because the hospital does not provide food, it is the relatives who are supposed to feed the patient. Relatives of other patients sometimes help patients without relatives. Able patients' relatives looking after them in the ward are not allowed to sleep there. Instead, they sleep outside the ward on benches and mats on the floor. But patients who cannot do anything by themselves are allowed to have their relatives sleep beside them in the ward.

One male nurse claimed that if relatives who are not sick are allowed to sleep in the ward, they would also fall sick by the time their relatives were discharged from the ward.

The following observation by Sarkodie illustrates the multiplicity of roles which relatives may play:

A relative of one of the patients was helping other patients whose relatives were not around. She massaged one patient, washed the towels of other patients and bought food for some of them.

Nurses

Sarkodie's double identity, a patient in the eyes of his fellow patients and a sociology student in the eyes of the staff, allowed him to conduct formal interviews with nurses and staff members and to carry on unobtrusive observations and conversations with the other patients. He had interviews with several nurses about their work.

There exists a general feeling in Ghana that nurses in hospitals are often unfriendly and rude, but this did not apply to the nurses of this ward. Sarkodie saw nurses buying food for patients whose relatives were not available. Sometimes the nurses even spent their own money to buy food or drugs for a patient. One nurse brought bread to the hospital to sell to patients and their relatives whenever she came on duty.

The nurses themselves explained their cordial relationship with patients by referring to the missionary origin of the hospital. The first nurses had been trained to be considerate and friendly to patients. Nurses who joined later inherited that attitude. In addition, the hospital has in-service training and its first objective is to equip the nurses to offer quality care to the patients. An observation:

A patient who had undergone scrotal surgery soiled his bedsheet. A liquid oozed from the sore onto the bed. The nurse dressed the wound and changed the bedsheet.

The presence of an AIDS patient, however, caused concern and fear, especially among the nurses:

"An HIV-infected man was admitted and put in the porch. The nurses told the mother of the patient to stay with the man because nobody could look after him. HIV patients do not pay an admission fee. I learnt that this patient's wife had died recently from HIV. According to the nurses the man had already been admitted on three previous occasions and had left the hospital in search of herbal treatment. His condition had not improved so he was brought back to the hospital for the fourth time.

The mother of the HIV patient became angry when the nurses directed her to go and throw the urine of her son in the toilet about 200 m away from the ward. The mother later asked for a cup to be used by her son to drink water, but the nurses told her to go out and bring a cup from the house. The HIV patient has wounds which need to be dressed. The nurses claim that they have only one forceps and other equipment which are being used to dress the wounds of other patients so they cannot treat his wounds".

Finances

Sarkodie visited the hospital secretary in his office and interviewed him about finances. The secretary explained that it is the hospital's policy that on admission patients are supposed to pay a minimum deposit of 5000 cedis (about US\$ 5) and patients booked for surgery pay a minimum of 30,000 cedis. The idea of paying a deposit before admission is relatively new. It was started when the cash and carry system was introduced in state-owned hospitals. Under normal circumstances, according to the secretary, patients are not supposed to pay a deposit before they are admitted. But past experience has shown that some of the patients bolt away and others pretend they don't have money after they have been discharged. If the sickness is severe, some of the patients are not asked to pay the deposit. The hospital may declare some patients as paupers, but the definition of pauper has become controversial even within the Ministry of Health*. The hospital has therefore employed a Social Welfare Officer, who, as an expert, interviews patients and advises the management as to whether

*Ten Asbroek (1992) found a huge gap between "rule" and "reality" in another Ghanaian hospital. Poor people in the Ho hospital were hardly ever (in 1992 three out of 5192 patients) exempted from paying, in spite of the ministerial directive. Patients were not even aware of the possibility of exemption. Similar problems are reported by Booth *et al.* (1994) in Zambia.

such patients should be allowed to go free or not. In other instances, some of the patients give the assurance that they are getting in touch with their relatives and so they are asked to stay in the ward, waiting for their relatives to come and pay the bills.

According to the secretary, the legislative instrument which gives the hospital the authority to collect fees, gives discretion to attending medical officers to waive fees. Depending on their recommendation, patients are able to go without paying the fees.

The patients

The most valuable aspect of the research experiment was the observation of patients in the ward. Many small events and conversations could be recorded which together convey a realistic picture of everyday life in the ward. One common aspect is patients' help for one another when one of them lacks financial means or assistance by relatives.

"When I arrived at the ward, a patient with a strangulated hernia who had undergone surgery, asked me if I was selling drugs. I asked him what drugs he wanted and he said he wanted sleeping tablets. He wanted to use them without the knowledge of the nurses on duty. After some time, the same patient came to ask me if I had some soup. I should give him some to drink. This patient has spent nine days in the ward. He came to the hospital with his brother and the brother has been taking care of him since he was admitted. The brother left for their hometown about fifty kilometers away, because the money they brought to the hospital was gone. The brother had gone to bring additional cash.

When I asked the patient whether he still had money at home, he said he had brought all he had to the hospital. There was no money left in the house. The brother was now going to find some loan for him. He said since his brother left the hospital, the nurses and other patients' relatives had been caring for him. They had bought food for him, dressed his bed, and fetched and heated water for his bath".

Many interactions between patients regard the purchase and use of medicines:

"I saw a relative applying eye drops to the eyes of one of the patients. I went to inquire from the relative whether the drops had been given to her by the nurses and she told me that the patient's eyes were causing problems before he came to the hospital, so the patient was already using the drops in the house. She, the relative, had brought the drops to the patient when she came from her home. The relative later on asked me if it is not good to use the drops and I told her that she should ask the nurse.

A patient had a visitor/relative and the relative went to buy a drug which was injected into the patient to relieve him of pain. The relative boiled

water to make tea for the patient and then used some ointment to massage his neck. I asked the relative if she was using the ointment with the permission of the nurses. She told me that the patient had been complaining about pains in the neck and when she asked the nurses the previous day for an ointment to massage the patient, the nurses told her the hospital had no ointment and so she had gone to town to buy some".

Religion too occupies the minds of patients and their relatives. At six o'clock in the morning, Sarkodie noted:

A preacher came to visit us. He stood in the middle of the ward and started to preach the gospel to the patients. He spoke very loudly, as they normally do in the street. He exhorted the patients that their sickness is not beyond God's power. Whatever we shall ask God, He will do it for us. The preacher spent about fifteen minutes preaching. He said he comes to the ward every Friday. He is a member of the Baptist Church.

This amalgam of observations records both medical activities and transactions — often informal ones — which have a broader social significance. These informal activities made life in the ward more bearable and had become somewhat routine. Examples are the sale of bread by a nurse, the use of the sterilizer for bath water, coffee and tea, the visit of a lottery ticket seller, the selling of candies and the sermon of a preacher. A longer stay at the ward would have enabled the researcher to record more such activities and to write an ethnography of the ward in the same vein as anthropologists describe life in a village community. However, the purpose of this research note is not to describe the ward as a social and cultural phenomenon but to assess a research strategy.

DISCUSSION

There are mainly two issues which we want to discuss with regard to this research experiment and to the use of a disguised researcher or "confederate" in particular: the approval by the hospital and the methodological pros and cons of hidden participant observation. A third issue, the ethical aspects, is only briefly touched upon.

The easy entrance into the hospital surprised us most. We were prepared for a long discussion with the hospital authorities and an eventual refusal. That expectation was mainly based on experiences with hospital research in the home country of the first author and in other "Western" countries. The reluctance of medical institutions to allow social scientists on their grounds has already been mentioned in the introduction. How should we interpret the quick permission in the case of this Ghanaian rural hospital?

It appears that the staff of this hospital was little concerned about the privacy of the patients and did not see any harm in allowing a non-medical

researcher to observe proceedings in the ward. "Informed consent" was never mentioned and seems a very culture-bound concept. The near anxiety of "Western" people — and patients in particular — about their privacy is largely absent in the Ghanaian context, certainly in a rural environment. The presence of relatives at every conversation and medical intervention is a case in point.

Another factor may be the greater hierarchical distance between doctor and patient in the Ghanaian hospital. Doctors *can afford* to be less concerned about the personal feelings of their patients. Patients in hospitals enjoy few rights and have even fewer sanctions than patients in Western Europe when they disapprove of doctors' or nurses' actions. Their only way of showing discontent is to leave the hospital and try their luck somewhere else, which they frequently do. In government institutions medical staff salaries do not depend on patient fees, so a patient's departure does not affect doctors or nurses. Another point to consider is the common refusal by doctors to allow outsiders to observe their work. It has already been suggested that doctors — and nurses — may conceal their personal objection to "prying" behind the excuse that it will disturb the patients. We cannot see any good reason why this objection would be less strong in Ghana. In the case of our research study, however, we purposely dissembled that we intended to observe the work of the medical staff. Our request only referred to studying the ideas and behavior of patients. Doctors and nurses may not have been aware that they were studied as well.

In that sense, the researcher did not only hide his true status from his fellow patients but also from the medical staff as they believed that he was studying patients alone while they themselves also formed part of the research "object". As we have seen, similar tactics were used by Greenhalgh (1987), when she studied prescription behavior by Indian doctors.

Finally, some positive discrimination in the reply of the hospital should not be ruled out. Foreigners in Ghana are often treated more courteously than Ghanaians. One wonders if the same request by a Ghanaian anthropologist would have received the same positive reaction. It is certainly true that the European who submitted the request to the Ghanaian hospital would have had a very hard time obtaining the same permission from a hospital at home.

The advantages and disadvantages of unobtrusive participant observation have been spelled out in various methodological handbooks*. The most frequently mentioned disadvantage is that the hidden identity restricts the researcher's activities. He cannot conduct formal interviews without betraying his real identity. The advantage of "normal" participant observation is that casual observations and conversations can be complemented with interviews about events and ideas that cannot be readily observed. For the same reason the researcher cannot make use of notebook or cassette recorder, at least, not openly.

In our case it meant that Sarkodie could not collect systematic information from the other patients. His data were fragmented, bits and pieces as usually appear in human conversation. We do believe, however, that with some art and training, good information can be gathered from people without the use of formal interviews. This point will be taken up again in the conclusion.

The fact that in our experiment the staff was aware of the researcher's double identity made it possible to carry out formal interviews with them, which was an important addition to the covert part of the research.

A second methodological limitation was that the researcher only partly shared the condition of a patient in the hospital. Apart from the fact that he received some kind of VIP treatment, it should be emphasized that he was *not sick*, not a patient in the true sense of the word. That basic difference between his and the other patients' condition colored the entire experiment. Not suffering pain and discomfort, not having to worry about the future, about how to feed the family and how to pay the hospital bill, makes a lot of difference. Observing and making notes from such a comfortable vantage point robs the researcher of the possibility to participate fully in the experiences of hospital patients. Missing the inside experience of the other makes it unlikely that the fieldworker will succeed in grasping the patient's point of view. In that respect our research experiment was as deficient as most other participant observation: it was "fake". How lucky is the anthropologist who really falls sick and has to spend a long period in a hospital!

A last issue is the ethical implications of the experiment. Social scientists will never agree about the ethics of their profession. Ethical principles are not only culture-bound, they vary from person to person, from situation to situation. We do not expect that we can "convert" colleagues to our views, neither will we try. We will only briefly expound our position on the acceptability of "deceit" in social research†. We agree with Glazer (1972), p. 118, that every research involves some form of deception, as indeed nearly all human interactions do, including the most intimate ones. For us the

*For example: McGall and Simmons, 1969; Filstead, 1970; Spradley, 1979; Ellen, 1984; Hammersley and Atkinson, 1995.

†Bulmer (1982) contains an extensive discussion on the ethics of covert participant observation. The contributions vary from outright rejection of any form of deceit in research to the liberal position that the end justifies the means.

acid test of the ethical quality of a research project is: What purpose does it serve? Mild forms of deception, let us call it role-playing, are acceptable if they lead to better understanding, better data, and to better conditions for those who are involved in the research. Ethical experts may warn us that we are skating on thin ice. We know.

Anthropological societies have drawn up ethical codes which tell their members to approach their study "objects" as subjects. They should treat their informants with respect, disclose the purpose of the research to them, maintain their confidentiality, and make sure that they do not suffer any harm from participating in the research. But, unlike the law, a code of conduct is only a guideline for the researcher to interpret and apply to a specific situation. An ethical code is not an unambiguous prescription for correct activities. The implication is that the anthropologist is accountable, first of all to the people who take part in his research. They are able and qualified to judge the ethical quality of the research, more than any professional code.

CONCLUSION

The experiment, which lasted only three days, has been largely successful. Although we do not know whether a second request to the same or another hospital, will again meet with such a positive reaction, the experiment has at least shown that unobtrusive participant observation in a hospital is feasible. The experiment also proved an excellent training for the Master's student, "a superb pedagogical innovation", as one anonymous reviewer remarked.

The question can be raised, however, whether unobtrusive research was necessary in this particular case and whether the outcome justified the deception of patients (and staff). A method should be judged — at least in part — by its results. Did Sarkodie learn something he could not have learned if he had told the patients that he was doing research and trying to understand the hospital life by spending long hours with them, talking to them and their relatives? The answer is probably: no. Or: hardly. We suspect that the patients would have been as willing to talk to Sarkodie as a researcher as they did to him as a "patient". Openness about his research intentions would have had the additional advantage of being able to conduct more formal and systematic interviews with them. The high quality of data produced by anthropologists (cited in the introduction) who did open research in clinical settings, points in the same direction.

The crucial difference of this experiment was that, through his status as a patient, Sarkodie was able to spend 24 h per day in the ward. The main lesson to be drawn from this experiment is that the researcher, either as a patient or as a scientist, finds

a way to be in the ward continuously, day and night.

Another lesson is that if the pseudo-patient status is used, it should only be used with other patients. Trying to "deceive" the staff will not only (most likely) prove idle, but it will also anger them and harm the fragile relation between social researchers and medical professionals. The more subtle deception of the staff which took place in the experiment seems therefore risky and may prove self-defeating in the long run, certainly after the publication of this article.

In our case, we think it worthwhile to continue this approach in the anthropological study of hospital life. A stay of about one month in one ward — obtrusively or unobtrusively — seems to us a reasonable period to obtain insight into the culture and social dynamics of the work of doctors and nurses and of the lives of patients and relatives in a hospital ward.

Acknowledgements—We are grateful to the hospital authorities for their permission to carry out this experiment in one of their wards and to the doctors, nurses, patients, relatives and others who, knowingly or unknowingly, cooperated. We thank Kodjo Senah and two anonymous reviewers for their comments on earlier versions of this article.

REFERENCES

- Barley, N. (1986) *The Innocent Anthropologist. Notes from a Mud Hut*. Penguin, Harmondsworth.
- Bayer, A. E. and Köbben, A. J. F. (1959) De Lou-mensen: Sociografie van een afwijkende religieuze groep. *Sociologisch Bulletin* 13, 76–97.
- Bettelheim, B. (1943) Individual and mass behavior in extreme situations. *J. Abnormal Social Psychology* 38, 417–452.
- Booth, D. et al. (1994) Coping with cost recovery. *A study of the social impact of and responses to cost recovery in basic services (health and education) in poor communities in Zambia*. Dept. of Social Anthropology, Stockholm University.
- Bovenkerk, F. (1977) Geen woorden maar daden. Het levensexperiment als methode van sociaal onderzoek. In *Anders Bekeken. Wet en Werkelijkheid in Sociaal Onderzoek*, ed. L. Brunt, pp. 127–143. Boom, Meppel.
- Bulmer, M. (ed) (1982) *Social Research Ethics. An Examination of the Merits of Covert Participant Observation*. Macmillan, London.
- Caudill, W. (1958) *The Psychiatric Hospital as a Small Community*. Harvard University Press, Cambridge Mass.
- Caudill, W. et al. (1952) Social structure and interaction processes on a psychiatric ward. *Am. J. Orthopsychiatry* 22, 314–334.
- Cole, L. (1962) *Life in the Ward*. Michigan State University Press, East Lansing, MI.
- Diamond, S. (1974) *In Search of the Primitive: A Critique of Civilization*. Transaction Books, New Brunswick, NJ.
- Ellen, R. F. (ed) (1984) *Ethnographic Research: A Guide to General Conduct*. Academic Press, London.
- Favret-Saada, J. (1990) About participation. *Culture, Medicine and Psychiatry* 14(2), 189–199.

- Filstead, W. J. (ed) (1970) *Qualitative Methodology*. Markham, Chicago.
- Fox, R. C. (1959) *Experiment Perilous: Physicians and Patients Facing the Unknown*. The Free Press, Glencoe.
- Frohock, F. M. (1986) *Special Care: Medical Decisions at the Beginning of Life*. University of Chicago Press, Chicago.
- Glazer, M. (1972) *The Research Adventure*. Random House, New York.
- Goffman, E. (1968) *Asylums. Essays on the Social Situation of Mental Patients and Other Inmates*. Penguin, Harmondsworth.
- Greenhalgh, T. (1987) Drug prescription and self-medication in India: An exploratory survey. *Soc. Sci. Med.* **25**(3), 307–321.
- Guillemin, J. H. and Holmstrom, L. T. (1986) *Mixed Blessings: Intensive Care for Newborns*. Oxford University Press, Oxford.
- Hammersley, H. and Atkinson, P. (1995) *Ethnography. Principles in Practice*. Routledge, London, New York, 2nd edition.
- Hansen, E. H. (1991) Censorship or bias: The conditions for critical medical sociology. *Soc. Sci. Med.* **33**(6), 743–744.
- Igun, U. A. (1994) Reported and actual prescription of oral rehydration therapy for childhood diarrhoeas by retail pharmacists in Nigeria. *Soc. Sci. Med.* **39**(6), 797–806.
- Kirkpatrick, J. (1980) *The Sociology of an Indian Hospital Ward*. South Asia Books, Columbia.
- Krumeich, A. (1994) *The Blessings of Motherhood: Health, Pregnancy and Child Care in Dominica*. Het Spinhuis, Amsterdam.
- Leonard, T. L. (1990) Male clients of female street prostitutes: Unseen partners in sexual disease transmission. *Medical Anthropology Quarterly* **4**(1), 41–55.
- McGall, G. J. and Simmons, J. L. (eds) (1969) *Issues in Participant Observation: A text and a Reader*. Addison-Wesley, Boston.
- Nichter, M. A. (1986) The Primary Health Care center as a social system: PHC, social status, and the issue of teamwork in South Asia. *Soc. Sci. Med.* **23**(4), 347–355.
- Osei, Y. (1994) Family support for psychiatric patients in Kumasi/Ghana. *Curare* **17**(1), 35–38.
- Pool, R. (1996) *Vragen om te Sterven. Euthanasie in een Nederlands Ziekenhuis*. WYT Uitgeefgroep, Rotterdam.
- Rätch, Chr. (1992) Their word for world is forest. *Ybk. Ethnomed. Study Consciousness* **1**, 17–32.
- Rosenhan, D. L. (1973) On being sane in insane places. *Science* **179**, 250–258.
- Roth, J. (1963) *Timetables: Structuring the Passage of Time in Hospital Treatment and Other Careers*. Bobbs-Merrill, Indianapolis.
- Schatzman, L. and Strauss, A. L. (1973) *Field Research. Strategies for a Natural Sociology*. Prentice-Hall, Englewood Cliffs, NJ.
- Sciortino, R. (1992) *Care-takers of Cure: A Study of Health Centre Nurses in Rural Central Java*. Dissertation, Free University of Amsterdam.
- Solzhenitsyn, A. (1968) *One Day in the Life of Ivan Denisovich*. Prager, New York.
- Spradley, J. P. (1979) *Participant Observation*. Holt, Rinehart and Winston.
- Sullivan, M. A., Queen, S. A. and Patrick, R. C. (1952) Participant observation as employed in the study of a military training program. *Am. J. Orthopsychiatry* **22**, 314–334.
- Ten Asbroek, G. (1992) Exempting the Poor. An Exploratory Study in Ho Government Hospital. M.Sc. Thesis Health Sciences, University of Limburg, Maastricht.
- The, A.-E. (1997) "Vanavond om 8 uur..." *Verpleegkundige dilemma's bij euthanasie en andere beslissingen rond het levenseinde*. Bohn Stafleu Van Loghum, Houten/Diegem.
- Tijssen, I. (1978) Patiënten in een Ghanees ziekenhuis. M. A. Thesis Sociology, University of Amsterdam.
- Tomson, G. and Sterky, G. (1986) Self-prescribing by way of pharmacies in three Asian countries. *The Lancet* **ii**, 620–622.
- Van Staa, A. (1993) Myth and Metronidazole in Manila. The popularity of drugs among prescribers and dispensers in the treatment of diarrhoea. Master Thesis, University of Amsterdam.
- Van der Geest, S. (1989) Censorship and medical sociology in The Netherlands. *Soc. Sci. Med.* **28**(12), 1339–1341.
- Wallraff, G. (1985) *Ganz Unten*. Kiepenheuer and Witsch, Cologne.
- Wolffers, I. (1987) Drug information and sale practices in some pharmacies of Colombo, Sri Lanka. *Soc. Sci. Med.* **25**, 319–321.
- Zwier, G. J. (1980) *Allemaal Projectie*. Elsevier Manteau, Amsterdam.