On the critical contribution of in situ social-behavioural research during COVID-19: A rejoinder to ‘Collecting qualitative data during a pandemic’ by David Silverman

RICK IEDEMA¹, CHRISTINE JORM²,³ AND DONELLA PIPER⁴
(1) Kings College London; (2) University of Newcastle, Australia; (3) University of New England, Australia; (4) NSW Regional Health Partners, Australia

This commentary offers a brief reflection on the suggestion in David Silverman’s Forum Discussion contribution that, at times of crises such as the present COVID-19 pandemic, social science is well-advised to accommodate to drawing on online data for its research and that it can benefit from doing so. While acknowledging the centrality to social science of co-present engagement with people and practices, Silverman appears unconcerned about relegating social science to the disembodied practice of online data gathering at times of crisis. His suggestion is admittedly pragmatic, and can be justified to a considerable extent in view of the richness of online data. We take the opportunity in the present commentary to develop a counterargument to this suggestion. We argue that crises should not lead to an automatic exclusion of social science from crisis sites and its relegation to online data gathering. Our stance is that social science’s unique contribution to the illumination of crises and human response mechanisms is at stake.

On a general level, it is undeniable that the COVID-19 crisis has given prominence to experts at a time when expertise was relegated to obscurity by the perfect storm of social media, populist politics and geopolitical upheaval. It is as if the pandemic hit at a time when humanity’s capacity for unreality and the denigration of scientific expertise had reached its apex – the point in time when, according to Latour (2018), reality had been so ignored that it could not but bring us ‘back down to earth’. Perhaps not everybody – and leaving aside for now the ongoing reservations held particularly by Black, Asian and Minority Ethnic (BAME) groups about vaccination (BBC News 2021) – but a good number of people saw their faith in science restored thanks to the improbable trial successes of the various COVID-19 vaccines.

This relegitimation of experts and expertise, however, has been partial. Those who have secured the media limelight are principally lab scientists, randomised controlled clinical trial researchers and epidemiologists. An exception is the well-known French philosopher Alain Badiou, who succeeded in attracting considerable attention. Unfortunately, instead of providing a painstaking social and philosophical analysis of contemporary complexity, Badiou chose to downplay the significance of the global crisis, stereotyping ‘Chinese markets’ as places known for ‘their dangerous dirtiness, and for their irrepressible taste for the open-air sale of all kinds of living animals, stacked on top of one another […] in conditions of rudimentary hygiene’ (Badiou 2020). Instead of targeting environmental destruction and degradation as the principal factors causing the pandemic (Robbins 2012; Vidal 2020), Badiou revives a cultural stereotype that only exacerbates our ignorance of these factors. Badiou’s antagonism adds urgency to the argument that we should involve those who have the skills to investigate and illuminate the complex social,
cultural and behavioural dimensions characterising the present crisis.

To date, all we know about how the COVID-19 crisis is unfolding and impacting on day-to-day care comes from a handful of junior doctors, nurses and allied health staff reporting their plight from the frontline of care (Johnson 2020; Leighton 2020; O’Kelly 2020), aside from the odd journalistic foray into hospital disaster zones (Russell 2020). Their reports are cries for help and attention in a world that limits COVID-19 research and reporting to epidemiology, virology and pharmacology. Instead of frontline clinicians’ cries being recognised as warranting that we pay close attention to the troublesome aspects of everyday care provision, decision makers and commentators continue to normalise the hegemony of the ‘hard sciences’. This trope is reinforced by the broadcast media through a looped vision of mechanised syringes squeezing coloured liquid into rows of test tubes, and fancy graphs visualising current trends.

Amidst all this, the research needed to detail and make sense of frontline clinicians’ experiences and desperation has been marginalised as unnecessary and intrusive. Many, if not all, healthcare services put a stop to in-house service-focused research. The UK’s National Institute for Health Research (NIHR), a major healthcare research funder, frames its COVID-19 funding priorities as follows: ‘Our primary focus continues to be on […] key vaccine studies and therapeutic “platform” trials’ (NIHR 2020a). In 2020, studies that sought NIHR resources to investigate how clinical teams and frontline clinicians went through this crisis were denied funding (for a list of funded studies, see NIHR 2020b).

This state of affairs is both sad and problematic. To be sure, we have made huge progress in vaccine development and distribution, and in mapping viral genetics and emerging strains. Some countries have perfected contact tracing to the point where individual carriers can be linked to source infections. However, even studies looking into the critical issue of viral transmission among individuals do no more than focus on host factors and environmental factors, leaving behavioural and interactive factors unaddressed (Meyerowitz et al. 2020), while it is otherwise openly acknowledged that COVID-19 spread involves a lack of behavioural control over bodily produced aerosols.

The seriousness of this situation becomes acute when we try to come to terms with the chaos of responses inside hospitals to emergent circumstances brought about by COVID-19. These responses were rendered painfully visible in documentaries such as 76 Days (Chen 2020) and The Frontline (Ge 2020). Both reveal patients’ panic and clinicians’ desperation close up and in real time. It is precisely these chaotic and desperate circumstances that sciences other than virology, pharmacology and epidemiology are attuned to illuminating – sciences that are geared to dealing with in situ complexities, competing imperatives and lived uncertainties.

The need for analyses of in situ crisis practices is rendered still more urgent by the news that hospital care of COVID-19 patients itself caused a considerable number of hospital-acquired COVID-19 infections (Jain 2021). The scope of this problem was such that in February 2021 the ex-UK Secretary of Health, Jeremy Hunt, circulated a paper to WHO members of the Global Patient Safety Network which estimated that 40.5% of COVID-19 infections have nosocomial sources (Blanchard 2021). Even before the advent of COVID-19, iatrogenic (healthcare acquired) infections (HAI) were a problem of considerable cost and scale (NHS n.d.). While research into HAI has shown that effective approaches to infection control analyse and enable clinicians themselves to reflect on in situ care behaviours in order to reduce viral transmission (Hor et al. 2017; Iedema et al. 2018; Gilbert et al. 2020; Hooker et al. 2020), the fight against COVID-19 has to date not been allowed to benefit from these insights.

If the current crisis has revealed anything, therefore, it is the paradox that social-behavioural research is deemed non-essential at a time of maximum social and organisational complexity, when, it would seem, studying how we act amidst complexity would be imperative. Yet in situ social science is seen as expendable by not just funders and services but by researchers too. This is while frontline behaviour is stretched to the limit, having to take on ‘wicked’ problems and emergent challenges. Sadly, there is a pattern here. Excluding social science research into in situ behaviour from attempts to strengthen how we navigate everyday complexity is nothing new. Think of pre-COVID-19 ethics committees that
would also deem medical, surgical and pharmacological trials and experiments to be more easily deserving of ethical approval than observational research of everyday care in health services (Iedema et al. 2013). Think of the methodological reservations raised by grant assessment panels to object to non-outcomes-driven and procedurally under-determined research collaborations and interventions. Now, the world of Covid-19 extends this same ethos by ruling that the witnessing of, reflection on and deliberation about in situ crisis practices is too risky, even though it is precisely the creativity that arises during crises that remains insufficiently understood. All the while, caterers, cleaners and other service personnel are instructed on how to keep safe and continue working, while social-science researchers are (again) excluded. This in effect points to a deep-rooted hesitation about holding a mirror up to question how we do troublesome, challenging and complex things.

Assumed to embody a liability and not a resource for managing complexity, social-science researchers are now advised to turn instead to the world of online data, and to fashion their enquiries according to the information and communication practices they find there (Goralska 2020). To be sure, the analysis of online data can be revealing, important and ground breaking. The success of ‘surveillance capitalist’ enterprises such as Google and Facebook provides ample evidence of this (Zuboff 2019); but advocating for social science to satisfy itself with analysing online exchanges misrecognises the role(s) it can and should play in addressing contemporary behaviour in the face of emergent complexity.

The most significant point about the need for social enquiry into in situ human crisis behaviour is that such enquiry is likely to counter the assumption (dispelled by the junior clinicians’ stories referred to above) that our frontline responses are most likely optimal and effective because our clinicians have grit and determination. The assumption is that they will do what is good and necessary, and that we should stand back, trust their reflexes and then (as was practised for a while in the UK) clap. The pervasiveness of this assumption explains why the literature about how to provide safe healthcare to COVID-19 patients still reaches for mythological conceptions like agility and resilience. These are notions popularised by patient safety and practice improvement commentators keen to talk up the sunny side of unexpected outcomes and urgent practice change so as to evade their darker, less manageable, highly political, deeply emotional and more complex-chaotic dimensions. What agility and resilience look like in situ, these commentators maintain, is determined by practitioners’ quanta of psychological reserves, situational intelligence and self-sacrifice. In contrast to those who propagate these kinds of assumptions, more attentive scholars have shown that social behaviour amidst complexity intensifies in supra-individual affect when entangled in emergent and not-yet-experienced situations (Weick 1993; Klein 1999). This group affect operates through semiotic but particularly through pre-semiotic resources (think of the various bodily, gestural, kinesic and haptic dimensions of interaction), and it is the latter that invest group connectivity with a unique speed and efficacy (Thrift 2008). From a social-science perspective, affect is therefore not just a subjective or internal response to crises, but also a crucial and observable social resource for navigating emergent situations and crises (Iedema et al. 2009).

In sum, excluding social-science researchers from the study of COVID-19 risks perpetuating simplistic understandings and inappropriate conclusions about crisis response behaviours. This risk remains masked by the plethora of advice about how to prepare teams for complex situations and crises (e.g. Tannenbaum et al. 2021) while avoiding questions about how teams evolve adaptive conducts and never-seen-before solutions from a complex situation or when facing a crisis. The extant advice literature presumes moreover that we can prepare teams for all emergent problems before a crisis hits, downplaying and even denying the likelihood that reality will be suboptimal or even wickedly troublesome.

For clinicians to gain a real grip on rapidly changing circumstances and complex situations, very different resources are therefore called for than sage advice from bystanders who are external to emergent circumstances. One such resource is the delicate practice of teams working through the complexity of local circumstances twice, once in real time and once in time-out, by reassessing their own interactions and behaviours. Another is teams confronting the in situ complexity of care work not as a theoretical or analytical problem
to be solved in advance and for good, but as experiential, affect-intensive and as an unending complex here-and-now reality amidst which actors reflexively and creatively work out how to go on (Iedema 2020).

To appreciate these complex dynamics and illuminate ways to strengthen teams’ real-time responses we need to insist that social science play a crucial role in how we approach and enact human conduct amidst in situ complexity. Specifically, social science must have a presence where professionals and services struggle to deliver healthcare to help contain the impact of crises such as COVID-19 illness and death. We have a unique opportunity now to learn from our own and each other’s behaviours in the face of never-before-experienced situations and circumstances. A retreat into online social science enquiry may satisfy the preconceptions of those who undervalue our research, but it will only leave us much less well prepared for the next pandemic than we could be and should be.

References


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Rick Iedema is Professor and Director of the Centre for Team-based Practice & Learning in Health Care at King’s College London, UK, where he oversees the interprofessional learning programme for King’s nine healthcare disciplines. His most recent books include *Visualising Health Care Improvement* (2013, Taylor & Francis), *Communicating Quality and Safety in Health Care* (2015, Cambridge University Press), *Video Reflexive Ethnography in Health Research and Healthcare Improvement* (2019, Taylor & Francis), and *Affected: Becoming Undone & Potentiation* (2020, Palgrave-Macmillan). Address for correspondence: Centre for Team Based Practice & Learning in Health Care Health Schools, Henriette Raphael House, Guy’s Campus, King’s College London, London, SE1 1UL, UK. Email: rick.iedema@kcl.ac.uk

Christine Jorm has doctorates in neuropharmacology and sociology and practiced as an anaesthetist before moving to roles focused on improving the safety and quality of care at unit, institutional and national levels. Most recently she has been Director of NSW Regional Health Partners, based in Newcastle, Australia. In this role she has been working to accelerate the translation of research into practice order to improve regional and rural health. Her PhD thesis explored aspects of medical culture, leading to a book titled *Reconstructing Medical Practice – Engagement, Professionalism and Critical Relationships in Health Care* (2012, Gower). Address for correspondence: School of Medicine and Public Health, University of Newcastle, University Drive, Callaghan, NSW, 2308, Australia. Email: Christine.jorm@health.nsw.gov.au

Donella Piper is employed by the Hunter New England Central Coast Primary Health Network as the Program Manager and Evaluator for the
Embedded Economist Program, a program funded by the Medical Research Future Fund (MRFF) and coordinated by NSW Regional Health Partners. She is an experienced researcher, and a lawyer by background, and she has a PhD in social science and healthcare from the University of Technology Sydney. Addresses for Correspondence: New South Wales Regional Health Partners, Wisteria Lodge, James Fletcher Hospital, 72 Watt Street, Newcastle, NSW, 2300, Australia / School of Medicine and Public Health, University of Newcastle, University Drive, Callaghan, NSW, 2308, Australia.

Email: donella.piper@health.nsw.gov.au