

A personal perspective on the impact of COVID 19 on research: A rejoinder to ‘Collecting qualitative data during a pandemic’ by David Silverman

GERALDINE LEYDON

University of Southampton, UK

On being an academic in a pandemic

Experiences of the recent lockdown due to COVID-19 will inevitably be shaped by context and individual positionality. Silverman rightly, and poignantly for me as a woman with a young child, observes that many women have been ‘restored’ to traditional at-home duties during this pandemic. Anecdotally, it seems for many this happened without question, and some interesting debates have ensued. Certainly, there are gender inequalities in the academic workplace that are well established – and the ‘Athena Swan’ initiative in the UK attempted to right some of those wrongs – but the pandemic is likely to have deepened already existing divisions. In the United States, Vice President Kamala Harris spoke of the disproportionate displacement of women from work and labelled it a ‘national emergency’ (Harris 2021), and burnout more generally has been raised as an issue, potentially more prevalent in women (Gewin 2021).

Unquestionably, one year on, I feel on a back foot, with no principal investigator (PI) grant written during that time but an impressive collection of design technology projects crafted with my daughter from cardboard remains! Institutions are under pressure and consequentially so too are staff and the metric-based expectations that guide them; metrics that cannot so readily be recalibrated to account for the juggle that so many have had

to perform. Certainly, in my institutional context senior staff are aware of a need to reverse the downward trend for individual grant income.

Of course, the reduction in grant activity across the sector places increased pressure on institutions and the individuals who have been less grant productive during lockdown. So too, it may also work to intensify the already widespread career uncertainty for contract researchers; the very individuals most likely to be in ‘the field’ – however defined. Speculatively, in the short term, the market is likely to become even more competitive for non-tenured staff as research posts are likely to be in shorter supply. Only time will tell what kind of fall-out these experiences will have for academics and researchers.

Silverman’s point about pausing studies is not something I have been able to do. Despite a pandemic some funders have been steadfast in keeping to the originally agreed deadlines for delivering studies. Whilst no-cost extensions may be possible, this often leaves a beleaguered PI without staff and having to navigate a project to completion with all the additional challenges of a pandemic. Fortunately, I have not had to abandon a study, but I am sure that if we were to cast all studies that proved impossible to run during this last year into a single pile it would make for a gloomy graveyard of unfulfilled research ambitions. Certainly, on a national level the need for a ‘state bailout’ to safeguard the sustainability of both research and

education in the UK University sector has been mooted (Grove 2020).

On re-conceptualising how we do our research

Despite the obvious challenges, more locally and optimistically, I have been struck by a new language in my research meetings around research design and conduct; a kind of Kaizen-infused discourse about improvement in terms of how we think about and do our research, the need for innovation in research design and agility in terms of how efficiently we respond to the shifting research landscape that COVID-19 continues to present to us.

COVID 19 has provided an opportunity to reflect on and question some long-held practices of, for example, privileging face-to-face over telephone interviews, accepting the struggle of slow-paced research approvals processes and sticking with traditional boundaries between what ‘we’ as the researchers do and what our partners who support our research do (the clinicians, service providers). Given the transformed research landscape there is a clear need for researchers to become even more aware of the comparative pros and cons of different approaches, of remote vs. close-up methods for data collection and the use of primary vs. secondary data. Certainly, Silverman’s advice to ‘keep it simple’ when it comes to data collection seems more relevant in the current context (Silverman 2014).

Recent research examples

Primarily a conversation analytic study, the OPEN Project¹ commenced pre-pandemic in April 2018. It aimed to understand the antibiotic prescribing communication practices in out-of-hours primary care for common infections, with the aim of developing training for antibiotic prescribers to contribute to the UK antimicrobial stewardship agenda.

Prior to the pandemic, we had completed our video recordings of out-of-hours home visits, nursing-home visits and primary-care-based visits. Today, it is hard to imagine having our video-based

field leads (Drs Joseph Webb, Catherine Woods and Rebecca Barnes) travelling in despatch cars with badge cams at the ready. We were not so lucky when we began collecting our final data in the form of clinician advice calls in March 2020. At that time one of our out-of-hours service providers was fielding more than 400 extra calls per day. As a team we were faced with a decision about what to do: push hard to help us deliver to our funder, or accept that the provider priorities were paramount? Clearly, the latter won the day and we ceased data collection – 50 clinician advice calls not collected, and for good reason.

During this period, it became evident that the success or otherwise of our data collection relied so heavily on us as a research team having access to ‘the field’. Whilst previously this was standard practice, it alerted us to the plain fact that researchers may need to rethink the design and costs of their studies. As Silverman suggests, we need to think more creatively. As we designed our COVID 111² study – an extension to the OPEN Project to collect calls – we recognised a need to think differently about roles; of who does what and how. We reconceptualised our collaborator as ‘the provider of services’ to our ‘researchers on the ground’. This necessitated a clear protocolised framework for what we wanted them to do, how and when, and demanded strong working relationships.

Dingwall’s reflection, cited in Silverman’s paper, that our research collaborators might be willing to do more certainly corresponds with my recent experience. Moreover, I believe it is possible to continue to collect naturalistic interactional data despite the field no longer being in touching distance; we just need to think differently about how we do it.

On not being reticent to ask people to support one’s research, even in a pandemic

I have reflected on my own attitude to research over the years and that of some of my colleagues. Quite often as a profession we have a rather apologetic and self-conscious predilection, driven perhaps by a deep gratitude to participants taking time to collaborate / take part in our research. With this can come a mindset of not wishing to bother people and assuming they would not want to take part in

research or go the extra mile to support data collection, so we do not ask. I have found that even amid a pandemic, our providers were committed to delivering research and patient participants and Public Patient contributors were still happy to work with us. So, despite everything, I remain optimistic about what we can do as researchers, about the data we can collect, the questions we can perhaps more creatively attempt to answer and the differently configured working relationships we can build.

Summary points

Let go and know when enough is enough

It is so easy to be steadfast in our goals as researchers, to just keep going on in order to deliver to our funders, but when faced with the impact of the pandemic, we were quite rightly aware of the need to step back from collecting clinician advice call data and be happy with the data we had managed to collect pre-pandemic. And, as Silverman has said before (pers. comm.) it is far better to say a 'lot about a little' rather than a 'little about a lot'; in this sense 'losing' data was okay.

Cost research time for partners/providers

Working through a pandemic may mean negotiating a greater 'research' role for collaborators / service providers where, for example, they, not a researcher, are responsible for identifying and getting the consent of participants. This kind of work may not be eligible for funding by Clinical Research Networks (in the UK) and will need to be factored into grants.

Do not assume one will be met with a 'no' to participation/collaboration

It is easy to assume research will be impossible in times of difficulty, but there is a long history of research conducted in contexts that *prima facie* would render any research activity unethical or impractical. In my experience, with a facilitating team, and a grant properly costed to support people's contributions, research is eminently possible, and people will still contribute their time.

Establish whether there are existing data sets that might help answer the research question

I agree with Silverman that the value in existing data can be rather underestimated and the irresistibility of gathering one's own data can lead researchers to miss opportunities to explore what might already be available. Research studies rarely exhaust all possible analytic avenues, and many PIs will be only too pleased to have their hard-won data reused to answer further questions, where permitted. Moreover, there are excellent opportunities for secondary analysis using formalised archives (see Appendix).

Final comments

Silverman's paper provides a timely message of a need to take stock of what, as researchers, we do. We need to consider the personal impact the pandemic has had on individuals in our research community and, methodologically, on the questions we can ask and the studies we can feasibly undertake.

Appendix: Data archives

Data archives available include the following.

HealthTalk

<https://healthtalk.org/HERG>

Run in partnership with the Dipex Charity and Health Experiences Research Group at the University of Oxford, HealthTalk holds hundreds of video-recorded interviews with patients on different health topics. Interviews in the archive are copyrighted to the University of Oxford and available, under license, to qualitative researchers for secondary analysis (subject to approval and administrative costs).

The One in a Million Primary Care Consultations Archive

<http://www.bristol.ac.uk/primaryhealthcare/researchthemes/one-in-a-million/>

This archive at the University of Bristol holds more than 300 video-recorded general practitioner–patient consultations, and other related data at

practice, GP and patient levels. Data are available to *bona fide* researchers subject to NHS ethical approvals and administrative costs.

TalkBank

<https://talkbank.org/>

TalkBank supports the study of human communication with an emphasis on spoken communication. Currently, TalkBank provides repositories in multiple research areas and in over 30 different languages.

UK Data Archive

<http://reshare.ukdataservice.ac.uk/>

The ESRC has a longstanding arrangement with the UK Data Archive as a place to deposit research data.

Notes

1. The OPEN Project was funded by the National Institute of Health Research School for Primary Care Research (NIHR SPCR). It was co-led by me at Southampton University and Dr Rebecca Barnes at Bristol University, in partnership with University College London and Oxford University, with out-of-hours primary-care service providers Partnering Health Limited (PHL) and BrisDoc.
2. The COVID 111 Project was funded by the National Institute of Health Research School for Primary Care Research (NIHR SPCR). It was led by Dr Rebecca Barnes at Oxford University, in partnership with Southampton University, with out-of-hours primary-care service providers Partnering Health Limited (PHL) and BrisDoc.

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Geraldine Leydon works as a Professor in the Primary Care Research Centre (PCRC) at Southampton University. Her work encompasses many topics in primary care, with an overall interest in understanding and improving the patient experience and enhancing communication between patients and healthcare practitioners across a range of healthcare encounters. She uses qualitative methods, including conversation analysis (CA). Address for correspondence: Primary Care Research Centre (PCRC), University of Southampton, Aldermoor Health Centre, Aldermoor Close, Southampton, SO16 5ST, UK. Email: G.M.Leydon@soton.ac.uk