International Qualitative Research Toolkit Webinar
27/8 May 2021

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Qualitative research in health: Video-reflexive ethnography

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Healthcare: rising complexity

- Multi-morbidity
  - we now die with +/- 3 diseases; 20% dies with 5+ diseases: complex treatment trajectories;
- More, new, and increasingly intersecting treatments
  - new drugs, technologies, tests …;
- Scientific progress and uncertainty
  - "40% of 363 [published trials] resulted in medical reversal" (Prasad et al 2013)
- People churn
  - staff/patient mobility; workforce changes: short-term relationships, etc;
- Service redesign
  - new models of care; care integration; co-design;
- Regulatory pressures
  - new policies & guidelines; more reporting, monitoring, accreditation …
- 'Shrinking' £ resources

Prasad V, Vandross A, Toomey C, et al. (2013) A decade of reversal: an analysis of 146 contradicted medical practices. *Mayo Clin Proc* 357(2013):790-98.

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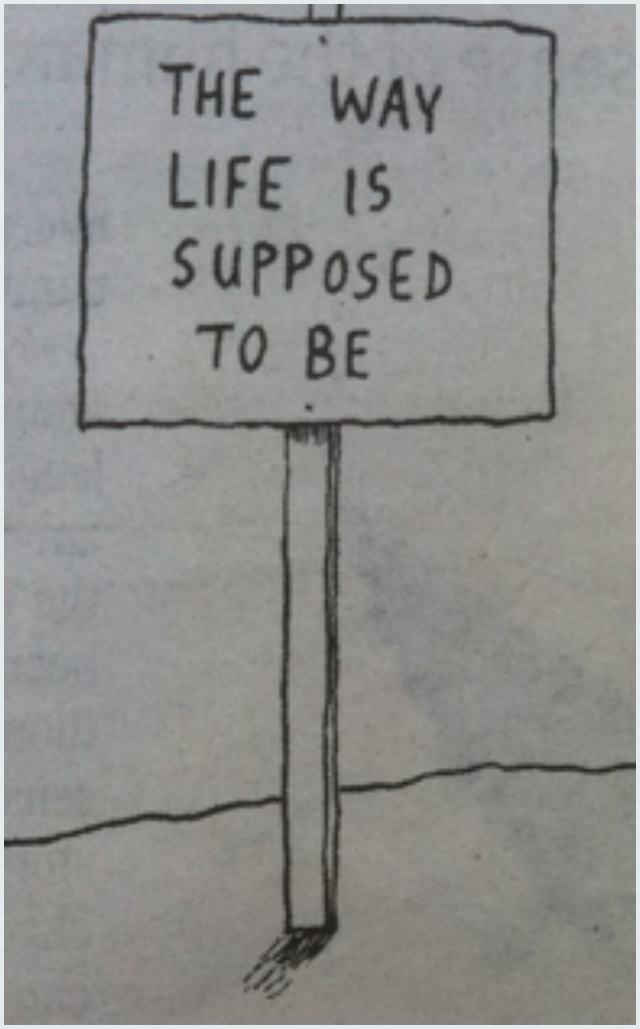
Our response to complexity … simplification



- Best practice
- Guidelines, protocols, procedures
- Evidence based medicine; evidence-based healthcare practice
- Cochrane Library
- Measurement (cf. ICHOM (International Coalition for Healthcare Outcomes Measurement) and PROMs (Patient Reported Outcome Measures))
- Monitoring, audits, accreditation

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Taming complexity: 'CAS' ("Complex adaptive systems")

Claim 1: 'Taming complexity' is a research and policy priority.

Claim 2: Understanding the principles of complexity & CAS (e.g. emergence, self-organisation, attractors, etc) guarantees our understanding of complexity and our ability to 'tame complexity'.

Braithwaite, J. *et al.* (2017) *Complexity science in health care: Aspirations, approaches, applications and accomplishments*. Retrieved from Sydney (Australia) http://aihi.mq.edu.au/resource/complexity-science-healthcare-white-paper

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Efforts to 'tame complexity'...

"... operate by seeking to explain a particular phenomenon through constructing an idealized model that abstracts away from the complexities of the real world, especially context, values and time, in order for certain regularities to be reliably identified." (Tsoukas 2017)

JOURNAL OF MANAGEMENT STUDIES

Journal of Management Studies 54:2 March 2017
doi: 10.1111/joms.12219

Don't Simplify, Complexify: From Disjunctive to Conjunctive Theorizing in Organization and Management Studies

Haridimos Tsoukas
University of Cyprus and University of Warwick

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Analysing *in situ* practices

Another division level meeting is that of the Division of Medicine. Issues dealt with at this meeting include: the secretarial situation (sharing of workload and hierarchy among secretaries); Medication subcommittee (looks at medication dispensation and means of monitoring); the care-by-parent unit; medical appointments; training in Trendstar; doctors' availability for public speaking appointments; the Canberra outreach centre, and the possibility of setting limits on lab tests that are commissioned

The Head of Medicine Chairs the meeting and works through the meeting's Agenda point by point. Agenda items tend to comprise reports from other meetings and committees. An example here is the point about medication utilisation:

> [Department Heads, Division of Medicine; turn 7: Chair]
> Medisal utilisation, medication utilisation committee that met for the first time um I think about a week ago, I I went there as a representative for the division during it's first meeting. Nobody's um .. I'm still interested to see whether or not someone wants to participate ... in that meeting on behalf on the division um so but I'll, it's not urgent so I'll um leave that for the moment. [talk in the background]

Some issues, such as medication utilisation, engender little reaction among those present, while other issues produce questions and comment. The Chair is called on to answer questions related to billing procedures and other administrative technicalities, for example.

[Department Heads, Division of Medicine; turn 2-3]
[MMC=male medical clinician; HM=Head of Medicine/Chair]

2	MMC	ah can I just ask one question yeah that will do but chance consulting someone for example under scheme A is that any different to people on
3	HM	well there's two issues, there's the issue of um you know billing which is up to you know if a scheme A staff specialist would would get the hospital to bill, but the real issue is you know the fact that you know in a, it's a, it's a separate institution and you have to have some sort of um right of entry and right of um practice and at the moment nobody's got that unless they've got a separate appointment with the hospital, so you've got that

When the Chair considers the questions answered and reverts back to the Agenda.

[Department Heads, Division of Medicine; turn 7: Chair]

Analysing *in situ* practices

indication of the extent to which some surgical clinicians tend to distrust health policy initiatives encouraging hospital staff to become explicit about their clinical practices in terms of quality and resource usage.

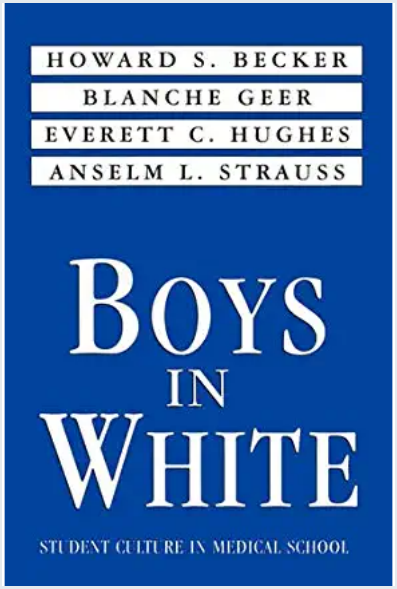
3.2.3 Summary

The analysis of the Department Heads meeting and the Division meeting just discussed signals that medical clinical unit meetings tend to operate from the profession-specific assumption that medical expertise and bureaucratic panopticism are hard to reconcile. The Division of Medicine's Department Heads meeting demonstrated how the two discourses can co-exist without too much friction, but also

Iedema/Degeling/White '98

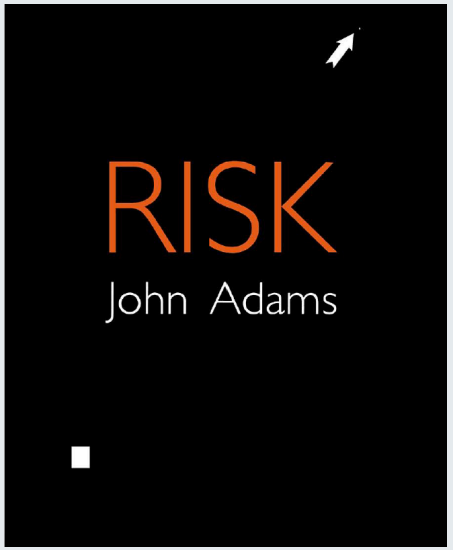
Qualitative research may 'appropriate that which is held to be precious'

"… the sociological view of the world … necessarily deflates people's view of themselves and their organisations [because] something precious is treated as merely an instance of a class …"



Becker HS, Geer B, Hughes EC, Strauss A. (1964) *Boys in White: Student Culture in Medical School*. New Brunswick: Transaction Publishers. (p 273)

Analysis, evidence and knowledge …



"… divert[s] attention away from the question of how to act in the face of uncertainty [in local circumstances] by focusing [people's] energies on **the impossible task of removing uncertainty**."
(Adams 1995: 194)

Adams, J. (1995). *Risk*. London: UCL Press

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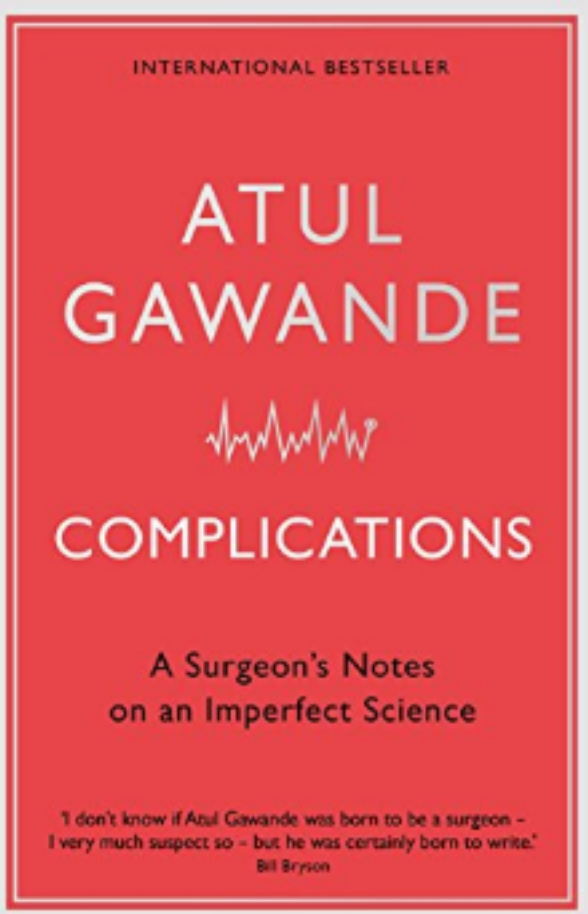
Uncertainty

"**Medicine's** ground state is **uncertainty**.

And wisdom - for both patients and doctors - is defined by how one copes with it."



Gawande A. (2002) *Complications: A surgeon's notes on an imperfect science*. New York: Henry Holt and Company.

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BECOMING A PHYSICIAN

Tolerating Uncertainty — The Next Medical Revolution?

Arabella L. Simpkin, B.M., B.Ch., M.M.Sc, and Richard M. Schwartzstein, M.D.

"At once it struck me what quality went to form a Man of Achievement . . . when a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason."

— *John Keats, December 1817*[1]

These words penned by John Keats, who was a physician as well as a poet, remind us of the human struggle to live in a gray-scale space where uncertainty is rife — a space that is neither black nor white. Our quest for certainty is central to human psychology, however, and it both guides and misguides us.

Although physicians are rationally aware when uncertainty exists, the culture of medicine evinces a deep-rooted unwillingness to acknowledge and embrace it. Embodied in our teaching, our case-based learning curricula, and our research is the notion that we must unify a constellation of signs, symptoms, and test results into a solution. We demand a differential diagnosis after being

iterative and evolutionary nature of clinical reasoning — is the very antithesis of humanistic, individualized patient-centered care.

We believe that a shift toward the acknowledgment and acceptance of uncertainty is essential — for us as physicians, for our patients, and for our health care system as a whole. Only if such a revolution occurs will we thrive in the coming medical era.

In medicine today, uncertainty is generally suppressed and ignored, consciously and subconsciously. Its suppression makes intuitive sense: being uncertain instills a sense of vulnerability in us — a sense of fear about what lies ahead. It is unsettling and makes us crave black-and-white zones, to escape this gray-scale space. Our protocols and checklists emphasize the black-and-white aspects of medicine. Doctors often fear that by expressing uncertainty, they will project ignorance to patients and colleagues, so they internalize and mask it. We are still strongly influenced by a rationalist tradition

Refererence:
Simpkin, A. L., & Schwartzstein, R. M. (2016). Tolerating uncertainty—the next medical revolution? *New England Journal of Medicine, 375*(2016), 1713-1715.

Great tensions are created by the conflict between the quest for

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Uncertainty in practice

"When my mother was at the end stage of lung cancer she was coughing up large volumes of blood. … [She] was admitted to hospital to have a scan and potentially start on anticoagulants.

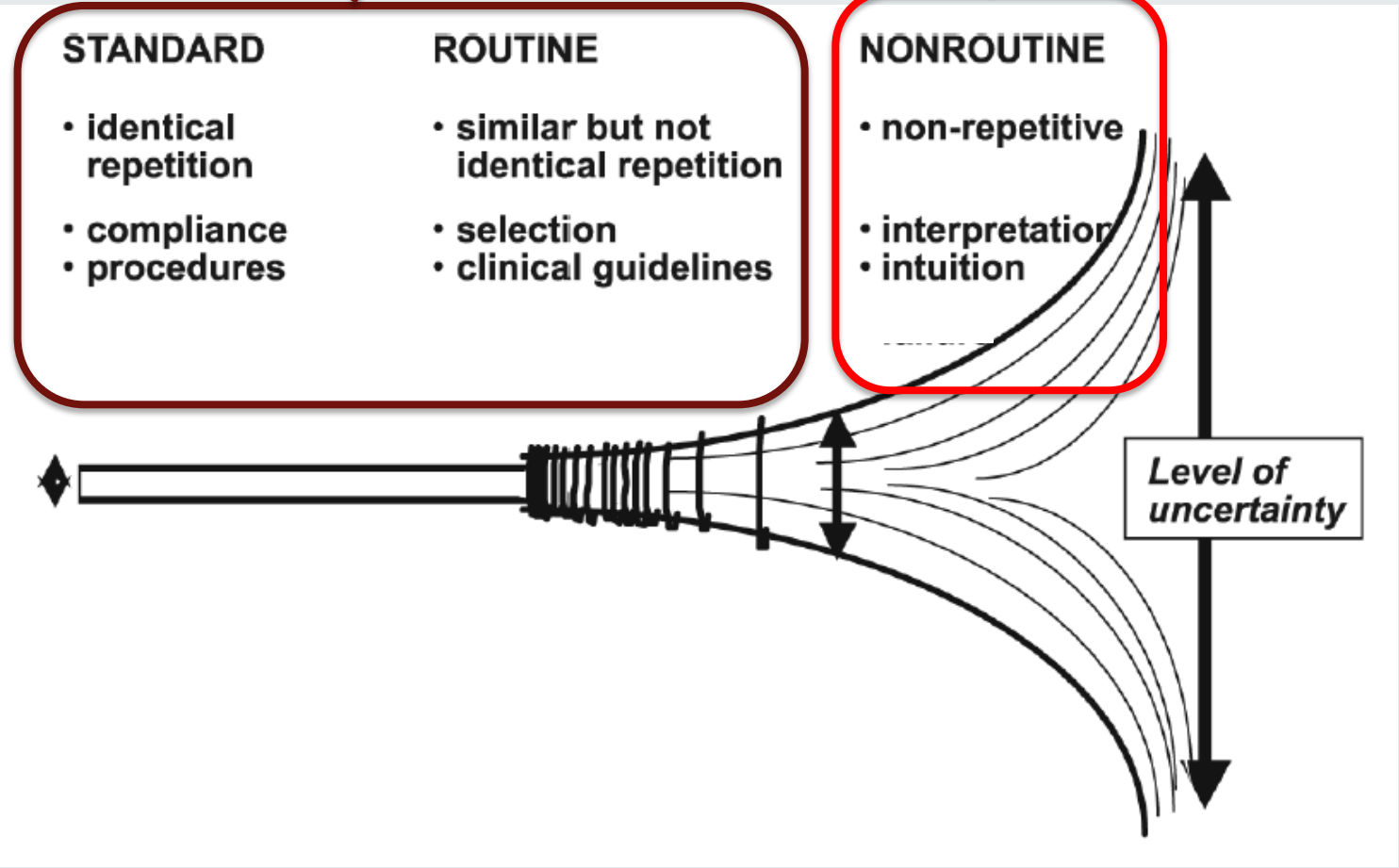
Fortunately we were able to discuss the implications of this with the medical staff and agree that, in her case, the risk of increasing the bleeding from her lungs meant that deviating from the national guidance would be safer than adhering to them.

The lesson from my mother's experience is that **the central goal of safety is to avoid potential harm rather than compliance with systems and processes**".

Dr Elaine Maxwell, Assistant Director, Health Foundation
(p. iii of the Vincent et al 2013 report)

Report: Vincent, C., S. Burnett, and J. Carthey. 2013. *The measurement and monitoring of safety*. London: The Health Foundation.

Standard / routine vs 'nonroutine'



Lillrank, Paul. and Matti. Liukko. 2004. "Standard, routine and non-routine processes in health care." *International Journal of Health Care Quality Assurance* 17:39-46.

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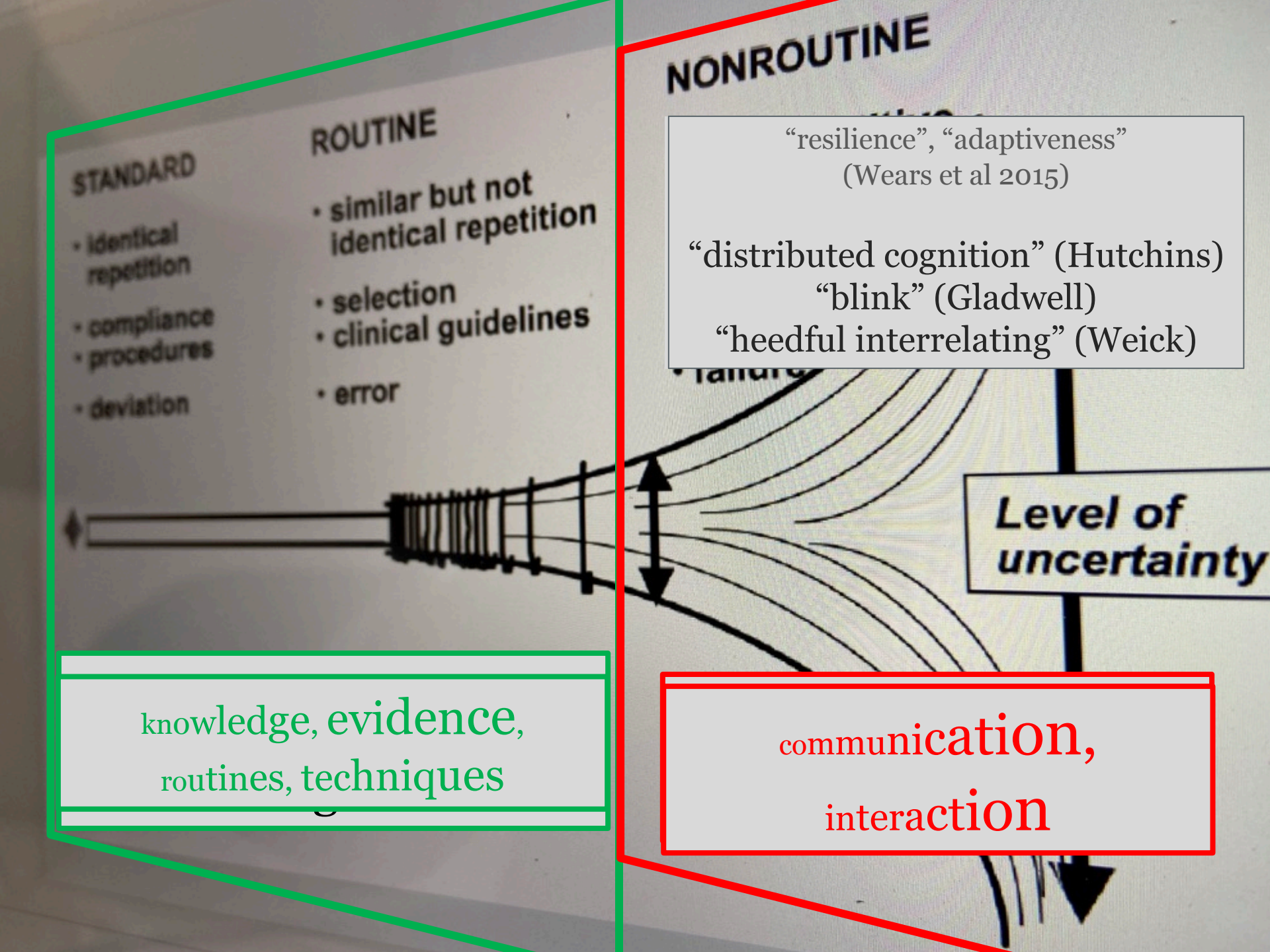
STANDARD
• identical repetition
• compliance
• procedures
• deviation
ROUTINE
• similar but not identical repetition
• selection
• clinical guidelines
• error
NONROUTINE
"resilience", "adaptiveness"
(Wears et al 2015)
"distributed cognition" (Hutchins)
"blink" (Gladwell)
"heedful interrelating" (Weick)
Level of uncertainty
knowledge, evidence, routines, techniques
communication, interaction

Resilience:

Wears, R. L., Hollnagel, E., & Braithwaite, J. (Eds.). (2015). *Resilient Health Care: The resilience of everyday clinical work*. Farnham: Ashgate.

Focus on practical outcomes

Intuitive (individual) wisdom:

Klein, G. (1999). *Sources of power: How people make decisions*. Cambridge, MA.: MIT Press.

Gladwell, M. (2005). *Blink*. London: Penguin.

Focus on personal 'phronesis'

Distributed cognition:

Hutchins, E. (1995). *Cognition in the Wild*. Cambridge: MIT Press.

Focus on psychological inter-connectedness

Mindful/heedful interrelating:

Weick, K. (2004). Reduction of medical errors through mindful interdependence. In K. Sutcliffe & M. Rosenthal (Eds.), *Medical Error* (pp. 177-199). San Francisco: Jossey-Bass.

Brown, P. (2020). Studying COVID-19 in light of critical approaches to risk and uncertainty: research pathways, conceptual tools, and some magic from Mary Douglas. *Health, Risk & Society, 22*(1), 1-14.

Focus on the psy-behavioral dimensions of 'inter-dependent inter-relating'

Performing safety *in situ*

Dr Do you want a gown, Don [Social Worker]?

Social worker comes back, doctor hands social worker gown

SW Oh thanks.

Doctor gets gown for himself. Doctor and social worker gown up.

Doctor walks up corridor tying apron around the front. Sticks head in consult room A, walks out again back towards procedures room, nurse exits consult room A and follows.

N Um, Kim *[Dr turns, nurse indicates apron],* don't tie it round the front.

Dr Uh, ok, sorry.

Doctor re-ties apron at the back.

Iedema, R. (2011) Creating safety by strengthening clinicians' capacity for reflexivity. *BMJ Quality and Safety*. 20: S83-S86.

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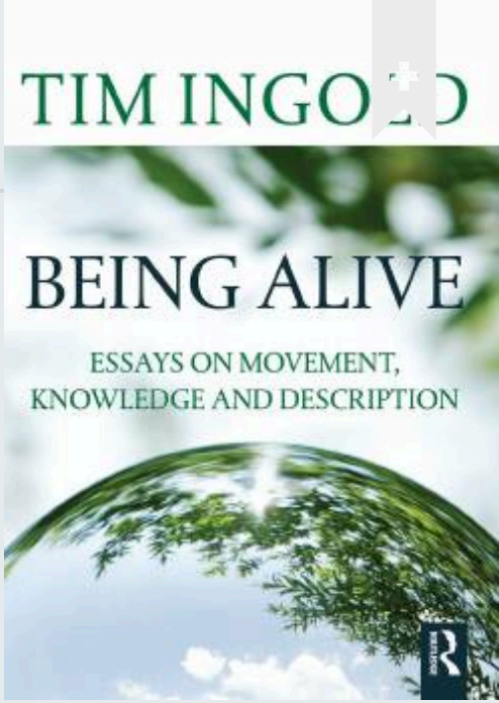
We've privileged 'head over heels'



"As the designer Ralph Caplan wryly remarks, 'a chair is the first thing you need when you don't really need anything, and is therefore a peculiarly compelling symbol of civilisation' (Caplan 1978: 18). Nothing … better illustrates the value placed upon a sedentary perception of the world, mediated by the allegedly superior senses of vision and hearing, and unimpeded by any haptic or kinaesthetic sensation through the feet. Where the boot, in reducing the activity of walking to the activity of a stepping machine, deprives wearers of the possibility of thinking with their feet, the chair enables sitters to think without involving the feet at all. Between them, the boot and the chair establish a technological foundation for the separation of thought from action and of mind from body …"

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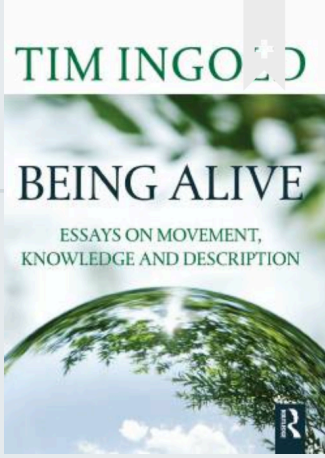
‘Life is experimentation’



“Anthropologists … are enjoined to observe and describe the forms of life they encounter more or less as they find them, and to do their theory-sing after the fact. Of course they recognise, as many experimental scientists do not, that by the very fact of their presence, they cannot help but participate in the situations they observe. But it has been more common to interpret this involvement as a potentially problematic source of observer bias than as a procedure of discovery. Fearing that their observations might be contaminated by their own designs or preconceptions, and to avoid the charge of ethnocentricity, most anthropologists are keen to play down the experimental dimensions of their work in what they call ‘the field’. Yet for the people who live there, quotidian life is experimental through and through. Inhabitants the world over grow into the knowledge of how to carry on their lives by trying things out for themselves, often guided by more experienced companions, in the anticipation of what the outcomes might be. And as self-confessed students of the everyday, anthropologists – in practice – do much the same. Is not experimentation, then, as fundamental anthropological inquiry as it is to the ways of life it seeks to understand?”

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'Video reflexive ethnography':
Experimenting with healthcare practices

1. Negotiations with funders, practitioners and patients about what they are interested in

2. Observation of how work is currently enacted

3. Video-filming of how work is enacted + editing into clips (with advice from in-house 'champions')

4. Feedback to teams using clips enabling discussion, reflection, questions

5. Reassessment (+ redesign) of how the work is understood and done

6. Identification of learnings carried forward

Complex dynamics of participant engagement

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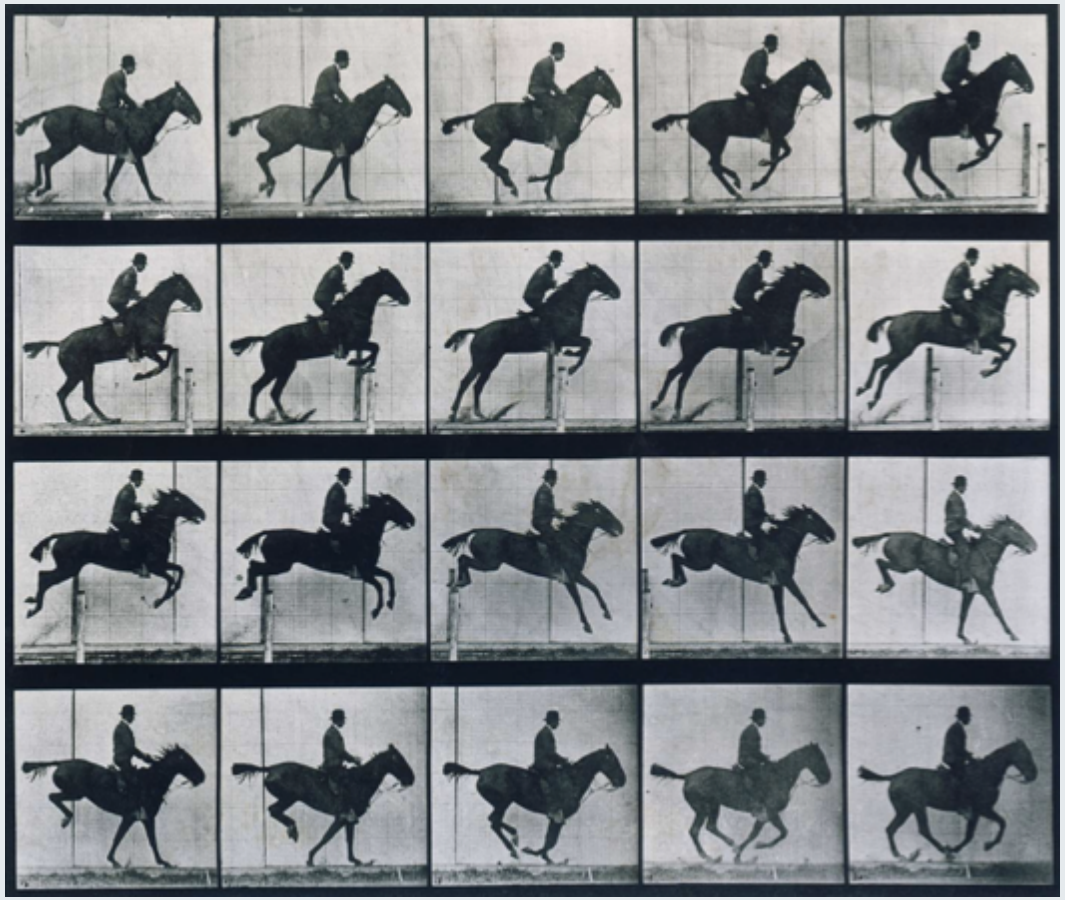
Camera reveals the not-(yet-)seen



Eadward Muybridge (1830-1904) produced ‘images of animals and humans in motion, capturing what the human eye could not distinguish as separate movements’.

Deleuze G. (1983) *L'Image Mouvement (Cinema 1)*. Paris: Les Editions De Minuit.

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Heedfulness: being (having the power to be) affected

"Allowing oneself to be affected symbolises the situation of all those who intervene in themselves through allowing others to intervene in them". (p. 593)

> "Sich-Massieren-Lassen symbolisiert die Lage all derer, die auf sich inwirken, indem sie anderen erlauben, auf sie einzuwerken"

Sloterdijk, P. (2009). *Du mußt dein Leben ändern: Über Anthropotechnik*. Frankfurt am Main: Suhrkamp.

‘The power to be affected’

“Whatever so disposes the human body that it can be affected in a great many ways, or renders it capable of affecting external bodies in a great many ways, is useful to humankind” (Spinoza, 2001: 4-38).

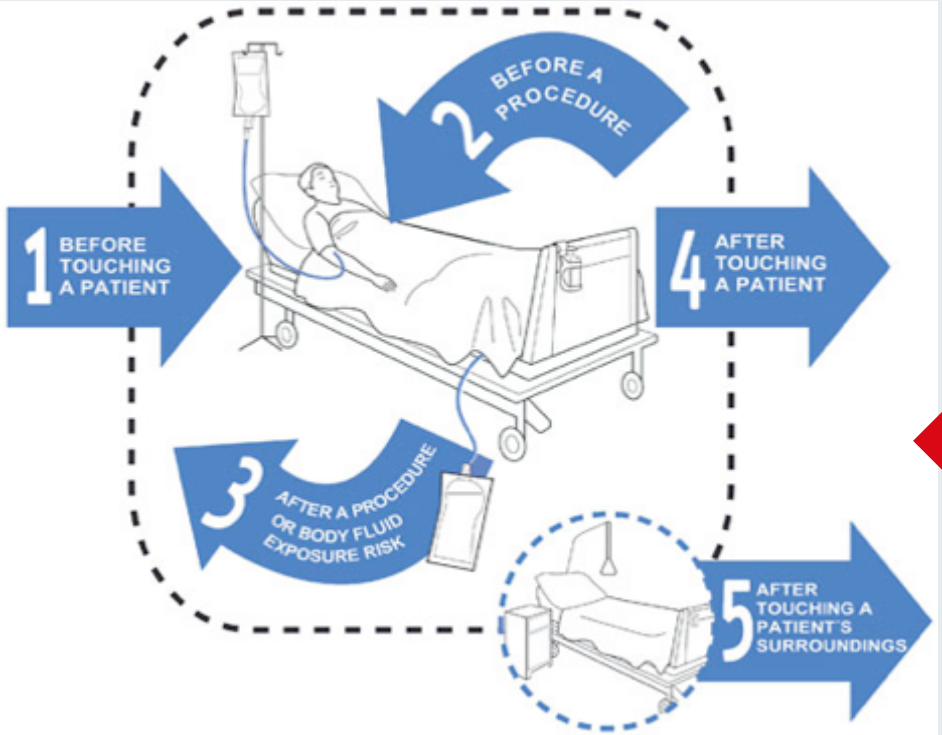
Spinoza, B. (2001). *Ethics* (W. H. White & A. H. Stirling, Trans.). Ware: Wordsworth Editions.

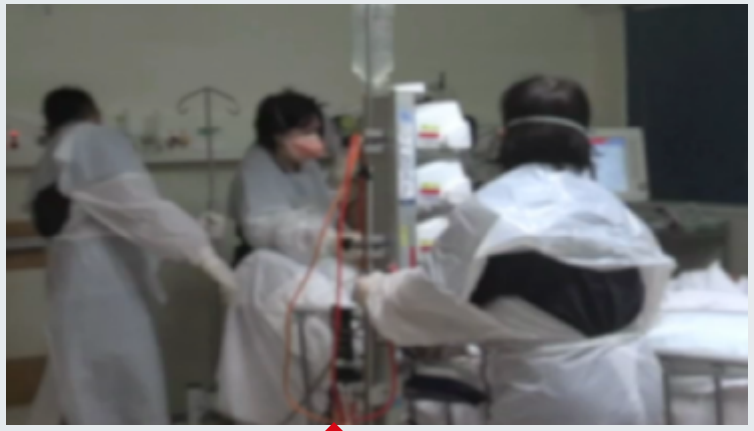
”… every increase of the power to act and think corresponds to an increased power to be affected … the increased autonomy of the subject, in other words, always corresponds to its increased receptivity” (Hardt 2007: x)

Hardt, M. (2007). Foreword: What affects are good for. In P. Ticineto-Clough & J. Halley (Eds.), *The affective turn: Theorizing the social* (pp. ix-xiii). Durham: Duke University Press.

Gaps between guidelines, interpretations and *in situ* activities

WHO 5 moments





Mismatch between the generality of guideline instructions, the diversity of individuals' interpretations, and the complexity of *in situ* care activities.

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Making complexity visible

INSIGHT: What is *now possible and necessary?*

CONSEQUENCES: What were / are the consequences of how we are and act together

FUTURE: What happens/ed next

CONTEXT: What else is/was going on

SYSTEM: What is *pervasive and constraining* about this situation

PAST: What happened leading up to this

HABITS: How are we habituated to doing things in particular (unquestioned) ways

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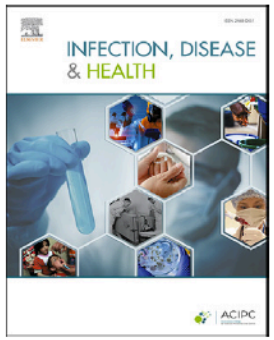
Infection, Disease & Health (2020) **25**, 140—150

Available online at www.sciencedirect.com

ScienceDirect

journal homepage: http://www.journals.elsevier.com/infection-disease-and-health/



Research paper

Sustained fall in inpatient MRSA prevalence after a video-reflexive ethnography project; an observational study

Gwendolyn L. Gilbert [a,*,1], Suyin Hor [b], Mary Wyer [b,1], Rosemarie Sadsad [a,d,2], Caro-Anne Badcock [c], Rick Iedema [b,2]

QUALITATIVE RESEARCH IN PSYCHOLOGY
https://doi.org/10.1080/14780887.2020.1794087

Video-reflexive ethnography as potentiation technology: What about investigative quality?

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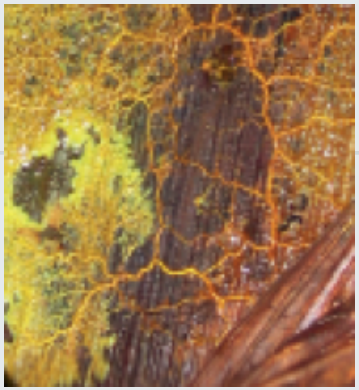
ABSTRACT

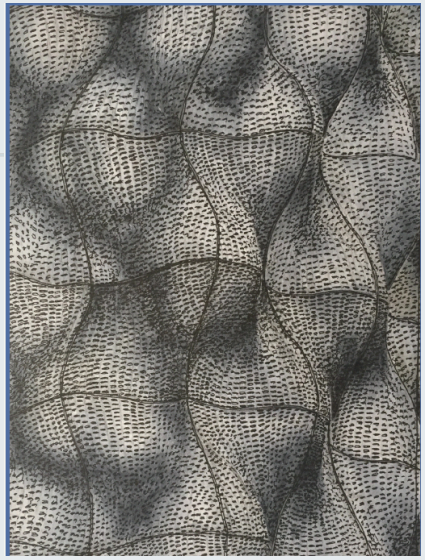
This article has three aims. First, it will set out the 'potentiating' premises of video-reflexive ethnography (VRE) and the ways in which VRE potentiates learning through visual feedback as 'self-irritant' that invites 'liminalisation'. Liminalisation invites people to learn by stepping away from their taken-as-given ways of being and saying. Potentiation capitalises on this loosening of identification with what is assumed to be the real, thereby expanding people's action potential. The article's second aim is to exemplify what VRE looks like in and as practice. Two case studies provide instances of liminalisation. This leads into the article's third aim: to reflect on research quality in relation to liminalisation and potentiation. This part of the paper explains that VRE's quality standard turns on two 'relational' indicators that apply to both the researchers' *and* the participants' conducts and experiences: engagement and movement. The article theorises engagement as a measure of researchers' and participants' investment in the overall VRE process. Movement is theorised as the pace and degree of liminalisation experienced and potentiation achieved through people's psychosocial becoming (undone).

KEYWORDS

becoming; liminality; participatory video research; potentiation technologies; reflexivity; video ethnography

Conclusion





The complexity of practice:

- can't be fully 'tamed' by drawing up rules to cover all future behavior, nor will it be resolved by relying people's 'natural' resilience;
- obliges people to co-negotiate optimal (least worst) on-the-spot actions through reciprocal heedfulness;
- represents not simply a negativity but primarily a learning potential.
- demands an openness to others and to situational complexity that may be engendered through video feedback and reflexive deliberation.

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Some VRE references

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Iedema, R. and E. Merrick (2008). *HELiCS: Handover - Enabling learning in Communication [for] Safety. A Handover Communication Improvement Resource*. Sydney, Australian Commission on Safety and Quality in Health Care.

Iedema, R., Merrick, E., Rajbhandari, D., Gardo, A., Stirling, A., & Herkes, R. (2009) Viewing the taken-for-granted from under a different aspect: a video-based method in pursuit of patient safety. *International Journal for Multiple Research Approaches,* 3(3): 290-301.

Iedema, R., Merrick, E., Kerridge, R., Herkes, R., Lee, B., Anscombe, M., Rajbhandari, D., Lucey, M., & White, L. (2009). 'Handover - Enabling Learning in Communication for Safety' (HELiCS): A Report on Achievements at Two Hospital Sites. *Medical Journal of Australia,* 190(11), S133-S136.

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Iedema, R., Mesman, J. Carroll, K. (2013). *Visualising health care improvement: Innovation from within*. Oxford UK, Taylor & Francis.

Iedema R, Hor S, Wyer M, et al. (2015) An innovative approach to strengthening health professionals' infection control and limiting hospital acquired infection: video-reflexive ethnography. *BMJ Innovation* 2015:doi: 10.1136/bmjinnov-2014-000032.

Iedema, R., Carroll, K., Collier, A. Hor, S., Mesman, J., Wyer, M. (2020) *Video Reflexive Ethnography in Health Research and Healthcare Improvement*. Taylor & Francis.

Iedema, R. (2021). *Affected: Becoming undone & potentiation*. London: Palgrave-Macmillan.

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