

that could do more to prevent death and other serious non-fatal events. The prospect of managing performance in primary care to improve key outcomes is attractive but speculative; more evidence about the sensitivity of monitoring and its feasibility in routine use is required. Nevertheless, there is an important lesson for all with an interest in safety and quality improvement—always monitor key outcomes. If you don't, you won't

know when the outcomes are poor. Why then should your patients trust you?

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Ethnography in health care

What can ethnography do for quality and safety in health care?

M Dixon-Woods

Used carefully, ethnography can identify errors in health care and provide explanations for their occurrence.

Originally developed within anthropology, ethnography is one of the most longstanding social science research approaches. Its emphasis is on the description and analysis of “the everyday”—routine behaviours in their natural settings. Many would characterise ethnography as the process of querying understandings and practices that are taken for granted: it renders the everyday world problematic by making the “ordinary” into the “extraordinary”. It is best understood as a holistic approach that does not rely on any single method of data collection. Observation, which may be unstructured “hanging out” or more structured and purposeful scrutiny of situations to look for particular things, is perhaps the defining feature of ethnography. These observations are often supplemented by interviews (sometimes very informal and part of the “hanging out” process) or documentary materials collected from the setting (e.g. posters, internal memos, reports of meetings), photographs, artefacts, and so on.

The interpretation of these data is very much a function of the researcher's own skills and judgement,¹ and will usually involve searching for themes and patterns in the data and generating explanations and theories grounded in them. Like literary criticism, there is no prescribed set of procedures or techniques but there are expectations of good practice. For example, researchers are required to be reflexive—that is, to reflect on and be able to give an account of how they produced their interpretations—and to be able to show that their interpretation is warranted by the data.

Ethnography is not for the faint hearted. It is a time consuming and demanding research process and can be a profoundly uncomfortable experience for the researcher. Ethnographers have often identified a natural affinity for their methods with relatively disadvantaged groups, seeing themselves as offering these groups a voice and a means of making explicit systems of oppression and coercion. When the ethnographer's role changes to one where s/he is attempting to explain professional practices, important problems can arise. Access to the field may be difficult to negotiate. When that has been gained, further challenges lie ahead. It can sometimes be difficult to access the people who may be most important to understanding a particular phenomenon: they may be impossible to get hold of, or unwilling to speak or be seen. Covert observation may be ethically unacceptable, but clearly obtaining consent to observations is not always easy and introduces risks of the ethnographer influencing the behaviours under observation. Participants in the process can begin to feel they are being inspected and judged, and to feel disempowered. They may “act up” in the presence of the researcher. The participants may also become hostile or uncooperative, and much depends on the skill of the researcher to overcome these obstacles. Sometimes this is done by creating an “insider” status, identifying the researcher with the group being studied—for example, a nurse studying nurses. However, such groups, having accepted the researcher as “one of us”, may feel betrayed by the research account that is

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subsequently produced. Some researchers begin to feel voyeuristic and exploitative in some settings, or to experience conflicting loyalties. Ethical dilemmas about when and how to intervene are not uncommon. In addition, ethnographic research will also be subject to criticism of its apparent subjectivity, and researchers can find themselves accused of producing partisan, partial, or misleading accounts.

Many of these difficulties should and can be overcome, particularly in making a contribution to quality and safety in health care. Much can be learned relevant to quality and safety from already published ethnographies. Strong's account of the “etiquette rules” governing face-to-face interactions between parents and doctors² demonstrates how difficult it is for patients to raise concerns about possible errors: to do so disrupts the “ceremonial order” of consultations and puts their status as “good patients” at risk. Patients may therefore be silenced when it comes to pointing out things they are concerned about. Pope's work on waiting lists demonstrated the importance of gatekeepers, both clinical and administrative, in controlling access to health care.³ An ethnographic study of interactions between consumers and pharmacy staff and patient interviews⁴ challenges traditional professional assumptions about how the public understands the role of pharmacists, with important implications for medication safety. Findings from ethnography can also be integrated with findings from other study types including quantitative or other qualitative research.⁵

Generally, however, the obvious potential for ethnographic approaches to make a contribution to the study of safety and quality in health care has been under-exploited. Ethnographic research is well suited to identifying conditions of risk, particularly where these involve human performance, organisational and cultural dynamics, and interactions between people and technology. Ethnography is especially good at probing into areas where measurement is not easy, where the issues are sensitive and multifaceted, and where it is important to get at the tacit, not the already evident. It can capture the winks, sighs, head shaking, and

gossip that may be exceptionally powerful in explaining why mistakes happen, but which more formal methods will miss.

The paper by Taxis and Barber⁶ in this issue of *QSHC* makes a welcome addition to the canon. It shows how, used carefully, ethnography can identify types of errors and provide explanations for why these occur, through interrogating the everyday understandings that staff have of their own practices and identifying the cultural contexts of practice. It is difficult to see how the latent conditions for error described in this paper, which are likely to be hugely

important, could have been characterised appropriately using any approach other than ethnography. Much more research of this kind is needed, particularly in complex areas where long chains of causation exist in terms of health and safety outcomes.

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Clinical databases

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Basing decisions on better quality routine clinical data

T A Sheldon

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 Clinical databases, properly used, have the potential to contribute to quality improvement.

Over the last decade there has been increasing pressure to make health care more accountable and to identify variations suggesting poor quality care which can be improved. While special studies can be conducted with these aims in mind, quality improvement activity will only become part of the fabric of health services if it can draw on data that are routinely collected. In North America extensive hospital data have been available; however, because they are generated as byproducts of administrative systems collected for other (usually financial) purposes, they are severely limited. Without the ability to adjust for patient case mix, for example, incorrect inferences about the cause of variations in patient outcomes are likely.¹ The sort of detailed clinical data needed to make sensible analyses of patient outcomes are rarely generated from routine systems, and it may not be feasible or cost effective for this to be a core administrative function. Instead, bespoke clinical databases have been developed in parallel, often as the result of the cooperative efforts of clinicians seeking reliable data on their practice and ways in which quality might be monitored and improved. However, as one finds with other sources of data collection, the validity and reliability of clinical databases are variable. As the number of such databases grows, it is important to ensure

that we have enough information to be able to interpret the results of studies based on them and to decide if they are fit for the purpose. As with the conduct and reporting of trials² and systematic reviews,³ we need common high standards for establishing, running and reporting clinical databases, an appraisal tool to assess the degree to which these standards are being applied, and an accessible source of information on clinical databases and their quality.

The Directory of Clinical Databases (DoCDAT) described by Black and Payne⁴ in this issue of *QSHC* is the first important step in providing such a resource in the UK. By providing key information on and critical appraisals of clinical databases which provide individual data, it will help people to find databases suitable to their needs and, more importantly, it will act as a pressure to improve standards. Inevitably there are ways in which this resource will need to mature. The methods of development and validation of the assessment instrument are probably not as robust or as explicit as that developed for the reporting of trials or systematic reviews.^{2,3} Ideally there should be double checking of the appraisals and independent verification of the claims of the database custodians. There is also room for further conceptual development, possibly including a clearer separation of information and criteria about the internal

validity of the data (accuracy and susceptibility to bias), usefulness for comparative work, and national representativeness. With sufficient investment this directory could develop into an important national and possibly international resource.

While the development and proliferation of clinical databases will inevitably contribute to audit and research, there is a danger that they will be misused. In England, for example, the Department of Health has made a commitment to publish cardiac surgeon specific mortality data based on the UK Cardiac Surgical register developed by the Society of Cardiac Surgeons. Sampling of this database revealed it to be both incomplete and unreliable in its ability to yield accurate, risk adjusted outcomes data.⁵ Thus, publication is likely to result in misleading information about individual performance entering the public domain, with potentially damaging results. Even if the data were accurate and risk adjustment sufficient, it is still not obvious that the individual surgeon is the right unit of analysis or that publishing the data is the optimal way to promote quality improvement. Clinical databases, if properly used, have the potential to contribute to quality improvement. However, if they are used by those who lack sufficient scientific intelligence or are exploited for political ends, then clinicians will become cynical, data quality will fall, and the public interest will not be well served.

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