Adaptability and change: A rejoinder to ‘Collecting qualitative data during a pandemic’ by David Silverman

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As David Silverman acknowledges in this timely piece, the fact that the pandemic has scuppered many of the plans of qualitative researchers is far from the most pressing of the COVID-19 consequences. But the ways in which people have adapted their approach to research is impressive and – let’s face it – we need to be able to grasp every opportunity to be impressed this year.

Writing as an academic qualitative health researcher and director of a funding programme, I think I can detect a few shifts in perspectives. Initially, we all had to adapt to the realisation that our 2020 plans for fieldwork, conferences, visits and exchanges were going to be either heavily postponed or abandoned. It was illuminating how swiftly and cheerfully some of these commitments were jettisoned while final decisions about others were delayed before the inevitable cancellation. Instructive, perhaps.

Many of us found ourselves needing to develop new ways to check in with students and team members and, anecdotally, some struggled to maintain productive and amicable relationships with colleagues during multi-participant Zoom calls. However, it is fair for Silverman to remind us that some (mainly those who have more secure, senior-level contracts) benefited from an opportunity to conduct particularly thorough, scholarly analyses and to complete tasks on their personal ‘guilt lists.’ Those who had been writing about the consequences of digital communication – including comparisons between online and face-to-face interviews (e.g. Davies et al. 2020) – found that articles that had been regarded as rather niche, and that were languishing with reviewers and editors, were suddenly fast tracked to publication.

We must acknowledge that many early- and mid-career researchers were facing the very real potential that their jobs might disappear or that their intended postdoctoral positions might never start. In health research this was additionally complicated by the wholesale swivel to urgent public health research, which consumed nearly all attention and resource for a large part of 2020, leaving scant capacity for clinicians to engage in recruiting for, or otherwise supporting, access for qualitative researchers. This is not to say that qualitative research has no role in understanding the true impact of the pandemic on people’s lives, including the implications for communication in consultations that are no longer face to face (or unmasked). A number of studies have now been funded to do just this, but in the clamour for attention qualitative researchers were unlikely to force their way to the front of any queue comprised of trials of potentially life-saving treatments and vaccination studies. This has caused little complaint, although the unpredictability of when research might start up again has been hard for researchers to manage.

During the first six months of the coronavirus pandemic much of the research activity focused on
the numbers: rates of infection, death and excess mortality, comparisons between ethnic groups, nations, care settings and geographical locations. Statistics helped to illuminate what was happening and have continued to indicate the effects of different policies, and more recently, the vaccination programme. But to understand what the illness means to people, and to elucidate the rationale for how care and communities might change, we also needed qualitative research. This second phase of 2020 saw a slew of grant proposals for new funding to address the numerous qualitative research questions that were arising in relation to COVID-19. Naturally, this meant that the research community was also kept occupied reviewing other people’s proposals and serving on funding committees. In the UK alone this was a considerable volume: for example, the ESRC published a 23-page list of COVID-19 research it is funding (Economic and Social Research Council 2020).

This middle phase also saw a lot of adaptations so that researchers could continue their work. In many interview-based studies, including our own narrative research on people’s experiences of COVID-19, interviews are being conducted remotely via videoconferencing technologies that can be used from a smartphone or laptop. There are inevitably issues related to General Data Protection Regulation (GDPR) that limit the platforms that can be used in UK higher education institutions, but teams are sharing what they have learnt and finding solutions. For example, while a large focus group discussion may be hard to manage, most online platforms offer breakout room and ‘chat’ options and the judicious use of these can successfully stimulate involvement from participants who might be reluctant to speak in a group. The dynamics are different of course and the researcher must be aware of the potential for online interviews to lack privacy – while this can be a mild nuisance if the participant is distracted it is vital when the topic (such as domestic violence) requires privacy for reasons of safety.

Serious consideration needs to be given to how to engage with communities that are seldom heard in research (for example migrant workers, people who are overwhelmed, living in poverty or in overcrowded conditions) and whose living and working circumstances make it particularly hard for them to take part, even if they are keen to participate. COVID-19 has disproportionately affected these very groups whose perspectives may be harder to access. As ever, patient and public involvement (PPI) colleagues can be very helpful – for example, our own PPI colleagues suggested that we provide some tablet computers with the necessary software, headsets and wi-fi dongles for people who might be willing to be interviewed online but do not have their own equipment or wi-fi at home. We thought this was an excellent idea and have earmarked costs in our research study, which has recently started, for courier services to deliver and collect equipment as and when needed.

Researchers are an inventive bunch, especially if allowed some quiet time to ponder, and some impressive workarounds and innovations have been proposed, sometimes as agile shifts in existing studies. For example, my talented colleague Charlotte Albury, a conversation analyst, when faced with the problem of how to record vaccine consultations, proposed offering a recording device on a lanyard to participating patients on the way into the consultation; the device would then be dropped into a receptacle on the way out. Given the difficulty of reminding clinicians to check consent and turn on recording devices during consultations, if this approach is successful it certainly has the potential to outlast the pandemic. In my experience research funders have often been happy to approve adaptations that enable the work to continue – including some streamlined systems that may well survive the pandemic and become routine practice.

While we should applaud those who have found new ways to continue or adapt their research, we need to recognise that there are many who have lost their post, their mojo or their field contacts or for whom the struggle to maintain home schooling while trying to keep on top of their research has been too great. They are, as Silverman points out, disproportionately women. We owe it to our colleagues and our disciplines to do what we can to help get the show back on the road.

References

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