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## RESEARCH ARTICLE

# Entering the "Field": Challenges of conducting fieldwork in an infertility clinic

RASHMI PATEL

### Abstract

Carrying out fieldwork in private infertility clinics poses its own specific set of challenges. Gaining access to these field sites not only obliges researchers to negotiate with gatekeepers but also to deal with structures of hierarchy and power. Based on my preliminary fieldwork in Lucknow city of Uttar Pradesh, I discuss the challenges of conducting fieldwork in infertility clinics and how methodological challenges push the researcher to question the academically established notions of the "field," "fieldwork" and

"research ethics." The paper stresses the importance of discussing the challenges of doing fieldwork in private health setups and is an attempt to answer vital questions about the nature of fieldwork, how the fieldwork was conducted, and the need to include questions and dilemmas that anthropologists might face in the process of making decisions in the field.

**Keywords:** infertility clinics, fieldwork challenges, clinical ethnography, negotiating access, ethical challenges

### Medical anthropology: A historical context

Medical anthropology first emerged in the 1950s; however, it was only after the second world war that anthropologists began to focus directly on health research and issues related to patient and doctor relations [1]. By the 1980s and early 1990s, medical anthropologists had begun studying caregiving at hospitals and clinics as well [2]. Medical anthropologists believed that if doctors were aware of patients' perceptions of an illness, it would enable them to deliver better quality care [3]. The study of hospitals and clinics within medical anthropology is a recent trend and is rife with varied methodological challenges. Finkler et al

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observed that hospitals are complex and constantly changing spaces [4]. A hospital is a space “where the core values and beliefs of a culture come into view” [5]. The same can be said about clinics, which operate on a smaller scale, engaging with their patients on a closer, more personal basis. The patient-centric approach at clinics makes them a fascinating site to study the interplay between a society’s culture and its views.

In her introductory note for a special issue on Hospital Ethnography in the journal *Social Science and Medicine*, Marcia Inhorn said that “medical anthropologists—and anthropologists in general—have an ethical obligation to be more transparent about their methodology and the potential constraints of ethnography when dealing with difficult subjects, in difficult places, at difficult times” [6]. When hospitals and clinics are privately owned, gaining access to them becomes “much more difficult and may ultimately depend upon the goodwill of powerful individual patrons” [6]. Thus, detailed documentation of how researchers manoeuvre around the restrictions in medical institutions, especially at the initial stages of entry and rapport building, becomes vital. Such accounts give heart to new researchers venturing into closed medical places and allow them to gain from the experiences of researchers in similar field settings.

### Focus of the paper

The present paper narrates the experience of fieldwork and challenges encountered while negotiating access into infertility clinics in Lucknow, my hometown, which is the capital of Uttar Pradesh — the most populous state of India. The paper aims to discuss the challenges of gaining entry “when the field is a clinic” <sup>a</sup>. The paper also brings into discussion the significance of in-field decision making while seeking access into and building rapport in private health clinics; infertility clinics in this particular case.

### Ethics committee approval

The patients and clinics mentioned in the article have been sufficiently anonymised and an ethics committee approval has been obtained from the Department of Anthropology, University of Delhi, for conducting the research work.

### Infertility and Assisted Reproductive Technologies

Infertility is “a disease of the reproductive system” and is defined by the World Health Organization (WHO) as “the failure to achieve a clinical pregnancy after twelve months or more of regular unprotected sexual intercourse” [7]. Infertility is mainly of two types: primary infertility, when a woman is unable to become pregnant or to carry a child to live birth; and secondary infertility, when a woman has previously had a live birth, ie, she had the ability to carry on pregnancy but no longer has it for a variety of reasons [7]. People who visit infertility clinics may have either primary or secondary infertility. These clinics use a number of assisted reproductive technologies (ARTs) to treat their patients. There are no detailed figures of the extent of infertility prevalent in India.

However, WHO reported that around 8% to 12% of couples around the world have difficulty conceiving a child at some point in their lives which is roughly 50 to 80 million people [8]. Another study reported that 40.5 million (56%) of 72.4 million infertile women in developed and developing countries seek medical care [9]. According to Ganguly and Unisa, the total number of infertile people in India stood close to 13.9 million [10].

Assisted Reproductive Technology or simply assisted conception means “all the techniques that attempt to obtain a pregnancy by handling or manipulating the sperm or the oocyte outside the human body and transferring the gamete or embryo into the uterus” [11]. As ARTs have become an increasingly popular method to treat infertility, specialised infertility clinics have been mushrooming in all parts of the country. These clinics can be found not only in metropolitan cities but also in tier two and tier three cities. These clinics are primarily private in nature and operate without much interference or regulations from the state authorities. They are tightly closed spaces and owing to the social stigma surrounding infertility and its treatment, negotiating access to these specialised health facilities continues to be a demanding task.

### Before entering the field

In order to understand how to negotiate access to infertility clinics, I carried out a focused literature review and found that only a handful of researchers documented the process of gaining access in detail [6, 12, 13], while most ethnographers presented knowledge on various aspects of assisted conception, and mentioned medical patrons (acquaintances in the medical field who could prove as a point of entry into the hospitals and clinics) and experiences with gatekeepers only in passing [14,15,16]. This made me turn towards the available literature on negotiating access in privately owned clinics or hospitals other than those for infertility. While analysing the literature, my apprehensions regarding the lack of a medical patron grew, as most published work seemed to have come either from people who had at least one insider source to ease their way into the field, or had sterling credentials to work to their advantage. While studying doctor-patient interaction during pregnancy and childbirth, Danziger narrates how her father, a practising obstetrician-gynaecologist, provided her the first opportunity to observe labour and delivery units in the clinics where he practised or where he was a friend of the chief of staff [17]. Additionally, “a letter of introduction” from her father “proved to be a door opener” at the clinics where she had no links. Danziger was able to build a rapport with the head nurses at the maternity units, who were both extremely receptive to her ideas and flattered that she was seeking their counsel. They would help push the research forward and tell her “how to go about receiving permission” from the doctors [16]. In Bangladesh, Zaman gained access easily to a government hospital’s orthopaedic ward, being an ex-student of the institution, and not an “outsider” [18]. I

had none of these resources at my disposal, and had to resort to the old-fashioned way of approaching the clinics, as explained in the next section.

Another significant problem arising when the “field” is a clinic or a hospital is the degree of participant observation that is essential to ethnography. However, when working in hospitals and clinics, ethnography and participant observation “tends to be more contained in time, and dispersed in terms of field sites” [19]. The degree of participation, in my experience, was determined by the size of the clinic and the administrative force behind it. Working in a non-corporate, privately owned clinic allowed me to participate in the activities at a more intimate level. A smaller workforce in the clinic obliged the doctor to allow me to shoulder miscellaneous responsibilities, which I could otherwise have been kept away from.

Describing her fieldwork experience in the rheumatism wards and clinics in Denmark, Wind expressed how she felt a sense of uneasiness that she hadn't been able to do “proper” fieldwork and “proper” participant observation because she didn't manage to become an active part of the ongoing activities and events in the hospital settings [20]. She described her observation sessions in the clinics as:

*It was not the first time that the doctor perceived me as 'doing nothing'. She had seen me sitting in the nurse's office at the outpatient clinic earlier that day, and she had seen me 'hanging around' at the rheumatology ward in the weeks beforehand. The evident clash between her having to rush, to actually run to fulfil her job responsibilities, and me just sitting there 'doing nothing' made my presence the more trivial and her work even more stressful. [20]*

Discussing the inadequacy and limitations of participant observation in specialised healthcare systems, Wind further found that there does not exist a “singular narrative”, as the field is ambiguous and a differentiated social space. When conducting participant observation in such clinics and hospital settings, the ethnographer should not try to assume the role of a doctor or a patient. The ethnographer should also realise that degree of participation can depend on factors such as the type of field space, personal characteristics, specific situation and activities going on in the field [20]. Most of the studies I reviewed before starting my fieldwork were carried out in hospital settings [4, 17, 18, 20]. There was little to almost nothing on conducting fieldwork in health clinics. A clinic is a smaller facility than a hospital and is mostly seen as a primary or secondary care centre. Unlike in a hospital setting, where multiple, specialised wards can be found, a clinic normally provides treatment of a certain type. Foucault, in his seminal work, *The Birth of the Clinic* writes that within a clinic, “doctor and patient are caught up in an ever-greater proximity, bound together, the doctor by an ever-more attentive, more insistent, more penetrating gaze” [21]. This is particularly true of modern clinics that are more closely

administered than hospitals and deal with their patients on a more interactive basis.

Gaining access to these clinics — in most cases, privately owned — requires negotiating with a smaller administrative task force. An institutional review board structure is either absent or negligible in clinics. In this paper, I focus on gaining access to infertility clinics though the subject matter and challenges of entry can be loosely extended to similar privately owned clinics. Having said that, it is necessary to explain how the context of infertility clinics differs from other private clinics. Infertility being a socially stigmatised condition, access to such clinics tends to be more difficult and the administration tends to be more guarded and wary. Anonymity and privacy are often the primarily cited reasons for refusal of access.

### Entering the "Field"

As a continuously expanding urban centre, Lucknow witnesses the coming up of new infertility clinics every year. These vary from multi-city specialised centres to single room-based consultancies. I, based on my online research, estimated the number of infertility clinics in the city to be close to 25. Before starting the fieldwork, I hadn't set any criteria about which clinics to approach first. Almost every clinic on the list was privately owned and located in different pockets of the city. While the corporate-owned multi-city clinics could be found in the city's bustling centre, the relatively smaller scale clinics were located in prosperous residential areas of the city and a few in market areas.

For the sake of convenience, I decided to visit those clinics first that were within a ten-kilometre radius of my residence. I wanted to begin with the nearest clinics, and then spread out depending upon the response I got from the clinics approached initially. Bharadwaj in a similar study on infertility clinics across six major north Indian cities (excluding those from Uttar Pradesh), did not have any pre-determined criteria on which and how many clinics to approach; but remained flexible and made such decisions “on site” [22]. My model of choosing field sites was loosely inspired by Bharadwaj's description. In the first week, I made a list of five clinics that I intended to visit and used the internet to learn about them. I visited their websites if available, read customer reviews, and the lists of medical staff at the clinics. This gave me an idea of the hierarchy within the clinic as most websites provided a list of doctors and their specialty. This also helped me on my first visit, as the receptionist would ask me about the person I wanted to meet, and I always gave the name of the senior-most doctor. I did this for two reasons. First, I assumed that the decision-making authority rested with the senior-most doctor — a false assumption in some cases where the doctors working in the clinic did not own the facility. Second, I expected that if I had interacted with the senior-most doctor and gained

his permission to carry out my research at the clinic, the junior medical staff would readily accept my presence and be cooperative, which was disproved in the later stages of my study.

Within a month, I visited five infertility clinics, and each one presented its own set of challenges. I first chose to visit a moderately-sized treatment centre, about eight kilometres away from my residence, which had listed four infertility specialists. The senior-most doctor at the facility was available that day, and he granted me an audience. I began by introducing myself as a researcher from the University of Delhi. He interrupted me by asking “*to phir Lucknow me kaam kyo karna chahti hain?*” (Then, why do you want to work in Lucknow?); I reiterated the reasons I have listed above to explain the same. I then described my research objectives to him. By a lack of affirmative verbal cues from his end, I could sense that he was unimpressed and uninterested. I had begun talking about the two components of my research where I would need to interview his patients, but I did not get to finish. He interrupted me and explained that theirs was a very reputed clinic in the city, and researchers had approached them in the past as well. I assumed that he meant research organisations, and I attempted to re-iterate my research objectives to highlight that my work was quite different. However, he shook his head and exclaimed:

*We understand that your research is interesting, and I am happy to know that you have chosen our clinic for your study. But, unfortunately, we do not allow researchers in our clinic. It compromises the privacy of our patients, which is of utmost importance to us.*

The doctor further explained how patients who arrived at their clinic were looking for a “safe space” where they could be treated anonymously without attracting unwanted attention. Their patients were spending a premium amount not just for the treatment but also for the discretion their clinic offered, which he explained, could not be compromised for the sake of research. At this clinic, my identity as a researcher seemed to be the sole reason for denying access. It has already been well-documented by several researchers before me that physicians take great care “to circumscribe scrutiny by others” and this “is usually defended on the grounds of ethical concerns for the confidentiality of patients” [17]. Danziger wrote that this was despite the fact that most institutions already have “a vast set of bureaucratic guidelines for protecting the rights of patients from researchers” and “before one even reaches the point of going through the bureaucracy’s review channels, opposition from the medical professionals is encountered to limit exposure to its activities” [17]. However, in an Indian context, especially when the research setting is a clinic (not a hospital), there exist little to no safety guidelines to shield patients from researchers. Thus, though the refusal at the first clinic dented my confidence, I understood the doctor’s concerns. The next clinic had a similar setup to the previous one. It was a two-storied facility with three infertility specialists. I followed the same preparatory process for information about the clinic and

reached there without a prior appointment. On introducing myself as a researcher, I was asked to wait and told, after waiting for about four hours, that the doctor would be unable to see me because of the large number of patients. I went back to the clinic the next day and was given the opportunity to meet the doctor. My interaction with the doctor at this clinic was more fruitful compared to the first one. The doctor listened to my research proposal and agreed to be interviewed after a prior appointment. However, he refused to permit me to attend the clinic daily or to allow interviews with the patients. I had to give up any hope of conducting fieldwork at this clinic because documenting the doctor-patient interaction was an essential part of my research design.

My visit to a third clinic was also disappointing as I was bluntly denied permission to carry out my research. The doctor in charge said plainly:

*We are busy all the time. Just to meet you, I had to make you wait for an hour and a half. How do you think we will manage time for the interviews? Sorry, but we are not allowed to misuse our time, especially when it does not bring us anything in return.*

Naturally, my spirits were at an all-time low when I approached the next clinic expecting similar responses. However, my visits to the next two clinics were surprisingly fruitful. The doctors were professional but amiable and gave me a full audience. They listened to my research ideas with interest, asked questions and allowed me to visit their clinics. The doctor at the fourth clinic had no objection if I interacted with his patients at the clinic; while the one at the fifth clinic offered me restricted approval to visit the clinic for a couple of days and carry out my observation of the daily routine. However, if I wanted to talk to the patients, I would have to wait a few weeks. Both these clinics, which seemed to have no qualms about the presence of a researcher on their premises, were single-doctor based setups. Unlike the previous three clinics, these two clinics were not situated in high-end locations of the city and served a comparatively smaller clientele. Two of the first three clinics where I had been denied access, were in fact, corporate-owned multi-city infertility clinics and the doctors did not own the facilities but were employed there. It was evident that single-doctor setups, owned by individual doctors, had the liberty and authority to decide whether or not they could afford the presence of a researcher amongst them. Thus, I was successful in negotiating access at smaller health clinics that were run by doctor-owners themselves, as compared to high-end places that operated more on the basis of patrons and links within the medical fraternity.

At this point, it may be useful to take into account the relationship between time and qualitative research. When the nature of inquiry is ethnographic and the aim is to gain a rich insight into the functioning of any social space and its components (an infertility clinic in this case), patience



becomes a key aspect and may serve as an effective approach to gain access into the field and build the required rapport.

### The researcher's positionality in the field

This brings us to the idea of the "field". In traditional anthropological fieldwork, "the field" is often identified as a distant place or community, which the anthropologist visits, stays in for a substantial period, and participates in the daily lives of the people. It is the everyday participation in the lives of the people which allows anthropologists to "immerse" themselves in the community being studied and become one of "them" in order to gain an understanding of what is called the "insider's point of view" or the "emic approach". Concurrently, the researcher is expected to make observations and interpret the field while maintaining analytical and intellectual distance [20]. A well-executed "participant observation" thus results in the accomplishment of the "emic perspective" and produces what we call "ethnography". However, when working in a clinic or a hospital, the "field" is not so distinctly marked and readily accessible, thus making it challenging to carry out fieldwork. In such a highly-specialised setting, realising the participatory aspect of the fieldwork becomes problematic. Geest and Finkler [5] suggest three basic possibilities for researchers to choose from for fieldwork in a clinic or a hospital — to join the staff, the patients or the visitors.

*It is our impression that most researchers do the first and play—more or less explicitly—the role of doctor or nurse. They may put on a white coat and be regarded by patients as 'one of them'. [5]*

I chose to play the first role once access was granted. How my position as "one of them" inside the clinic impacted my interactions with the patients may be the subject matter of another article. However, it is worth mentioning that these interactions were more or less on the lines of "negotiated interactive observation" a recent approach for conducting fieldwork in specialised healthcare systems. Here, interaction means "that something is going on between people but not necessarily that there is agreement on what is going on or that they engage in the same narrative. It does not require that they (the researcher and the researched) are bound by the same kinds of strings" [20]. Interactive observation goes two ways, and "they" (those under observation) try to make sense of what "you" (the researcher) are doing or not doing and saying or not saying. There exists a constant negotiation of when and how the observation and interaction will and will not take place. This negotiation was a dominant theme during my fieldwork. Out of the five clinics that I visited, only two allowed me to continue with my visits, of which only one clinic permitted me to observe the space and interview patients. This authorisation of my presence in the clinic was not absolute but qualified. I was allowed to talk to the medical staff and, in fact, encouraged to take their help in getting to know the space. However, I was repeatedly told not to engage in conversation with the patients until the doctors introduced

me to them personally. There was constant monitoring of when, how and with whom I was interacting. The clinic staff had negotiated my presence in their space, and I was as much under their observation as they were under mine. Sometimes, while sitting in the waiting rooms for an hour or two, I would strike up a conversation with the other patients waiting in the room. If I talked to the patients for too long, the non-medical staff, whose job was to send patients to the doctor's office, would take notice and look at me disapprovingly. Sometimes, they would go back to the reception and report on my activities which in turn would get me an additional "please do not talk to the patients, they might get upset" directive from the doctor on my next visit.

While visiting the clinics and repeatedly being told by the doctors and the medical staff about whom I could talk to and what I could talk about, I began to look at my field sites from a new perspective. Unlike the traditional anthropological field, which is often a community or a group inhabiting a certain location, I began to view my "field" not as a single unit but as multiple "fields". Every clinic that I visited served as a "field" in itself, where the extent of my presence and involvement was negotiated and differed. At one clinic, I was a mere observer of the everyday routine, attempting to understand the flesh and bone, ie, the structure of the clinic. At another clinic, I was a participating observer (to the extent that I could sit in the waiting rooms like the rest of the patients and strike up conversations), and at the third clinic, I could be an interviewer where I could not only approach the patients but also ask them questions up to a point. I can freely admit at this point that during my rather short term of fieldwork, it was the circumstance that defined my method rather than the method defining the circumstances of my fieldwork [23].

The discussion on access to these clinics would seem incomplete without some reflections on my positionality as a researcher. As a young, unmarried female researcher without any patrons in the medical world to ease my way into the clinics, the feeling of being an 'outsider' weighed heavily on my mind during my initial encounters with the doctors. It would guesswork to assume how the doctors perceived me when I first approached them, but there were subtle signs that could be picked up during these meetings. Hospitals and clinics are spaces of "interaction between parties of unequal status and asymmetry is a key feature of the situation" [17]. Sitting across from me at the table in the doctor's cabin were professionally successful men and women in their late thirties and early forties. Clad in white coats, armed with a sense of entitlement and routinely used to getting their way in the clinic, they held the superior position and were keenly aware that the decision to allow me into the clinic was their prerogative. They were not obligated to give me some time out of their evidently busy schedules or to agree to my presence in their clinic as a researcher. I was supremely aware of that fact which made getting my point across the table all the more challenging.

## In-field decision-making

*This can be mutually beneficial for us. If you spread the word about my clinic at the other clinics you're visiting, I will get more patients, and thus, you will have access to more patients.*

Those were the words of an infertility specialist at one clinic I visited during the third week of my fieldwork. The doctor at the clinic was not only granting me access to space but was also willing to allow me to talk to the patients sooner rather than later. His only condition was that I should publicise his clinic to the couples I was visiting at other clinics. The offer seemed advantageous, but the question of ethics lingered in the background. By the end of the meeting, I had conveyed to the doctor in vague terms that I would not be able to promote his clinic to patients at other clinics I was visiting. When I say in vague terms, I must confess that the move was deliberate. I didn't want to refuse the proposal outright, which could lead the doctor to withdraw his permission to allow me to visit the clinic. Fortunately, when I replied that most of my conversations with the patients at clinics take place with other clinic staff working in the background, and it would be difficult for me to slip in a word about his clinic, the doctor seemed unaffected and nonchalant. However, on my next day at the clinic, one of the clinical staff informed me in clear terms that I could spend time observing the everyday activities at the clinic, but I was not to interact with the patients.

The above instance brings to the fore the issue of the ethical dilemmas a researcher faces when working in the field. The textbooks on methodology and classroom lectures on conducting fieldwork either omit this part or do not sufficiently stress the importance of on-site negotiations and decision-making. Malachowski points out that there is scarcity of literature on organisational politics, emotional trials and tribulations for young ethnographic researchers; a critical discussion of the same could better prepare these researchers enter the field [24]. In the case described above, I chose to express my position to the doctor in vague terms, which could be interpreted both as me rejecting the prospect of promoting the clinic or simply expressing my inability to promote the clinic because of the presence of other clinic staff. Another way to tackle this dilemma would have been for me to agree to the proposal before the doctor, gain access to the clinic and the patients, but not to actually promote the clinic to other patients. This second option would have involved deception on my part but made my research work somewhat easier. Not choosing the second option was a decision guided by my moral compass, and it was revealed to me that when in the field, moral and ethical dilemmas do arise and how you tackle them will shape the course of your research work and the nature of the data that you collect.

An interesting and partially similar approach has been discussed by Bonaccorso [12], which she calls a "without-method approach". Describing her study in the infertility clinics of Italy, she wrote that while granting access to

conduct fieldwork in the clinic, she was told by the doctors that access could be taken away at any time without any justification — access which was granted to her only for the space, and not for the patients or the staff at the clinic; and access to the later would have required prior authorisation. To overcome this precarious and conditional access, she used two strategies. First, she adhered to all the rules prescribed by the clinicians. Second, she employed a "without-method" approach where she attempted to cause the "least possible distress to the clinicians" by not making any research or methodological requests of the clinicians. She only claimed that in order to carry out her work, she needed to meet the couples undergoing infertility treatment. She did not specify any other requirements of participant selection such as age, socio-economic background, occupation or the stage of treatment programme of the couples [12]. Thus, she attempted to make her research project sound "as broad as possible" and "as aspecific and asystematic as it could be". This gave the clinicians a better sense of control and made them feel relaxed that she wasn't looking at anything specific. In course of time, this "loose" approach allowed her full access to the couples, and she could collect substantial data from the clinic. Thus, it is apparent that decision-making in the field is riddled with subjective contexts and includes such details in our writings can allow researchers to share and better understand fieldwork challenges in different ethnographic settings. In other words, documenting instances of "ethical decision making heighten the ability of fieldworkers to anticipate ethical dilemmas and to handle those they encounter, fostering wisdom and courage but not certainty" [25].

Apart from these ethical dilemmas involving on-site decision-making, I faced rigid, hierarchical ladders of rank and authority. As I began visiting the clinics, I realised that obtaining approval from the doctors-in-charge was not enough to justify my presence in the clinic. On my every visit to the clinic when spotted by a junior doctor, I would be asked to describe what I planned to do on that specific day and reminded again not to interact with any patient without getting permission from the concerned treating doctor. Even the non-medical staff at the clinics kept a tight vigil on my movements inside the clinic and reminded me not to probe the patients unless the latter seem interested in talking. There was an invisible thread of rank and privilege, which kept me on tenterhooks all the time and my initial interactions with the patients after the introduction was always limited to topics I thought would not be unsettling for the patients to discuss.

## Learnings from the "Field"

Medical anthropologists first began to study healthcare practices with the aim of understanding the perceptions of illness among both doctors and patients and how such knowledge could help in providing better healthcare [3]. This led to a closer inspection of hospitals and clinics as

spaces where there was a cultural interplay between the doctors and their patients. With an increasing number of hospital and clinic-based studies, the importance of divulging more details about methodology and data collection practices has been stressed. Following Marcia Inhorn's stipulation that anthropologists need to be more transparent about their methodology [6], I have attempted to discuss the challenges of conducting fieldwork in clinics, which are spaces closed to inspection by researchers. The process of gaining access to these institutions is just as complicated as establishing a rapport with the patients and getting them to open up on a sensitive topic such as infertility. Prior to starting the fieldwork, I had spent a considerable amount of time thinking about how to approach the clinics and what method to adopt once the clinics allowed me to visit and interview patients. Even after arriving in Lucknow, I spent the initial two days researching the clinics I was supposed to visit and collecting online information about their structure, facilities and medical staff. Thus, it becomes difficult to pinpoint when exactly my fieldwork began. Was it when I submitted the fieldwork leave application at the department before leaving for Lucknow? Was it when I began the online research into the clinics? Or was it when I walked in through the gates of the first clinic? The answer lies in how broadly you view the terms "field" and "fieldwork". Scholarship on how and where the "field" is constructed is burgeoning [23, 26] and on how, as in my case, conducting fieldwork close to home poses its own set of challenges [18].

For me, "entering the field" and "doing fieldwork" were two different processes, each with its own set of challenges. Both these processes required to be dealt with separately. While entering the field, it was necessary for me to convince the owners of clinics and gatekeepers that research in their clinic would not corrode the established system of privacy and confidentiality between them and their patients and that my presence would be a positive development for the scope of research in health settings. It required me to bargain and negotiate with the blurred lines of ethical code and morality and gain the trust of the doctors. The fact that my presence affected the structure and the bounded set of relationships and activities in the "field" was quite evident, and through the process of "doing the fieldwork", I attempted to discover the interconnections and the overlapping contexts within the clinics. I found myself shaping and being shaped by the interactions I had with the doctors. For instance, when I began my fieldwork, I had a very idealistic notion of the process. Having read a significant amount of published papers and books on the topic of assisted conception, I considered myself well-prepared to meet the doctors and their patients. An initial reluctance on the part of the doctors to participate in the research was anticipated, but I did not expect it to last longer. As well-educated and practising medical professionals, I expected readiness and cooperation from the doctors, which I soon realised to be an ill-founded misconception on my part. Gaining access to the field was an exercise that humbled me and taught me that conducting fieldwork in health settings,

especially as a researcher with no medical patrons, to back you up is a challenge in itself. However, once access has been gained, the problem arises in operationalising participant observation which is the key feature in ethnographic studies. Participant observation, in its traditional form, becomes a daunting task in hospital and clinics. Wind's method of "negotiated interactive observation" [20] to conduct ethnography in health settings is rather interesting where both the observer and observed are aware of each other's presence but do not share the same narrative on what is going on. Observation becomes a two-sided lane where both the researcher and the researched try to make sense of what the other is doing or saying.

During my fieldwork, which could only go as far as twenty days, I did not get an opportunity to engage in participant observation. Covid-19 blew and the entire process came to a standstill. Now that multiple waves of the pandemic have washed over, I find myself wondering whether upon returning to these clinics, I would not find them to be the same or not. Resuming fieldwork during or after the pandemic phase will be significantly different, not only in terms of risks and methods but also in terms of the time frame and distancing. Thus, it becomes all the more significant that we talk about the challenges of doing fieldwork in closed health setups and document how these challenges transform in a post-Covid world.

#### Notes:

<sup>a</sup>The expression is borrowed from the title of the introductory article of a special issue in *Anthropology and Medicine*, published in April 2008.

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