Doing qualitative health services research remotely: A rejoinder to ‘Collecting qualitative data during a pandemic’ by David Silverman

FIONA WOOD

School of Medicine, Cardiff University

Introduction

David Silverman makes some insightful observations regarding the threats to qualitative social research from the COVID-19 pandemic, but the focus of much of his paper is on ethnographic research and research on members of the public. As a medical sociologist working in a medical school, the majority of my research is conducted using methods of semi-structured interviews and focus groups – what one might call the ‘bread and butter’ of qualitative health services research. In this commentary, I would like to reflect on my own experiences, and those of my colleagues and students, of conducting qualitative health services research with patients, carers and health professionals during the pandemic. In doing so, I hope to consider both what we have lost and what we have gained through conducting remote data collection. I will also review some of the inventive adaptations my colleagues have made to their research methods. Finally, I will reflect on whether we could, or should, ‘return to normal’ in the way we collect qualitative data.

COVID-19 has affected all sections of society in many ways, and it is not my intention to over-egg the consequences for qualitative researchers at the expense of clinicians, patients, carers and those who have lost their jobs or livelihoods. As David Silverman points out, at the same time there have been quite important consequences for some researchers who have had to redesign studies, learn new skills and possibly even reformulate research questions. It is also likely that the disruption has been felt most keenly by colleagues early in their research careers. On the face of it, the collective response has been fairly simple – one should move to remote data collection using telephone, Skype, or platforms such as Zoom or Teams (the latter two being the preferred option in order to retain eye contact). However, these adaptations have consequences.

What might we lose when collecting data remotely?

Perhaps the most significant risk is that the technology we use might exclude certain populations. This is particularly important for health services researchers where projects focus on populations who are vulnerable, frail or generally unwell. In one study I support on physical activity for people with multiple sclerosis, we have worked really hard not only to deliver an intervention remotely, but also to conduct remote interviews with participants about the acceptability of the intervention (Lowe et al. 2021). Vulnerable patient groups often experience cognitive and physical fatigue, which makes trying to understand and operate technology as well as maintain focus while using it extremely difficult. For some, typical older adult, populations...
there may also be sensory problems such as vision and hearing deficits. In comparison, for our participants who are regular and efficient users of technology there may be implications of ‘digital burn-out’ and its effects of exhaustion and apathy. Issues with technology will also have a tendency to exclude under-served sections of society, those with poor internet or lack of access to a suitable device.

Trust and rapport between the interviewer / focus group facilitator and the participants are considered a necessary condition for good data collection. Indeed, a degree of trust is an essential part of everyday life for routine social interactions to be possible. Trust can never be taken for granted though and, even in face-to-face data collection, qualitative researchers must work hard to profess friendship across the barriers of education, age, culture and ethnicity. Trust is even more fragile when relationships are built across digital boundaries of Zoom or Teams. Even with longitudinal interviews, it is likely to be harder for researchers to build valued and continued connections with their participants.

Other issues that we have considered relate to lack of privacy (who else might be in the room) when conducting research on sensitive topics. Threats to privacy work both ways. Whilst managing home working alongside home schooling, many of us have been caught out with members of our own family making an appearance during data collection.

What might we gain when collecting data remotely?

Probably the greatest benefit of remote methods of data collection is the lack of geographical constraints to our field of research. Whereas previously we would have had to justify opening the study to participants recruited outside our own local areas, this now seems very possible. Remote data collection is time efficient as researchers are not required to travel long distances, which has both financial and environmental benefits. There may also be benefits here for equality and diversity, particularly for those researchers who have family commitments which make traveling away from home difficult or for researchers with physical disabilities who may not easily be able to access all public and private buildings to meet participants face to face.

Risks of physical harm to researchers collecting data in the field have previously been identified as an issue (Bloor et al. 2010), although the risks have likely lessened with increased use of researcher safety procedures. Remote data collection is clearly likely to reduce the risk of physical harm (if not emotional harm). However, the more rewarding day-to-day benefits for me are the lack of need to implement ‘just in case’ lone-researcher safety protocols during solo data collection at private addresses.

Some colleagues have suggested that remote data collection via platforms such as Zoom or Teams might facilitate research with adolescents, given their growing proficiency with conducting social relationships over remote devices. Although this seems logical and possible, I have found no evidence for this. I also do not know if ethics committees would have increased or decreased concerns about safeguarding issues.

Remote informed consent

David Silverman discusses the remedies that researchers could implement if data collection during a pandemic were to prove too difficult. However, if a researcher decided that it was possible to make progress with data collection, then issues surrounding how to obtain informed consent remotely arise. This was certainly a concern to a number of my colleagues in the UK during the first year of the pandemic. Guidance from the NHS (National Health Service) Health Research Authority (HRA) states that, for studies that are not CTIMPs (Clinical Trials of Investigational Medicinal Products), it is not a legal requirement to have a documented written signature, and verbal consent which is recorded on an audio device (either a dictaphone or using a video platform such as Zoom) is sufficient. It is also worth noting the HRA also states that any changes to physical arrangements for consent due to COVID-19 such as witnessed verbal or phone consent should be agreed with the sponsor and documented in the study protocol (NHS Health Research Authority 2020).
Many of my colleagues are now successfully taking remote verbal consent in situations where hard-copy signatures are difficult to obtain and may compromise the safety of participant and researcher. We follow guidance that the consent discussion is to be audio recorded: the researcher confirms their own name, that of the participant, and the date; the participant confirms that they have read the information sheet and had opportunities to ask questions; and the researcher reads through the consent form asking the participant to respond to each point individually. The recording is then ended, and data collection starts on a new recording allowing the storage of the consent taking and personal details to be kept separately from the data.

Adaptations to methods

For centuries humans have told personal stories over campfires and in their homes, but now are being asked to recount their experiences over Zoom. Intuitively, this might seem fraught with issues, but the transition to remote methods has perhaps been the easiest for researchers using individual interviews with participants. After all, research interviews have successfully been conducted by telephone for decades. My experience is that these adaptations are generally successful. Having read the transcripts of many of my students’ interviews, I confess I often forget that these were not conducted face to face until I stumble across sections of the transcript where the internet connection has been lost (equals sign stands for overlap):

Interviewer: Yeah. Your screen has frozen but I can hear you. Hello? Oh no, you’re frozen now.
Participant: You still there? Sorry, I think=
Interviewer: =There we are [inaudible].
Participant: It’s saying about my connection is unstable.
Interviewer: Okay.

Some researchers are engaging with interesting adaptations to methods such as online asynchronous interviews (Lupton 2020), where the researcher poses questions and the participant has time to answer before a further question is asked. The interview therefore unfolds a bit like a sequence of letters, with the fieldwork relationship developing over time.

Conducting online remote focus groups is likely to be more challenging. Focus groups are distinct from interviews, in that they really require in-person interpersonal interaction for a successful result. Colleagues who have tried online focus groups report that the method lacks spontaneity: interjections and overlapping speech cause confusion over platforms such as Zoom and – whether literal or electronic – hand-raising and ‘thumbs-up’ reactions do little to simulate natural discussion. Focusing exercises that are typically used to help generate discussion such as group ranking exercises, where participants are asked to look at a series of statements and rank them in order of correctness or importance, are also difficult to perform. Researchers may also need to consider how to accommodate participants who wish to keep their camera off (either because of internet issues or due to personal preference), and how this can affect group dynamics. However, virtual focus groups have been an accepted method of data collection for a number of years (Stewart and Williams 2005) and appear to work well when they become an asynchronous method of data collection with study populations who are comfortable with online discussion (Hinton et al. 2018).

Another method we have adapted for remote use in recent months is a form of cognitive testing using the ‘think-aloud’ method. This method is often employed for intervention usability testing, for example by gaining feedback from participants about the content, format and method of delivery of an intervention based on anticipated or experienced cognitive and emotional responses (Pasterfield et al. 2019). Our experience with using think-aloud to assess the acceptability of a decision aid is that the method can work remotely, but is more challenging due to difficulties in observing what aspects of the intervention the participant is looking at or referring to. We found that this could be partly resolved by video recording the discussion, which allowed us to match the participants’ gestures and use of the intervention to their speech during analysis. Think-aloud methods are also characterised by long silences, which some people might find more uncomfortable remotely.
We have also successfully run on-line expert consensus meetings as part of a Delphi exercise (Shepherd et al. under review). In many ways these can be similar to online focus groups, but the moderator is more interested in the outcome of the deliberation process rather than the communication process. When used remotely over platforms such as Zoom, this method can enable good participation of experts from a wide geographical area, as the method is time efficient, convenient and cost effective. Online polling through Zoom also works well. However, there is much less opportunity for the experts to network over break times, which has always been considered a benefit of expert meetings.

Discussion

The vast majority of qualitative researchers in the field of health services research will have had to make at least some adjustments to their data-collection methods. It is worth noting that during the pandemic the National Institute for Health Research (NIHR) has paused non-COVID-related research with NHS patients and staff in order to prioritise COVID-related research (Department of Health and Social Care 2020), and this has had a huge impact on colleagues who were recruiting staff and patients through the NHS. As a consequence, many health service researchers have needed to redesign their research or turn their attention to desk-based research, such as writing or conducting a systematic review and narrative synthesis. Whilst I have outlined a number of challenges of conducting qualitative data collection remotely, I believe there are also a number of advantages that we can focus on.

This commentary has also made me consider what I think could, or should, happen post-pandemic. Will this new way of working be obsolete after the pandemic, or will we have adjusted enough to accept, or even prefer, remote data collection? In the future, will funders be willing to finance the extra costs of face-to-face data collection now that we have shown that remote methods are certainly ‘good enough’ for many participants? At the very least, the COVID years are likely to leave us with a greater portfolio of methods which we can draw upon and which we will need to teach our students. I also wonder whether our research contributions during this time will be judged in the context of a particular timeframe and whether the researchers who come after us will understand the restrictions in which we were working.

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Fiona Wood is a Senior Lecturer within the Division of Population Medicine at Cardiff University, specialising in medical sociology. She has a particular interest in beliefs and behaviours in relation to common infections, patient-centred care and healthcare communication. She has over 20 years of postdoctoral research experience, during which time she has developed a broad portfolio of expertise in qualitative research methods in health services research. Address for correspondence: Division of Population Medicine, Cardiff University, 8th Floor Neuadd Meirionnydd, University Hospital of Wales, Cardiff, CF14 4YS, UK.

Email: wood@cardiff.ac.uk