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Reshaping ICU Ward Round Practices Using Video-Reflexive Ethnography

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In this article, we outline a study method with which structural changes to clinical communication were achieved within a local intensive care unit (ICU). The study method involved in-depth, round-the-clock observation, interviewing, and video filming of how intensivists conducted their practices, as well as showing selected footage to the clinicians for feedback. This feedback component iteratively engaged clinicians in problem-solving their own communication difficulties. The article focuses on one such feedback meeting and describes changes to the morning ward round and planning meeting that this feedback process catalyzed: greater time efficiency, a greater presence of intensivists in the ICU, more satisfied nursing staff, and a handover sheet to improve the structure of clinical information exchanges. We argue that in embodying not a descriptive but an interventionist approach to health service provision, this video-ethnographic method has great significance for enhancing clinicians’ and researchers’ understanding of the rising complexity of in-hospital practices, and for enabling them to intervene in these practices.

Keywords: intensive care unit; ward rounds; communication; video ethnography; video reflexivity

The rising complexity of contemporary health care work means that clinicians need increasingly sophisticated means for organizing the work they do. This is particularly true for clinicians who work with constantly changing medical technologies, who treat patients with multiple comorbidities, and who achieve survival rates once thought to be unrealizable (Brown & Webster, 2004). These developments are conditional on communication among a growing number of specialty groups with diverse skill sets and increasingly complex interconnections (Clemensen, Larsen, Kyng, & Kirkevold, 2007), requiring a shift in authority relationships from apical hierarchies to quasi-egalitarian teams. This complexity is particularly evident in the intensive care unit (ICU). ICU clinicians have to manage and communicate information that is obtained from multiple sources, including a wide range of medical technologies and clinical specialties. This information, moreover, requires integration into team-based kinds of decision making (Nadesan, 2001, p. 262) in a context where knowledge remains “fundamentally ambiguous” (Deetz, 2003, p. 122).

This means, in turn, that clinicians have to communicate frequently. This intensification of communication is inherent in, first, maintaining the growing range of work connections, dependencies, and relationships, and, second, reflecting on and negotiating the processes of communication as well as the substance of the information that is communicated, both of which are central to negotiating uncertainties and challenges. The high degree of local and environmental unpredictability and uncertainty necessitates both functional and what we have termed “heterogeneous communication” among spatially and temporally dispersed members of multidisciplinary medical, nursing, and allied health teams (Iedema, Long, Forsyth, & Lee, 2006). This work necessitates not only excellent clinical competence, but

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also organizational and communicative competence (Iedema, Long et al., 2006, p. 158).

Over the last four decades, the emerging phenomenon of the ICU has become the focus of considerable research attention. Qualitative studies of ICU practices began to appear in the 1960s (Glaser & Strauss, 1965; Sudnow, 1967), with more recent landmark publications mapping the technological developments and growing ethical and communicative complexities that characterize this clinical field (Cassell, 2005; Seymour, 2001; Zussman, 1992). These research efforts have kept pace with the technological, organizational, and communicative developments of the modern ICU. They have initiated new research agendas to critically investigate intensive care practices, mapping their practices in great detail and with great sympathy. By the same token, we suggest that methodologically these inquiries into ICU practice might risk being out of step with the complexities that they are now called on to describe.

Yet health services research, too, is generally slow to shift toward modes of investigation that are better attuned to the service complexities evident in contemporary ICU settings (Grypdonck, 2006). As researchers, we are having to engage with increasingly diversified and rapidly changing contexts: “Rapid social change and the resulting diversification of life worlds are increasingly confronting social researchers with new social contexts and perspectives [and therefore] traditional deductive methodologies ... are failing” (Flick, in Denzin & Lincoln, 2000, p. 9). This is particularly true in technologically advanced domains of health care provision (Clemensen et al., 2007). To come to grips with the processes and practices that define the contemporary ICU, therefore, study methods are needed that make it possible for this complexity to become central rather than marginal to the analytical process.

In this article, we present an approach to research that sought to account for the ICU’s complexity by combining ethnography (observation, interviewing) with video-filming and reflexive viewing of clinicians’ formalized communication practices. The broader project of which this research is a part has been described elsewhere (Iedema, Long et al., 2006). In the present article, we detail the impact on practice of the video-ethnographic and reflexive research methodology, by outlining how, thanks to confronting the full complexity of in situ practice, it enabled clinicians to enhance their communication processes on four fronts. Our main argument is that video-ethnographic research enables researchers and clinicians to work in productive partnerships, providing them with a basis for articulating and thereby rendering negotiable knowledge and practices that clinicians might otherwise take as given.

To explain our approach, we will first provide an overview of research that has been done in the area where our video-ethnographic study made its impact: hospital-based ward round communication. We then move on to consider existing video-based studies of actual or simulated clinical practice, and compare these to video-ethnography as a means for focusing clinicians’ attention on specific details of their work practices. We then outline our methodological approach in greater detail. This includes describing how we collected video-ethnographic data, and how we facilitated the video-based reflexivity sessions with ICU clinicians. The empirical section that follows presents the issues that became apparent on observing and filming this ICU’s ward round communication. This includes recounting both intensivists’ reactions to viewing footage of their own practices and the structural changes that they made to their communications in the weeks following the video-reflexive session.

In its conclusion, our article rearticulates its contribution to research in the fields of medical communication, health services organization, and patient safety. The principal defining features of our work are twofold. First, in using real-time video data for reflexive feedback, we aim to capitalize on the complexity of in situ practices rather than reduce it to abstracted models or simplified case studies. Second, this reflexive feedback becomes possible only as a result of the positive quality of our relationships with clinicians. Here, we speak about the “entanglements” that we develop and maintain with our “researchees.” These two principles guide how we engage clinicians in reviewing real-time visual footage and secure their interest in reflexive learning: the use of in-situ complexity and entanglement with researchees is central to the success of this work, being able to engender dramatic organizational change achievements. The use of video, we suggest, is also crucial here: the visual medium enables clinicians to recognize the distributed, unspoken, and risk-prone dimensions of their taken-as-given sayings, knowings, and doings (cf. MacDougall, 2006). By creating a space for inquiry that goes beyond epidemiological and descriptive approaches to health service provision (Shojania & Grimshaw, 2005) that we believe have limited the impact of research outcomes on in situ practice, this work presents significant interventionist
possibilities for hospital-based research and transformational change.

Background

Medical and Ward Round Communication

Observational research has produced rich descriptions of the “busy-ness” that characterizes clinical environments and practices. This research has shown that clinical routines (e.g., handovers) are hybrids of formal (highly structured), nonformal (i.e., ad hoc and dynamic, as well as medically/clinically focused), and informal (e.g., social and interpersonal) kinds of communication (Atkinson, 1995; Hill, Tyson, & Riley, 1997; Hunter, 1991; Manias & Street, 2001). Particularly in fast-moving environments such as the ICU, urgent events on the ward normally require immediate attention. This puts pressure on social relationships and requires (then or afterwards) much emotional labor (James, 1992). Here, communication practices are essentially heterogeneous: formalities are unpredictably interspersed with ad hoc organizational or “nonformal” as well as informal kinds of communication across areas of professional expertise.

The ward round is one practice as part of which this heterogeneity is enacted (Fox, 1993). Hill et al. (1997) regard the ward handover as a “refuge in a professional sea of uncertainty and change” (Hill et al., 1997, p. 600), having survived several waves of cost-cutting and health reforms. A period of twice-daily formalized hospital communication, the ward round encompasses a host of clinical and organizational functions (Hill et al., 1997). Manias and Street (2001) describe ICU ward rounds’ formal functions as providing a time for health professionals to come together to develop an integrated and improved quality of patient care, share information, address patient problems, plan and evaluate treatment, and provide learning opportunities for staff. Descriptions provided in Atkinson (1995) and Hunter (1991) further demonstrate how the “oral culture” of medicine exploits the ward round for reaffirmation of social roles and hierarchical control, with Hunter (1991) suggesting that ward round interactions are “storytelling events” that inject (narrative) structure into the working day and into educational and supervisory relationships.

Given the importance of medical ward rounds to clinical practice and continuity of care in the ICU, consideration of how they are enacted, analysis of their role in patient safety, and greater understanding of their complex character are crucial.

The ward round’s heterogeneity becomes particularly visible in Carmel’s (2003) study on clinical leadership in the ICU. In this study, the ward round is described in detail and captures how clinicians dynamically provide updates on what has happened, distribute details about admitted patients and clinical plans, negotiate with one another to resolve patients’ speed of progress or decline, and decide on procedures that might need doing and discharges that need to be made from the unit. Carmel’s study is highly detailed and rich, but his representation of ICU events is purely linguistic, and he adopts a descriptive-analytical rather than an interventionist orientation to his research sites. Where Carmel’s approach centers on producing a detailed scholarly analysis, the approach outlined here springs from clinicians’ and researchers’ engagement with visual data and their involvement in reflexive-iterative feedback about that data with the aim to produce self-organized change.

Video Studies of Clinical Practice

Video has begun to be used widely in examining social communications and in situ interactions (Hargie & Morrow, 1986; Hargie & Tourish, 2000). Approaches to video research vary widely, however (Bottorff, 1994). Pink (2001, p. 89) outlines a range of ways in which video research can engage participants, from stylized documentary interviews to modes where participants “become part of the research project.” Although the latter mode is not uncommon in educational and organizational training contexts, it has thus far rarely been used to engage hospital clinicians with the full complexity of their own work.

This is not to say that video has not been deployed in tertiary care settings. On the contrary, video has been applied to a number of fields of specialized clinical practice. In nursing, video serves instructional (Jeffers & Guthrie, 1988), as well as reflexive (Latvala, Vuokila-Oikkonen, & Janhonen, 2000) and research-oriented purposes (Halimaa, 2001). It has, however, remained restricted to issues affecting nursing practice rather than extending to team practice and interprofessional communication. In medicine, video has been used predominantly as a means of quality control of established procedures (Michaelson & Levi, 1997; Santora, Trooskin, Blank, Clarke, & Schinco, 1996), and only sporadically to engage doctors in reflexive practice (Lundeavall, Njolstad, & Aaraas, 1994). Recently, reports have appeared about video being deployed to grasp the complexity of medical practices such as surgery and test-result interpretation (Heath, Luff, & Sanchex...
Svensson, 2007; Klemola & Norros, 2001). Despite these advances in the use of video, the reflexive potential of video has not been mobilized to investigate real-time communications among clinicians working in complex tertiary settings over extended periods of time and with ongoing reconfiguration of clinical teams. This is surprising, not just because communication now ranks highest on the list of causes that bear negatively on hospital patients’ safety, but also because risk severity correlates with the amount of time patients spend in the hospital (Murphy, Shannon, & Pugliese, 2006; Patient Safety and Clinical Quality Program, 2005; Sugrue, Seger, Kerridge, Sloane, & Deane, 1995).

Video is also used in contemporary forms of medical education to provide clinicians with visual feedback about how they interact with patient actors to improve their clinical skills and communication (Dequeker, 1998; Roter et al., 2004). It is recognized that video-based feedback can assist clinicians in tapping into visual and auditory patient cues that are not available through text-based learning (Kamin, Deterding, Wilson, Armacost, & Breedon, 1999). Ker, Hesketh, Anderson, and Johnston (2006) go one step further, in that they use video footage of ward-based simulations to create an environment for junior medical staff to learn about clinical work and communication, and to provide feedback about students’ practical assumptions and responses. Similarly, simulator-based human factors training increasingly focuses on complex team dynamics. Although this use of video is taking important steps toward reflexively engaging clinicians with practical complexities, two drawbacks remain. First, video reflexive feedback is as crucial as a quality improvement technique for established teams and senior clinicians as it is an important component of junior staff training. The importance of reflexive practice does not diminish once students graduate. Second, video simulation relies on generalizations about how ward dynamics, team practices, and patient treatments unfold. This reduces video simulation to engaging learners in reflecting on their enactment of set procedures rather than confronting them—as does video-based ethnography—with the heterogeneity that is at the heart of in situ practice.

In contrast to these approaches, we present a research methodology that draws on visual footage of actual, in situ clinical practices in complex tertiary environments to engender clinician reflexivity. Unlike approaches that focus on making practice more rule-convergent and communication more accurate in its exchange of pre-established information (Coiera, 2000), the video-ethnographic study outlined here captures and exploits the dynamic negotiation of information and the heterogeneity of ward-based communication. Our approach is based on the assumption that the simplifications inherent in simulation deny learner-practitioners the opportunity to confront in situ complexity in ways that suit and benefit their own learning focus, style, and pace (Boud & Miller, 1996).

The ICU Ward Round and Planning Meetings

The field site for this study was an intensive care unit in a metropolitan tertiary referral and teaching hospital. The hospital has approximately 800 beds, and serves as the adult and pediatric tertiary center for 840,000 people. The general ICU has 14 funded, ventilated beds; additionally, there are four cardiosurgical beds and four HDU (non-ventilated) beds. The unit has approximately 2,170 admissions per year, with an average length of stay of 3.03 days. Staffing includes 6.2 full-time equivalent (FTE) medical specialists (intensivists); 5 FTE trainee medical specialists; 115 FTE nursing staff, plus allied health staff. Care of the patients in the unit is also provided by the admitting medical officers and their team, with whom ICU shares care.

The admitting medical team usually visits the unit during their daily rounds, most commonly twice during the morning. The larger of the two ward rounds takes place at 8:00 a.m. outside the glass partition of the patient’s room, with clinicians scrutinizing the patient, the records, and the monitors on machines, and discussing issues (cf. Murray, 2000). The trainee specialist (registrar or fellow) presents a report of the main clinical developments and overnight occurrences to a mixed group of clinicians who include specialist intensivists and trainees, nursing staff, and allied health professionals. There is usually dialogue between junior and senior medical staff, with occasional nursing input and with rare input from allied health, as also noted in Hill, Tyson, and Riley’s research (1997, pp. 596-597). This dialogue centers primarily on the junior medical staff displaying their memorized knowledge of medical histories, test results, biochemistry, and patient symptoms. Their performance centers on displaying their ability to organize and present this information in the form of “a recognisable clinical story” (Hunter, 1991, p. 7).

The second meeting is referred to as the “daily planning meeting.” The daily planning meeting is
attended by medical staff, the in-charge nurse, and social worker in a small meeting room adjoining the main ICU. The meeting’s duration is between 30 and 90 minutes, and each patient in ICU is discussed in-depth by senior and junior medical staff. The “appearance” of the daily planning meeting is different from the ward round: Rather than a rapid information update, the planning meeting centers more on problem solving, planning, and teaching. The clinicians noted that the meetings were enacted in different spaces, at different times, and sometimes with different people, but they described both meetings as handovers. Interestingly, the practical differences between the two meetings only became evident following our in-depth interviews with staff, and during our video-reflexive sessions, enabling us to link what was said in the meetings to where and when they took place, and with whom. Before elaborating on these elements of our study, we will describe how our study unfolded.

The Study Method

Prior to the medical communication reflexive session held with ICU medical staff, 12 days, or approximately 193 hours, of general ethnographic observations were undertaken in a general ICU located within a regional tertiary hospital in New South Wales, Australia. Of this time, 7 days were “24/7” observations. These observations were undertaken by a team of three researchers who observed and recorded ICU practices around the clock for one whole week, both day and night (Long, Carroll, & Nugus, 2005). This intense practice of participant observation provided not just content for subsequent field interviews with clinicians, but also served to establish trust relationships. Further, a significant amount of time was also spent prior to the study by a local clinician (also a study investigator) who helped promote and explain the study to ICU staff. This contributed to the building of trust and smooth entry into the unit by the research team, and ensured that researchers and clinicians were mutually involved in negotiating the terms of research. The research project occurred at a fortuitous time: the ICU had undergone recent upheaval and management change, leaving fertile ground for the changes that arose from the present study.

The 24/7 observations captured medical ward rounds, planning meetings, nursing handovers, and clinico-organizational tasks such as staffing allocation and rostering, allied health practice, and nonformal, yet clinical-organizational, “corridor” communications (Long, Iedema, & Lee, 2007; Zimmerman, Lindberg, & Plsek, 1998). Field interviews involved semistructured and unstructured opportunistic interviewing with medical, nursing, allied health, and clerical staff. All observations and field interviews were transcribed from handwritten notes into computerized files.

After just 2 days of continual observation and interaction, the ICU staff indicated that they were happy for filming to commence, provided this was done in accordance with the agreed protocols for the project. Staff agreement to be filmed later turned out to be motivated by their previous discussions about the communication problems that affected the department before the commencement of the research project. Eight, 1-hour formalized medical communication periods were recorded using a handheld, digital video camera, by the primary researcher. This footage formed the basis of a DVD that was edited for the purpose of being shown at the reflexive session discussed below. This footage encompassed four ward rounds, four daily planning meetings, and two periods of general interactions in the ICU. All filming was overt: it was done with the knowledge of and with consent from all ICU staff who appeared within the frame of filming. Although aware of the filming, most participants appeared to ignore the camera.

Eight hours of video data capturing formal medical communication were coded by the primary researcher. The two key questions asked by the researcher during coding were, “Who is and who is not speaking?” and “What information is being communicated?” Three themes emerged. The first was “big picture”; this included talk of patient trajectory and medical diagnosis. This knowledge was generally held and communicated by senior intensivists without much input from junior and other staff. The second emergent theme was “small detail”; that is, current individualized physiological knowledge of each patient, which was reported by junior doctors. The third theme was the lack of a multidisciplinary voice, evident from an absence of allied health professional talk time in the recorded video data. The footage produced from this filming that was then considered for the DVD was chosen using the guideline that footage was representative of the emergent themes. Clips that had inferior sound or visual quality were then excluded from use in the reflexive DVD. The reflexive DVD was constructed from remaining clips, with each DVD track portraying one of the three aforementioned themes. Ethical judgments also guided which clips were selected for thematic representation, leaving out
material that was inappropriate or problematic in view of existing tensions and dynamics in the unit. These sensitivities, aided by arranging previews of the DVD of potentially problematic visual choices with relevant team members who might be affected by them, made it possible to produce DVD footage that engaged the whole team and ensured clinicians’ continuing collaboration with the study.

The resulting DVD was 10 minutes in length and contained three different tracks. The first track detailed two ward rounds, where junior medical staff present at the two different ward rounds. The first track included typical communication between junior and senior medical staff. To stimulate reflexive discussion, the second track shows the daily planning meeting, with edited clips of both intensivists (senior medical staff specialists in intensive care medicine) and junior medical staff reflecting on the planning meeting’s efficacy. The third track presents an edited interview with an intensivist speaking about the ad hoc approach to communicating with allied health colleagues during the ward rounds and daily planning meetings. Participants gave consent for their footage to be included in the DVD. The reflexive session was video-recorded as well, and the footage of this session constitutes the data for the present article.

A Video-Reflexive Session: Analysis

This section reports on the video-reflexive session, and is divided into two subsections. First, we outline the tensions that ICU clinicians articulated about the purpose, length, and complexity of their handover meetings. Second, we turn to describing clinicians’ responses to how we visualized the communication complexities affecting the ICU ward round and the daily planning meeting.

Purpose, Length, and Complexity of Clinical Meetings

The ICU ward round and the daily planning meeting were both considered to be essential to patient care. Interviews revealed both the ward round and the planning meeting were characterized by the ICU doctors as being about updating of cases, problem solving, planning, and educating students. However, our observations showed the meetings meandering from patient details and their trajectory of care to scheduled or required tests and procedures, potential admissions to the unit, recounts of the most recent medical emergency team (MET) calls, and the quizzing and education of junior medical staff. Subsequent interviews revealed that clinicians themselves felt there was limited focus on clearly delineating the different dimensions of what needed to be communicated. Most problematic, junior clinicians were not apprised of “big picture” patient issues, enabling them to come to terms with what were often complex patient cases, to plan and prioritize their tasks. As one intensivist commented shortly after we commenced our research:

... for the junior staff, for everyone, there is a lot of information to take in for the whole unit. The specialist covers the whole unit, there is a lot of stuff you need to be aware of and checking, so you need to know the important things, but you don’t want to know the things that aren’t important. That’s often a bit of a problem as well.

Nurses, too, mentioned the need for concise meetings that disseminated knowledge in a more structured fashion:

Registered Nurse: Planning and staffing, it’s like, I shouldn’t say this but it’s dangerous for patient safety. Doctors go on a planning meeting every day. They do a round then spend about 1 to 2 hours away. ... You just have to wait till they come back.
Researcher: Would you call them still?
Registered Nurse: Yes, they’d come if we need them. Researcher: Are you more reluctant?
Registered Nurse: Oh yes, we wouldn’t ring unless it was something urgent ... so much time is wasted unnecessarily.

Doctors themselves felt considerable frustration about these time inefficiencies, too, pointing to a commonality among both doctors’ and nurses’ concerns, and suggesting to us this was an important issue to pursue in the feedback meetings. A related reservation on the part of the nurses was the absence of medical staff in the unit or by the bedside because of their meetings:

Doctors spend very little time at the bedside, then disappear and make decisions in an office. They should do increased discussion and assessment at the bedside.

In the morning, 8:00 a.m., doctors do a round. They get a handover from the night doctor. For 2 to 2.5 hours they are in the meeting room, from 8:00 a.m. to 10:00 a.m. Therefore no doctor is in the trauma unit and there is only so much you can do as a nurse.
In sum, the frustration expressed here centered on two issues: the unstructured character of the meetings, making it difficult for junior staff and new shift staff to master the handover practice, and the protracted nature of the meetings, rendering doctors inaccessible to those continuing the work on the ward.

**Video Reflexivity and New Ways of Seeing**

The video reflexive session described here lasted 90 minutes, with ten intensivists attending. The researcher structured the sessions around the following three questions (see Figure 1): “Given the multiple functions of the two formal communication periods, what are the clinical-organization functions of the ward round in this ICU?” “How are these functions different from those that characterize the daily planning meeting?” and “Given the complex and large amounts of information generated in a constantly changing environment, how is information pertaining to the ‘big picture’ (patient trajectory, diagnosis, treatment, and ventilation progression) and that pertaining to ‘small detail’ (physiological monitoring knowledge) currently conveyed between junior and senior medical staff?”

As soon as the DVD ended, discussion and debate erupted spontaneously. On viewing the DVD of their communication practices, the medical staff realized how much their meetings lacked in order and structure. With regard to the handover meeting, one intensivist commented:

I . . . realized there was quite a complex flow of information going on as there were several contributors about each patient but there was talking at different levels about different things, there were fragments of things that people needed to say and then the big picture about this, and then suddenly a small detail issue . . . and they leapt from one to the other and then back to the big picture. There is no build up . . . they just get thrown in as fragments from one to the other.

Intensivists also commented on the confusion apparent during the daily planning meeting:

There was also the planning situation going on at the same time, what was happening with this patient suddenly turned into what we are going to do with the patient.

The footage enabled the clinicians to appreciate the intricate nature of the contributions made by both junior and senior medical staff during the meetings: they mixed physiological details with broader patient trajectory planning issues, and these discussions were interrupted by phone calls, pagers, and visits from others, as well as being interspersed with educational transactions. Visually displaying their multipurpose, fast-moving, and often-interrupted communications to the clinicians helped them to once again appreciate the complexity of their own practices and what this might mean for junior staff:

The things that I was noticing . . . was this is quite daunting for the junior doctors. I realized there was a semicircle of people standing in front of them . . . it looked quite an intimidating situation . . . they were forced to try and create and maintain people’s attention . . . they had to put on an act to try and get people not to be bored . . . Other people were struggling to maintain interest by bed 14 . . . Not only is it a daunting role but to have to put on a show to try and get people to listen to them . . . I hadn’t realized it was an acting skill as much as a communication skill.

This statement, we suggest, is evidence that this clinician is enabled to articulate a new way of apprehending his own practices. As the intensivists themselves acknowledged, this new apprehension is achieved
thanks to them being confronted with video footage that does not edit out the complexity of their practices:

One thing that struck me from watching the video is the endless interruption.

It just showed what a shammozel it is because you couldn’t even hear it half the time . . . it’s the worst of what it is actually like, and it’s like that a lot of the time.

Besides commenting on the importance of taking in the content of the footage, the clinicians also gave indications of the dramatic impact of watching the footage: “I learned something and it only took 15 seconds.”

This type of realization is at the heart of the video-reflexive methodology. We suggest watching the footage of our own practices can have a dramatic effect on how we experience our own practices. The point at which watching footage of one’s own practices can have such dramatic effect, in turn, is important for understanding the impetus that clinicians gained from the reflexive feedback session, and for explaining the array of initiatives that flowed forth from it. We turn to outlining the latter changes in the section that follows, and we will return to the former issue of impetus in the article’s concluding discussion.

**Structural Changes to Medical Communication**

Changes to the ward rounds and planning meetings occurred within the 2 weeks that followed the clinician video-reflexive session. The ward round and daily planning meeting were restructured, and a new documentation system called the “ICU daily worksheet” was implemented. A nurse unit manager who saw the impact of the changes from the outside, commented to us:

The lessons are valuable to us. Since you did that with the medical staff we have had a complete turn-around with how they do the morning handover. Where [name of the director of the ICU] was having a big challenge in getting them [the intensivists] to come up with consensus and agreement about needing to change they are now willing to try and have changed the way they do their morning handovers. They get on with the day . . . they see the patients. Then at 12 o’clock when they have examined the patients and seen all the things . . . the patient with the X-rays, with the bloods, they come together to confirm their plan. In one week it is amazing. They see the X-rays in continuity with the patient, they teach while they are doing. The light globe came on. How successful was that—letting them see themselves! It’s amazing. It’s exactly the way that we’ve been asking them to look at changing. One exposure to seeing themselves . . .

First, the ward round was split in two and occurred concurrently in the two sections of the ICU. Half the intensivists and junior doctors would attend one ward round at one end of the ICU, dealing with up to seven patients, and the remaining clinicians would attend the other half of ICU patients starting at the other end. This reduced the burden of the communication in three ways: it halved the number of people present; it more than halved the time the medical staff were engaged in the ward round, and it increased the amount of time for direct patient care such as assessment and treatment. These improvements raised the medical presence “on the ground” and enhanced the character of interprofessional relations (cf. Carmel, 2003, p. 64).

Second, the daily planning meeting was moved from immediately after the ward round, being held from 9.30 a.m. to 12:00 noon. This created further economies: it made time available for medical staff assessment immediately after the ward round, rather than time being taken “off the floor” for another meeting, and it freed up a period of time post-ward round, allowing a more “public” viewing of X-rays and blood results, and enabling junior and senior doctors to gather with other interested staff to hear and watch, as well as question or interject comments. This, in turn, enhanced instruction by creating time for discussions between junior and senior medical staff about work allocation and clinical priorities for the morning. Similarly, as expressed by the nurse unit manager (NUM) in the quote above, the visibility of the doctors on the floor much earlier in the morning was helpful to many of the nursing staff.

Third, a daily worksheet that had already been designed by the chief intensivist of the ICU was now finalized, formally accepted, and distributed. This worksheet enabled an organised review of each patient in ICU and ensured clear instructions and goals were communicated between all staff. The worksheet was structured to coordinate the different facets of patient care, ensuring that no major contributor to the care is overlooked. The worksheet is now used as a guide to facilitate and shape the planning meeting, making it more efficient and closing off potential “misses.” It also assists junior staff in clarifying and focusing on their work tasks.
Concluding Discussion

This article has described how our research tackled communication issues among doctors. By listening to various clinicians express their views (often indirectly and tentatively), and by observing their practices, we became sensitized to issues of importance to both professional communication and patient safety. These understandings were transformed into an edited selection of video data, with the purpose of showing these to professionals in the unit, and using this to ask them to confront the implications of what they were doing and saying. As in other instances where we have done this, the effect of this methodology exceeded both our and the clinicians’ own expectations (Iedema, Forsyth, Georgiou, Braithwaite, & Westbrook, 2007).

In this article, we have detailed some of the most telling responses produced during and following the video-reflexive session, and we have outlined the most significant practical achievements flowing from this work. In this last section, we will revisit our methodology to draw out some principles about video-ethnographic reflexivity that are of importance to practitioners and researchers alike.

At the beginning of the article, we referred to the importance of using real-life footage in such a way that what is shown “chimes–in” with concerns expressed by stakeholders in the unit. This process of editorializing real-life footage to be used at reflexive meetings such as the one described above plays an important role in enabling reflexivity. Nevertheless, this practice of responding to practitioners’ expressed concerns does not fully explain the impact that the video-reflexive session, and we have outlined the most significant practical achievements flowing from this work. In this last section, we will revisit our methodology to draw out some principles about video-ethnographic reflexivity that are of importance to practitioners and researchers alike.

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Previously, we began to touch on the reason behind the commitment shown by clinicians to making the changes they initiated. We framed this reason as centering on an affective intensity that appeared to be inherent in the clinicians’ watching themselves engaging in activities that they are more than familiar with. This affective intensity arises, we argue, from the fact that visualization “both enlarges and diminishes” sociocultural practices (MacDougall, 2006, p. 3). Vision enlarges the real not just by foregrounding particular events or perspectives on events at the expense of others, but also by intensifying one’s apprehension of what has thus far remained in the background. “Showing becomes a way of saying the unsayable” (MacDougall, 2006, p. 5). Viewers might be confronted with meanings embedded in the footage that might thus far have remained un- or under-appreciated. The visual brings these backgrounded aspects of practice to the fore and invests them with immediacy. Vision brings the lifeworld closer by revealing or “presencing” it in a new way.

Vision at the same time diminishes the real, thanks to operating at multiple levels at once (MacDougall, 2006). Vision diminishes not just because the visual frame separates the filmed from the not-filmed, excluding some facets of sociocultural practice at the expense of others. Vision also diminishes in that it reduces sociocultural practice to the size of a screen. This, in turn, has the potential to distance and unhinge viewers from these practices. Vision renders these practices “other,” placing them outside the life worlds of which they have thus far been an integral part. This makes questions possible about the assumed inevitability of practices, and about the “structures of feeling” that define them. This questioning, we argue, might lead to new practical and affective opportunities, or a new “structure of attention.” Alongside visual framing acting as a presencing device, then, it also has the effect of distancing and unhinging the viewer from their thus-far taken-as-given life world.

As a presencing-cum-distancing device, vision harbors significant affective potential: it can unsettle how people experience their own life worlds. This unsettling of the taken-as-given opens up multiple opportunities for revisiting ways of being, knowing, saying, and doing (MacDougall, 1998). But changes of this kind do not occur without emotional involvement. Used as a feedback device, vision capitalizes on this affective potential. Here, vision does not merely act as a catalog of representations that submit themselves for formal explanation, or as a springboard for interpretations that reveal individuals’ experiences and assumptions. Vision, rather, becomes an actor in the process of sociocultural reinvention. Its potential “is not simply to present the “indigenous view,” nor to invade voyeuristically the consciousness of other individuals, but to see social behavior, and indeed culture, as a continuous process of interpretation and reinvention” (MacDougall, 1998, p. 95). On this latter reading, vision does not reflect the real, but intervenes in it by enabling viewers to “re-appreciate,” revisit, and reshape facets of their life worlds, relationships and practices.

We believe that the introduction of these visual, reflexive, and interventionist techniques into health services research is important as it enables us to
hybridize existing descriptive-analytical and prescriptive approaches (whose impacts have thus far produced doubtful results), with approaches that afford different kinds of researcher–researchee relationships. The intensification of research partnerships, we suggest, is crucial to the new paradigm of inquiry promoted here: one which does not rely principally on objectification and numerification (Iedema, Braithwaite, & Sorensen, 2003), but on what we term “trustful entanglement.” As shown empirically above, by creating trusting kinds of cross-boundary relationships with practitioners, researchers can engender “rapid social change” and a “diversification of life worlds.” In the face of the rising complexity of contemporary health organizations, “traditional deductive methodologies . . . are failing” and “research is increasingly forced to make use of inductive strategies” (Flick, in Denzin & Lincoln, 2000, p. 9). The video-ethnographic work described above provides an important example of one such strategy.

Finally, we contend that video-ethnography, in generating new information relations and feedback intensities, provides an answer to Deetz’s recent challenge: “One of the invisible struggles of our time is the incorporation of new understandings of language and communication into social institutions” (Deetz, 2003, p. 121). The emerging hospital environment is increasingly dependent on highly integrated, reflexive, and flexible communication practices for clinicians to adequately manage patients with complex comorbidities and multiple needs. Video-assisted research is an important means to prepare the contemporary hospital for these challenges, as it hones in on relationships and partnerships that are capable of reappraising and lastingly reshaping existing practices.

Notes

1. Ethics clearance was obtained from the university ethics committee (HREC03271) and the area health services (04/04/07/3.13) in which hospital-based data collection occurred. Ethical research principles guided all phases of the research and clinician reflexive feedback sessions, including a 100% informed consent rate before filming would occur. Filming ceased or was erased if participants requested this during or after the filming. Patients were not filmed. All names used in this article are pseudonyms.

2. Although now a social scientist, the primary researcher has a clinical background which enabled near-full grasping of clinical talk and clinician protocol in the hospital setting. This assisted with identifying issues associated with communication early in the research process.

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