

# Video-reflexive ethnography in health research and healthcare improvement

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VIDEO-REFLEXIVE  
ETHNOGRAPHY IN  
HEALTH RESEARCH  
AND HEALTHCARE  
IMPROVEMENT

THEORY AND APPLICATION

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RICK IEDEMA  
KATHERINE CARROLL  
AILEEN COLLIER  
SU-YIN HOR  
JESSICA MESMAN  
MARY WYER



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Video-Reflexive  
Ethnography in Health  
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# Video-Reflexive Ethnography in Health Research and Healthcare Improvement

## Theory and Application

Rick Iedema

King's College London, London, UK

Katherine Carroll

Australian National University, Canberra, Australia

Aileen Collier

University of Auckland, Auckland, New Zealand

Su-yin Hor

University of Technology, Sydney, Australia

Jessica Mesman

Maastricht University, Maastricht, The Netherlands

Mary Wyer

The Westmead Institute for Medical Research, Westmead, Australia



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# Authors

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**Rick Iedema** is a Professor and the Director of the Centre for Team-based Practice and Learning in Health Care, King's College London, London, United Kingdom.

**Katherine Carroll** is a Research Fellow in the School of Sociology, Australian National University, Canberra, Australia.

**Aileen Collier** is Senior Lecturer, Te Arai Palliative Care and End of Life Research Group, School of Nursing, Faculty of Medicine and Health Sciences, University of Auckland, New Zealand.

**Su-yin Hor** is a Lecturer in Health Services Management, Faculty of Health, University of Technology Sydney, Sydney, Australia.

**Jessica Mesman** is an Associate Professor, Department of Society Studies, Maastricht University, Maastricht, the Netherlands.

**Mary Wyer** is a Postdoctoral Researcher at the Centre for Infectious Diseases and Microbiology, The Westmead Institute for Medical Research, Westmead, New South Wales, Australia.



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# Introduction

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## 0.0 VIDEO-REFLEXIVE ETHNOGRAPHY AS PRACTICE

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We start this book with a vignette to provide an example of video-reflexive ethnography (VRE) as practice (Iedema et al., 2015):

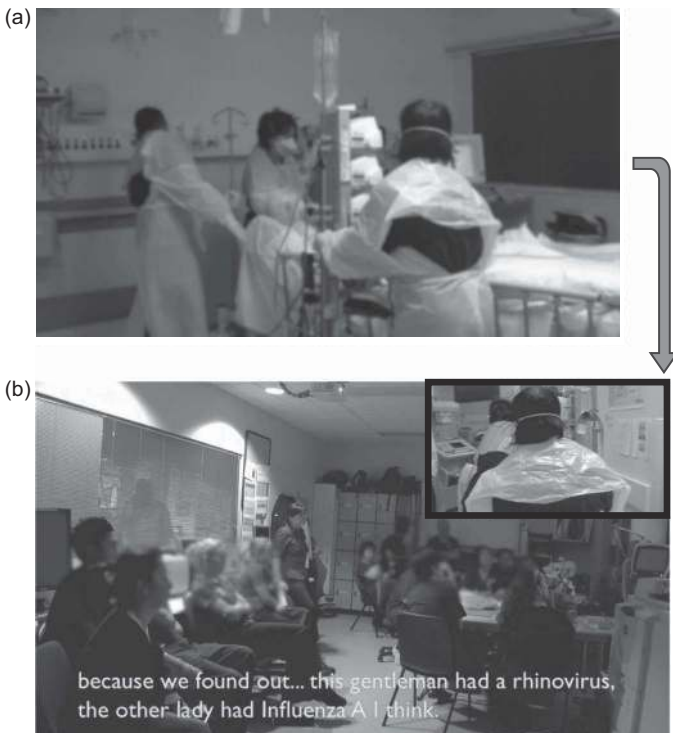


Figure 0.1 (a) Clinicians in sterile gowns and gloves pushing an infectious patient through the intensive care unit. (b) Clinicians observing footage of how they push an infectious patient through the intensive care unit. The arrow points to the original footage being shown to the clinicians (in the box in the top right corner) while they're discussing this footage.

The image in Figure 0.1a is taken from a video clip that was filmed during a project on infection control practices. The clinicians in the clip are wheeling a bed through an intensive care unit (ICU), and they are wearing gowns and gloves so as to protect themselves from the patient's pathogens. The patient in the bed has rhinovirus and needs to be moved to an isolation room to prevent other patients becoming infected. As the bed is wheeled through the ICU, the clinicians encounter different obstacles, among them an X-ray machine, which needs to be pushed out of the way. Given that every one of them is potentially contaminated with the patient's pathogens, touching these obstacles encourages cross-contamination.

Figure 0.1b shows an inset box that displays the original footage, and the rest of the image shows the clinicians viewing that footage and engaging in practice reflexivity. When they were given the opportunity to reflect on this event using video footage in this way, the clinicians realized that their touching ICU technologies and instruments may have compromised the barrier precautions that they set out to achieve. As they reviewed the footage of this event, they talk about how to prevent similar problems from re-occurring. Could they prepare their trajectory better? Could they identify someone to alert other ICU clinicians to the patient needing to be moved, and ask them to clear the way? Could they anticipate these kinds of problems better by thinking ahead, and by planning their activities in smarter ways?

The above vignette highlights the essentials of VRE. Using VRE, we approach care as a locally unfolding dynamic process. This process is captured on video and prepared for feedback in the form of short clips. Participants in the process and their colleagues are invited to review the resulting footage. Their involvement in this process serves the purpose of enabling them to identify the aspects of practice that they have started to treat as given – that is, seeing their activities as normal, natural and necessary.

The expression 'taken-as-given' is often used in VRE to refer to activities that have become not just habituated but *invisible* to the actors – the clinicians or the patients – themselves. While not all our habits are necessarily invisible to ourselves, some we have learned to find no longer remarkable. These are the habits we now treat as normal, natural and necessary. These are the habits that we tend to justify in the face of challenges because they provide anchorage for who we are and how we are with others. In short, these are habits that we have decided or learned *to forget*.

VRE invites professionals and patients to approach care as that which results from our actions and intentions, as well as from habits that we no longer see reason to question. Our activity harbours many such habits, and such habits may underpin activities that are suboptimal. VRE grants us opportunities to reassess and reshape precisely those dimensions of our own behaviour that otherwise remain inaccessible (Iedema et al., 2013). VRE targets these dimensions of human behaviour because they define, shape and constrain how everyday care unfolds. Where other endeavours regard behaviour as a manifestation of professional culture or personal psychology, VRE approaches it as a facet of practice – that is, of how people are and work together. VRE targets behaviour on the view that people rarely get the opportunity to scrutinize themselves and each other in action,

and that this denies them the opportunity to reshape their behaviour, to become more intelligent about their behaviour and to orient their behaviour better to the exigencies of everyday patient care.

The remainder of this chapter introduces this book and its contents. This chapter will also expand on the role and rationale of VRE in relation to the existing healthcare research literature, and the relevant theoretical and methodological literatures. Finally, the chapter will explain how to navigate the applied and theoretical contents of the book, before finishing with an overview of each of the book's chapters.

## 0.1 WHY THIS BOOK?

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The field of healthcare improvement includes endeavours as varied as patient safety research, quality of care research, clinical practice improvement, health service research, health policy reform and implementation science. This book keys in to this array of endeavours in the following ways: first, without tying itself to any one of these types of research and improvement, VRE may unfold in ways that have relevance for one or more of the endeavours just listed. This is because VRE is agnostic about how to label an aspect of practice on which front-line professionals and their researchers or facilitators may decide to concentrate. Using VRE to address different staff members' understandings about and approaches to using clean and sterile gloves, for example, may have relevance for patients' safety, for the implementation of infection control (and hand hygiene) guidelines, for practice improvement and so on.

Second, most endeavours that are currently in use to achieve improvements in health care start with the assumption that specialized knowledge must be the first step towards change. These endeavours operate on the principle that specialists and experts are needed to produce formalized knowledge about what is going on. An example of such specialized knowledge is 'statistical process control' (Hart and Hart, 2002), which is a statistical analysis of everyday processes relying on numerical data about patients' movements, bed occupation and so forth. Such knowledge is reliant on elaborate kinds of reporting and analysis, and its conclusions need 'translating' back into everyday practice. This knowledge translation model is ubiquitous across most if not all areas of healthcare improvement, quality, safety and so forth. To be sure, the knowledge translation model may be suited to the improvement of those facets of care that are relatively technical and automated. Here, we can think of the more or less standardized dimensions of pharmacy, radiotherapy and nuclear medicine (Vincent and Amalberti, 2016). We acknowledge that even these three areas can be complex – think, for example, of pharmaceutical practices in palliative care which are far from simple and standardized. Yet such areas may nevertheless be amenable to being structured and organized according to generalized and more or less stable knowledge.

While few if any aspects of medicine are fully iterative and mechanical, and few are completely chaotic, some are definitely more complex than others. For example, both paediatric and geriatric patients are now displaying quite

complex disease patterns due to our ability to raise life chances for a greater number of patients. A paediatrician who attended one of our classes recently said, ‘On my wards I see increasing numbers of young patients with respiratory problems that are so complex that I feel unsure about not just how to treat them. I am also unsure about how to teach students on placements about what is going on in my ward’. The complexity that is inherent in these patients’ care means that professionals increasingly face care situations where novel ways of moving forward need to be devised and negotiated. This means that generalized knowledge now increasingly needs to be contextualized with knowledge of local circumstances, contextual constraints and emergent opportunities. The people who have access to these latter kinds of knowledge are not necessarily clinical specialists or experts, but people who know about patients’ situations and who understand what may be necessary or preferable (Fitzsimons and Cornwell, 2018). Here, we can think about how we negotiate patients’ end of life, about where and how they die and about whose knowledge and priorities are made to count (Collier, 2013).

Third, VRE is deliberately oriented towards giving front-line professionals and patients a say in what needs to be the focus of researchers’ and practice improvers’ attention. This ‘democratic’ underpinning of VRE will reappear as a theme throughout this book. For now, we will only note that this democratic orientation is not ‘just’ politically or ethically motivated, even though that in itself would be more than justified. Indeed, you listen to front-line clinicians and patients talking about day-to-day care, or observe what goes on moment to moment in primary care practices, hospital wards, medical specialties and anywhere else where care occurs, and you realize that front-line professionals’ and patients’ wealth of experience and insight deserves to be made more central to how we think about everything from safety and quality to improvement, implementation and policy reform.

Importantly, VRE’s democratic orientation is also *theoretically* and *methodologically* motivated. We want to involve professionals and patients at the front-line of care because they are the people who are experiencing the complexity of *in situ* care more than anyone else. In fact, we can put it like this: theoretically as well as practically speaking, *in situ* care is the zone of maximum complexity. Experts may talk about ‘complex adaptive systems’ that they describe as happening beyond your reach, but these are hypotheses or imputations. We, by contrast, hold the view that complexity happens in the ‘here and now’ of care, even if this complexity comes about as a result of innumerable influences whose origin may lie elsewhere. If we fail to meet the 4-hour rule in the emergency department, it may have to do with how ambulances are routed, with last year’s staffing decisions, with primary care referral habits or with 30-year-old corridor widths and ward designs preventing appropriate oversight over patient cohorts. The manifestation of these things occurs in and around the care of patients in the here and now.

Enabling those embroiled in these situations to step back and identify the sources of stress, and, if necessary, to look beyond ward and service boundaries, is critical to addressing situational complexity. But ‘the world is seen in a grain of

sand' (Blake, 1863), and too often do we ignore the sand around our feet in preference to impressive sounding promises of better shores.

## 0.2 OUR LEADING THESIS

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This then is the leading thesis of this book: *in situ* care is the zone of maximum complexity. Front-line clinicians and patients and their families inhabit this zone of maximum complexity day in and day out. By the same token, experts, researchers, business consultants and managers tend not to be party to that zone of maximum complexity, because they don't work there and spend little to no time there. They may wield symbols and representations about care (in the form of reports, data, statistics and narratives), but symbols and representations do not equal lived reality. Put differently, 'the map is not the territory' (to use a phrase coined by Alfred Korzybski (Kodish, 2011)). What the map lacks is a rich experiential dimension that only comes to life when we participate in the day-to-day unfolding of care.

To be sure, we do not want to dismiss the significance of analyses based on reported data, or of guidelines derived from such analyses setting out courses of action, or of expertise anchored in experience expressed through narratives or consensus guidelines. Yet we are conscious that contemporary care is frequently so complex that professionals and patients are more often now than ever obliged to update the ways they do care and devise novel ways of moving forward. A patient may wish to die only after having glimpsed the ocean. Parents of a severely disabled baby may wish for the baby to be kept alive against the advice of doctors. Collectively, professionals, managers, service users, policy makers and the public are now obliged to contemplate and venture into new domains where they may have to consider doing the not-yet-done, saying the not-yet-said or thinking the not-yet-thought.

This last point positions front-line professionals and patients as critical players in everything we do in health care: they inhabit this zone of maximum complexity. Admittedly this maxim – 'frontline professionals and patients are critical players in healthcare improvement' – is becoming increasingly prominent now in healthcare reform, health services improvement and implementation research. Clinicians are indeed more and more involved in practice improvement in one way or another; patients are surveyed and interviewed to within an inch of their lives, and outcome measures are now structured to reflect everyday experiential as well as clinical-technical priorities (e.g. 'patient reported outcome and experience measures').

But the everyday experiences of professionals and patients are not yet commonly or comprehensively allowed to inform or structure healthcare improvements, implementation programmes or healthcare policy reforms. People's narratives are becoming more prominent in online websites, interview quotes are now sprinkled throughout reports and videoed comments are more prominent in formal presentations. But only rarely do front-line professionals and patients get the chance to articulate and shape their views, feelings, ideas and insights together, and negotiate what is good and what may need to be changed, and how and why, *on their terms*.

### 0.3 VRE AS NOVEL PARADIGM

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We outlined the reasons for why VRE turns existing paradigms on their head. VRE's point of departure is the view that front-line professionals and patients and their families know everyday care by living it every day. They inhabit the zone of maximum complexity. They are a critical source of insight into the local ecology of care provision that unfolds there. The term 'ecology' refers to the complex historical, local and contextual facets of how care is provided by specific services. Each service is different due to the different ways in which technologies, guidelines, pathways and policies are put to use. Local people know their own services like no other, and their knowledge is critical to rethinking how care is to be provided. Their knowledge may not always be explicit and articulate, but it will certainly be fully embodied and deeply sensed (Iedema et al., 2018). VRE capitalizes on their experiences, feelings and insights.

VRE is further different from other improvement approaches because it acknowledges that 'life is outrunning the pedagogies in which we have been trained' (Fisher, 2003: 37). We have grown up with closely held assumptions about knowledge, authority and value that may no longer be in sync with the modern world. The modern world moves too fast for us to maintain old ways of knowing and learning. We need new approaches to running and shaping our lives, routines, habits and practices, because leaving these things to chance is now too risky (Iedema et al., 2018). For that reason, VRE presents a new research paradigm that functions as pedagogy, as a new way of learning about the world, starting from everyday *in situ* care and from those who populate and embody that care.

Giving primacy to 'what is', and to those populating it, VRE does not seek out specific kinds of data to suit specific kinds of analysis, other than footage and actors' interpretations of that footage. In that sense, VRE is not so much a qualitative methodology, as a 'post-qualitative' form of inquiry (Lather and St. Pierre, 2013). For St. Pierre, post-qualitative *inquiry* or *research* moves away from linear programmes and methodological rigidity, towards more creative approaches that allow for more possibilities in understanding and reshaping practice (St. Pierre, 2014).

As post-qualitative methodology (Wyer et al., 2017), VRE is open to different levels of participant–researcher engagement (Carroll, 2009). VRE produces video footage *and* reflexive discussion about 'what goes on', in collaboration with those who inhabit practices and services, the professionals and patients and their families. VRE's success depends on these stakeholders' enthusiasm and participation, but it welcomes a wide array of researcher–participant configurations (Carroll and Mesman, 2018).

Likewise, VRE may involve upfront agenda setting ('This project is about infection control', or 'We'd like to work with you on your clinical handovers'), or it may be fully clinician- and patient-driven (Iedema and Merrick, 2008). VRE may position the researcher(s) as the person(s) to select the resulting footage, or this selection may occur on the advice of, or be entirely under the control of, clinician participants. We, by no means, dismiss the significance and challenges



of working through these kinds of decisions and negotiations, and they will be addressed in detail throughout what follows. For now, we will only state as ideal that VRE hands the reins as much as is practically possible to those professionals and patients who regard viewing footage of their practices as an opportunity to enhance their agency in relation to how care is done from moment to moment.

Most likely, those who participate in VRE projects are people interested in exploring their own roles and responsibilities for how care happens in the here and now. They are people who are adventurous enough to do so. They essentially venture into a zone where the complexity of the 'here and now' is framed as a dimension of how they are with one another, how they work with one another, how they speak to one another, how they organize care together and how they feel about one another. This zone also confronts them with the aspects of their behaviour that may be below their level of awareness: (how) do they perform the expectations that are inherent in their organization's culture, systems, rules, identities, relationships and practices (Iedema et al., 2018)? They are people who are open to acknowledging that changing anything in health care is contingent on whether and how they can connect the change to their existing ways of working, and whether they regard the change as logical, reasonable, warranted, feasible and understood in similar ways by those with whom they work.

This brings us to the end of our initial introductory statement. Each of the points made here will be revisited in the chapters that follow. We will provide examples and offer advice based on the many studies we have thus far conducted and are currently conducting. What remains most central in all of this, however, is our basic philosophy, which can now be summarized and expressed in terms of the following four themes.

First, *in situ* care is the zone of maximal complexity. Clinicians and patients are most closely involved in care: they *embody* this complexity, and they are therefore the people who are critical to learning about and intervening in that complexity. Second, as outsiders and 'alongsiders' (Carroll, 2009), we the researchers collaborate with front-line professionals, patients and their families, in their quest to illuminate the ecology and complexity of care. Third, engaging professionals, patients and their families with footage of everyday care practices gives them the opportunity to reflect on and clarify what they do, how they do it and why they do it. Fourth, all this is contingent on the (psychological) safety of VRE participants. This safety results not just from being respected for adopting a reflexive stance but also from stakeholders in the service and the wider system respecting and acting on the wisdom embodied and articulated through this process.

In the remaining chapters, we frame these themes in the form of four principles: *exnovation*, *collaboration*, *reflexivity*, and *care*. The term 'exnovation' was promoted first in our 2013 book on VRE (Iedema et al., 2013). There, we explained the importance of front-line professionals themselves focusing on their practices, and thereby deriving and designing change. This bottom-up process we referred to as exnovation, to contrast it with innovation, or expert-directed change imposed from the outside or from the top down. The term 'exnovation' combines excavation with innovation: looking more closely at what is to identify opportunities for change, rather than looking farther afield for solutions.

Collaboration undergirds VRE in that professionals and patients are invited as participants from the moment an initiative or project is to be conceived. They are experts in the everyday unfolding of care, and their habits, assumptions and expectations are the anchors of that care.

For its part, reflexivity is central to VRE also. Reflexivity is to be distinguished from reflection. We regard reflection as a personal activity that focuses the individual on their past thoughts and actions. Reflexivity, by contrast, is a shared, social deliberation about existing circumstances and practices such that these are apprehended from new perspectives and in new ways. This creates the possibility not just for new insights but also for new identities and new social and organizational realities (Iedema, 2011).

Finally, care is the pre-condition of VRE per se. Without care, the collaborative, creative and practical dimensions of VRE cannot be realized. Participants need to feel safe, respected and valued to devote themselves to scrutinizing footage of their own ways of working, and to speaking openly, honestly and creatively about their own assumptions, habits, values and views. These four principles have important implications – methodological, political and ethical – and we will touch on these throughout the book.

## 0.4 CONTENTS OF THE BOOK

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Chapter 1 is designed for academic audiences who are interested in the theoretical links and underpinnings of VRE. Chapter 2 equips you with the necessary tools, processual knowledge and tips to fund, plan and obtain ethics approval for VRE in a healthcare setting. Chapter 3 focuses on participant recruitment for VRE projects, videoing processes and practices and the role of visual analysis in VRE. Chapter 4 prepares you for the techniques and strategies that are at the heart of videoing *in situ* practices. Chapters 5 and 6 focus on the dynamics and facilitation of video-reflexive sessions. Chapter 7 describes the challenge of evaluating VRE projects and achievements. Chapter 8 addresses the issues that arise when you want to publish or present about your VRE project. Chapter 9 concludes the book by returning to the more theoretical and philosophical underpinnings of VRE.

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## 0 Introduction

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