



Intrinsic ethnographic enquiry: towards a general practice research methodology

Ethnography is a term that is generically applied to the study of populations into which the researcher has traditionally entered as an interloper, and then gradually been accepted in various ways: "The ethnographer participates overtly or covertly in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions, in fact, collecting whatever data is available to throw light on the issues with which he or she is concerned".¹ This sounds very much like what a general practitioner does all day.

Apart from asking direct and indirect questions, data are gathered by participative observation.² This involves taking up various positions with regard to our connectedness to the patient. On the one hand, we can be noninvolved as clinical observers of pathology and detached from the life world of the patient. On the other, we can be immersed in the patient's behavioural complexities, psychologies and social life. Most of us work in the middle ground, called observer as participant.³ These positions have also been called the nil involvement role, the stranger role, the acquaintance role and the friendship role.⁴

In our daily practices, in the landscape known as the consulting room, we entertain and receive our practice populations, where we interview countless patients, listen to their stories, enquire about their lives and observe their behaviour. We also take in data from the peripheral events that surround the patient. Almost subconsciously, we take in remarks and conversations made by our colleagues and staff (called secondary actors), and also through observation of the interactions of the social and general business life of the practice and surroundings. Beyond this is the wider world of the village or suburb, where information is obtained from house calls, social occasions and glimpses into the everyday lives of our patients (called nonobtrusive sources).⁵

So how can we go about carrying out research within our practices without having to move outside of them? This would constitute research in the real world as it occurs in our daily working lives. It would use data that are taken from the life world that is intrinsic to the doctor's practice. It need not be accomplished outside of this in vivo milieu. Books have been written on ways of obtaining data and information from the "ground"⁶ and from the practice setting.⁷

Interviews performed and recorded during everyday contact with patients now form the basis of considerable clinical research that has been produced in family medicine. Taking research outside the practice might introduce artificial manipulations. Outside the privacy of the consulting room, the data may be introduced to exclusion criteria, and blinding and randomisation in the processes (almost adulation) of validation.

Most of the research that is derived from the ground of clinical practice is naive enquiry that forms the science of discovery on which theories are formed and which has intellectual foundations in the social sciences. Many of the ideas, hypotheses and revelations that occur to general practitioners during the consultation are dismissed as unresearchable, but this is not necessarily the case. It is possible to research these "soft" edges of our practices outside the mainstream of biomedicine in several ways. For many years, this form of enquiry has been present in medical anthropology, psychology and psychiatry.

Classified under the broad rubric of qualitative research, it has formed a basis for research into such diverse areas as dysfunctional families, healthcare delivery, cross-cultural interactions, intrapersonal conflicts and the effect of relationships on the nation's health.

Perhaps it may be time to look at the medical consulting room as one of the greatest laboratories for research in the 21st century.

Negotiating this in the powerful quantitative arena of biomedicine is another matter altogether.

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