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ETHNOGRAPHIC AND OBSERVATIONAL RESEARCH IN THE HEALTHCARE SERVICES: CREATING POLICIES IN DEMENTIA CARE

Carlo Lazzari*

*International Centre for Healthcare and Medical Education (ICHME), United Kingdom

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Abstract

Patient-centered care is becoming one of the primary targets in treating people with dementia. The current study aims to explore some of the advantages of conducting ethnographic observational research to investigate staff behaviors in clinical settings treating patients with dementia. Furthermore, one of the significant motors of quality of care for dementia is a successful partnership in multidisciplinary teams and teamwork. However, to create policy paper to regulate group skills and behaviors, standard interviews and quantitative research might not help in discovering target manners, attitudes, and skills especially if there are strict regulations that penalize professional negligence. The same applies for capturing personal accounts on behaviors by using standard interviews. In this case, the actor of targeted actions and skills might not like to disclose personal errors for fear of retaliation. Hence, ethnographic research by a participant observer might be the only viable option in capturing teamwork and organizational behaviors in dementia care. The writer works in dementia wards in a clinical role, therefore, by regular participation into wards and clinical activities he was able to outline the required policies and principles regarding behaviors in patient-centered care.

Introduction

In the current article, the author will illustrate how the ethnographic research method with observer as the participant can be used to perform quality assessment of interprofessional teamwork working in dementia and to generate policies for improving multidisciplinary teams. As the policies in dementia care also tend to promote desired behaviors of multidisciplinary teams, ethnographic research by a participant observer might be the only viable option in capturing teamwork and organizational behaviors that should be addressed by policymakers. Other research methods using more structured interviews and surveys might not be able to capture real conducts in dementia teams. In fact, these behaviors develop during the regular clinics, actions, and performances and there might not be clear policies on how to participate in joint care pathways. Indeed, one of the significant motors in patient-centeredness in dementia is the application of collaborative practice in interprofessional teams. As defines by Barr, healthcare workers who participate in interprofessional teams learn 'with, from and about each other.'[1] Besides, interprofessional learning is facilitated by collective knowledge of people cooperating in a small team.[2] By progressive cooperation in interprofessional teams, healthcare professionals working in dementia have also the opportunity to refine their emotional intelligence and empathy skills which diffuse in the whole team, hence reflecting in improved skills for patient-centered care. In fact, through emotional intelligence healthcare professionals can develop better compassion towards their patients.[3] Emotional intelligence is described as the aptitude to use emotions and the awareness about emotions to improve thinking.[4] Hence, the result is a professional behavior that satisfies quality requirements in dementia care. However, using policies to increase health carers' ability to do more complicated jobs does not indicate that these abilities are put into practice.[5] The strategy to approach dementia wards and workers by observing their behaviors and skills appears more appropriate due to significant biases in surveys and questionnaires. Besides, the Hawthorne effect

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suggests that the observer should already be part of the experimental team to avoid observational biases. The author's observations focused on the dementia wards where he was already working. This prerequisite will reduce the likelihood that the observed people alter their behavior because an outsider is collecting some data on them. Hence, ethnographic research helped the author classify the stages of development in partnership aiming to reinforce teamwork and patient-centered care in dementia. Germain (2001) suggests that ethnographic research helps to discover the unspoken as well as the overt aspects of a specific culture[6]. Besides, ethnography assists in determining the common interpretation of what is essential and significant to people under observation.[6] As healthcare assistants perform most of the work in nursing homes and dementia wards, ethnographic research has focused on their actions with researcher as active participant.[7] However, as ethnographic research uses disengaged observations, these are subject to the researcher's bias and have partial reliability when treated as isolated data.[8]

Methods

The method included ethnographic research with the author as a participant observed. Field notes were commented while an inductive approach helped in the translation of the observations into policies in dementia care. In fact, the author works in the healthcare system and has an interest in dementia care. Subsequent observations allowed the collection of behavioral and procedural strategies in collaborative practice and patient care. The observations were conducted for about eight hours daily for two months in several dementia wards of different hospitals. Data were also collected retrospectively after the author left the hospitals to work for different organizations. To comply with ethical requirements, no data are disclosed to identify persons, organizations, or professions involved in the observations.

Results and discussion

To be a model of care, a framework needs to be observable, measurable, and repeatable. If it is not observable, then it belongs to psychological and personal attitudes of healthcare professionals and, therefore, it cannot be regulated. If a model is not measurable, then there cannot be any conclusion about its frequency, intensity, and occurrence. If the model is not repeatable, then the skills or behavior observed represent either an exception or an anomaly and, therefore, more detailed analysis and observations are needed to understand the nature of the behavior underlying the observed model of care. In the current project, the author proposes several indicators to signal that partnership in dementia care was achieved, and that patient care was centralized. These indicators are developed out of the outcomes in the ethnographic observations. The need to approach dementia wards and workers by observing their behaviors and skills appears more appropriate due to significant biases in standard surveys and questionnaires. Besides, the Hawthorne effect would indicate that the observer should already be part of the experimental team to avoid observational biases. The observations focused on several dementia wards where the author was practicing as a doctor. This condition reduced the likelihood that the observed people/sample could alter their behavior because an outsider was collecting some data on them. Ethnographic research is usually applied to classify behaviors that cannot be anticipated by the existing research.[9] Furthermore, ethnography provides a more detailed and up-to-date explanation collected via extended observations and exchanges with target populations in their setting and with the opportunity to test hypotheses in their vigor also using extended site visits.[10] However, what appears central in conducting ethnographic research in dementia wards, is the development of appropriate observational checklists that help define the application of models of care without the interference of biases (Box 1).

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Box 1- Observational checklist in ethnographic research in the health system

- Is the observed behavior a regulated or spontaneous behavior for responding to the situation and patient condition?
- How does the institutional philosophy affect the observed groups' and individuals' behavior?
- What regulates people's behavior in a specific context that is observed?
- Does the observed behavior in teamwork develop according to the influence of patient and organization?
- What can be observed as being more relevant for people working in the organization and concerning patient care?
- Does what observed in the behavior represent the true nature of people or, instead, the observer's presence somewhat influences it?
- What is concealed and what, instead, is approved in the observed behavior of the health organization?

Besides, due to severe consequences of behaviors that do not conform to the organizational guidelines, the active participants might not openly acknowledge (hence disclose in surveys) that that behavior exists. Besides, people who act the observed behavior might not be aware of what is professionally required from them regarding their actions. Hence, due to its neutrality and the natural detachment between the observer and observed, ethnographic research can portray behaviors in their dynamics, also standing on the theory of communication where non-verbal behavior conveys about 65% of the content and intention of a message or information. Other times, workers in an organization might declare the goodness of their acts while, instead, these actions already have some element of conflict with national or local guidelines in dementia care. Moreover, quality assessment by a national organization is usually conducted according to observed parameters in care, like, self-neglect of patients, conditions of premises, workplace bullying, teamwork, work climate, dementia-friendly wards, and so on. All these aspects are observable thus approachable by observational ethnographic research. Some of the advantages of ethnographic research are explored in Box 2.

Box 2- Advantages of observational ethnographic research in the quality analysis in dementia care

- The observed behavior conflicts with what is verbally disclosed during standard interviews.
- The observed behavior represents the skill to be analyzed and cannot be explored by verbal accounts.
- As patients in advanced stages of dementia might have problems in communicating verbally their emotions and needs, their behaviors usually represent the more reliable account of their needs and reactions to the care provided.
- There might be local or professional regulations which restrict the disclosure of conflicts with local policies and any personal breach of it.
- Penalties for unapproved behaviors might be harsh so that people might not openly confirm that a certain behavior occurred or that certain skills were applied.

Another aspect which indicates the priority of observational ethnographic research over other research methods is the study of teamwork, group behaviors, and interpersonal interactions. As dementia care is a collaborative practice between many specialists and professional figures, it is difficult to record the dynamics of their interactions if each member of a team is approached individually. Instead, the main target of ethnographic research in the health care are groups of persons that are usually oriented towards community concerns.[11]

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Conclusions

Any model of health care can receive a quality assessment by ethnographic research. In fact, frequently, the topic to enter a quality assessment are observable conducts, behaviors, skills, and actions. For instance, the classical ABC model (Dryden, 2012) states that when persons are exposed to some events (A), they develop a series of beliefs about these events (B) which determine their psychological and behavioral response to them (C).[12] Hence, ethnographic research can focus on the components of behavioral responses in dementia care as these are those that more frequently quality analysis explores, more than beliefs, emotions, and opinions which are not regulated, observable and might not impact on the quality of care. Nonetheless, some limitations exist in the use of observations in ethnographic research which, as in any qualitative analysis, are strongly influenced by the attitudes and skills of the observer, and thus to his or her biases. The author of the current research was focusing on some behaviors which mostly affected partnership in dementia care. However, it does not mean that behaviors different from those observed would achieve other outcomes in patient care.

References

1. H. Barr. "CAIPE: Interprofessional Education-Today, Yesterday and Tomorrow", 2002. [Online] Available at: https://www.caipe.org/resources/publications/caipe-publications/caipe-2002-interprofessional-education-today-yesterday-tomorrow-barr-h
2. A. K. Kwan Ching Wong, F. Kam Yuet Wong, L. K. Chan, N. Chand, F. A. Ganotice, J. Ho, J. "The effect of interprofessional team-based learning among nursing students: A quasi-experimental study." *Nurse Education Today*, 2017; 53:13–18.
3. G. M. Lewis, C. Neville, N. M. Ashkanasy N. M. (2017). "Emotional intelligence and affective events in nurse education: A narrative review." *Nurse Education Today*, 2017; 53: 34–40.
4. J. D. Mayer, R. D. Roberts, S. G. Barsade. "Human abilities: Emotional Intelligence." *Annual Review of Psychology*, 2018; 59:507-536.
5. A. Felstead, D. Ashton, B. Burchell, F. Green. "Skills trends in Britain: Trajectories over the last decade. In: Coffield, F. (Ed.), *Speaking truth to power: Research and policy on lifelong learning.* Bristol: The Policy Press, 1999.
6. M. Montreuil, F. A. Carnevale (2018). "Participatory hermeneutic ethnography: A methodological framework for health ethics research with children." *Qualitative Health Research*, 2018; 28(7):1135 –1144
7. K. Scales, S. Bailey, J. Middleton, J. Schneider. "Power, empowerment, and person-centred care: using ethnography to examine the everyday practice of unregistered dementia care staff." *Sociology of Health & Illness*, 2017; 39(2):227–243.
8. E. Tewell, K. Mullins, N. Tomlin, V. Dent. "Learning about student research practices through an ethnographic investigation: Insights into contact with librarians and use of library space." *Evidence Based Library and Information Practice*, 2017; 12(4): 78-101.
9. M. Angrosino. *Doing ethnographic observational research*. Los Angeles, London, New Delhi, Singapore: SAGE.
10. E. M. Willis. "The problem of time in ethnographic health care research." *Qualitative Health Research*, 2010; 20(4) 556 –564.
11. M. Rashid, V. Caine, H. Goez. "The encounters and challenges of ethnography as a methodology in health research." *International Journal of Qualitative Methods*, 2015; 1–16.
12. O. A. David, S. A. Matu, S. Pintea, C. D. Cotet, D. Nagy. "Cognitive-behavioral processes based on using the ABC Analysis by trainees' for their personal development." *Journal of Rational-Emotive Cognitive Behavioural Therapy*, 2014; 32:198-215.