Taking the Pulse of Qualitative Health Research in a Changing World

Crafting a Critical Approach to Social Change and Health in the 21st Century

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Report from a workshop held on 25th June 2018 and hosted by the UCL Qualitative Health Research Network (UCL QHRN)

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Abstract:

Studying change—social, technical, environmental—within contemporary society has provoked novel challenges and reinforced previously encountered challenges within qualitative health research. To address these challenges and advance the qualitative study of change in healthcare settings, the University College London Qualitative Health Research Network (UCL QHRN) hosted a workshop—*Responding to Change: Perspectives from Qualitative Health Research*—in London in June 2018.

Twenty-three scholars from various academic disciplines (including anthropology, sociology, science and technology studies, psychology, and medicine), countries (including the UK, Canada, Australia and Hong Kong), and levels of experience (from PhD students to Professors, and people with direct experience of illness and care) participated in the workshop, having submitted abstracts to an open call for papers. Prior to the workshop, selected participants submitted short written papers for dissemination among those attending. On the day, participants gave a four-minute summary of their contributions, which supported subsequent group discussions. With participants' permission, we took detailed field notes to record the content and tenor of the overall discussion, provocations and responses.

This report summarises these contributions and discussions under three main themes: *Tensions and opportunities in evaluating and creating change; Methodological reflections on studying and responding to change; Theorising change and its processes*. While presenting a synthetic account of contributions we do not wish to impose false consensus among contributors. We therefore refrain from offering recommendations or guidelines, instead outlining points of consideration to stimulate others in the qualitative study of change in health, illness and care. Qualitative approaches are extremely capable of producing the rich and nuanced accounts that are much needed to help patients, health and social care practitioners, policymakers, and society at large, anticipate and navigate the social consequences of change as it unfolds continuously throughout multiple arenas.

[Key words: qualitative health research; social change; critical approach; interdisciplinary]

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We are also extremely grateful to Professor Catherine Pope for her insightful and inspiring keynote lecture, which did much to stimulate discussion in a manner both intellectually dynamic and supportive.

Finally, we greatly thank the Wellcome Trust for their generous support of the workshop and the broader work of UCL QHRN.

About the network and support

The UCL Qualitative Health Research Network (QHRN) is a cross-faculty collaboration between UCL Department of Applied Health Research, UCL Division of Psychiatry Qualitative Researchers Working Group supported by the Marie Curie Palliative Care Research Department, and UCL Research Department of Behavioural Science and Health, and it is open to anyone interested in qualitative health research in the UK and abroad.

The Wellcome Trust award [210576/Z/18/Z] supported the workshop in addition to our quarterly seminars and 2019 international two-day symposium. (http://www.ucl.ac.uk/qualitative-health-research-network/symposia).

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Introduction: Why a workshop on change?

On June 25th 2018, the University College London Qualitative Health Research Network (UCL QHRN) hosted a workshop on qualitative approaches to studying change in health, illness and care, supported by the Wellcome Trust. Our workshop—*Responding to Change: Perspectives from Qualitative Health Research*—also aimed to "take the pulse" of the qualitative health research community as it engages in the theme of change. Reflection on this theme comes as we look towards our 4th biennial symposium—*Crafting the Future of Qualitative Health Research in a Changing World*—21st-22nd March, 2019.

Change is happening constantly—it is nothing new, but it has what seems an intrinsic and inexhaustible capacity to present and assert itself as such. We are witnessing major change in healthcare environments across the globe and across multiple dimensions. Rapid technological advances, personalised medicine, and on-going demands for more patient involvement, to name just several fundamental shifts underway now. These advances are happening against a backdrop of major geopolitical and demographic change, with ageing communities, global austerity and the biggest wave of mass migration since the second World War. These bring significant social consequences for patients, practitioners, policymakers and society at large whilst seriously challenging established forms of care, the allocation of resources and the inscription of new roles, responsibilities and relationships. At a different scale, change is a fundamental feature of care—we aim to make people better or prevent them becoming ill—and we design ways of intervening in people's lives in complex ways. These changes also require nuanced analysis.

As a network of independent researchers engaged in qualitative work, we have become increasingly interested in contributions researchers engaged with qualitative approaches can make to the study of change. For example, how we can help healthcare communities to anticipate and navigate the many and complex social consequences entangled with it as commentators, theorists and as agents of change. We are also interested in the tensions it produces for researchers—as we too have to navigate its many flows. In short, our goal was to reflect on these questions: How can we study change qualitatively? How does change, by

virtue of its fleeting nature and unintended effects but also its more gradual shift, complicate normative approaches in qualitative health research? How can we respond to change in informed, meaningful and timely ways?

Our call for papers drew a healthy number of varied and fantastically thoughtful submissions from around the globe. From these, we selected 24 abstracts and invited contributors to submit brief papers for circulation before the workshop. This allowed contributors to become acquainted with each other's work and to encourage discussion. Researchers came from a variety of academic disciplines (including anthropology, sociology, science and technology studies, psychology, and medicine), countries (including the UK, Canada, Australia and Hong Kong), and levels of experience (from PhD students to Professors, and people with direct experience of illness and care).

Catherine Pope, Professor of Medical Sociology at the University of Southampton, started off the day with a rousing keynote lecture, setting the tone as one of deep reflection and progressive action. Reflecting on what will soon be 30-years of work that has done much to place qualitative approaches on a more solid footing in the academy of health and social care sciences, Professor Pope provoked us to think about what a community of researchers engaged in "radical change oriented health research" might look like. What followed certainly rose to her provocation.

In a packed and experimental day of discussion, each participant summarised his or her paper in a 4-minute speech, without PowerPoint and with an alarm to call time. Intervention … alarm … intervention … alarm—like a four-minute pulse sending forward the conversation. What might have been sacrificed in terms of longer and more detailed accounts was gained in the generative effect of keeping things open and at a point of imminence—itself a key feature of change.

We ordered papers into three sessions—*Tensions and opportunities in evaluating and creating change; Methodological reflections on studying and responding to change; Theorising change and its processes*—after which we drew breath and engaged in longer group discussions. During discussions, we took detailed field notes to record the content and tenor of the overall discussion, provocations and responses. Here, we present a synthesis of

the papers and ensuing discussions for each of these themes. However, we do not wish to impose false consensus among contributors. Indeed, while sharing an interest in the qualitative study of change, contributors often disagreed in how we should conceptualise change and study it. As such, we refrain from offering recommendations or guidelines, instead outlining points of consideration to stimulate others in the qualitative study of change in health, illness and care. We include the title, abstract and authors for each paper in the appendix, which follows.

Session 1: Tensions and opportunities in evaluating and creating change

In this first session, contributors discussed the features and complexities of studying change when the boundaries between "researcher" and "researched" were blurred. Papers offered examples from approaches broadly characterised as participatory, engaged, and co-produced, and suggested productive possibilities and tensions in researcher standpoint and positionality—that is, how researchers are located in the research field. Opportunities included the possibility of integrated accounts of change that could be co-constructed by researchers and members of the communities with which they worked. Tensions included the challenge of balancing impartiality in research with engaged practice when *researchers of change* are also *agents of change*. Together, we explored the following questions: How do researchers reconcile tensions between impartiality and engagement when they are both researchers and agents of change? What should be the role of "today's" qualitative researcher in the face of current transformations of health and society? How can service users or practitioners engage in research processes to effectively study change?

Impartiality and engagement

Workshop contributors commonly mentioned the tensions which arose in their ambitions to be both *insider* and *outsider*, and the associated principles of *engagement* and *impartiality*. Responses more specifically concerned contributors' relationships with research participants on one side and stakeholders on the other. Another concern and source of conflict for contributors was the extent to which they themselves were "agents" in the unfolding of change. Workshop discussions specifically considered how the observer, being him/herself an agent of change, often needs to negotiate his own wishes, those of the stakeholder and those of research participants. Hence the orientation of changes emerges from these negotiations. However, contributors also mentioned that the researcher still possesses some autonomy, and therefore has his or her own weight in the balance of opposing forces.

Being an 'insider' and the wish of 'going native,' offered the possibility for qualitative researchers to learn other perspectives by being close to research participants – for example, by understanding health concerns within local communities. However, participants also underlined a series of advantages associated with keeping an 'outsider' perspective. For instance, some questioned how we could remain autonomous and critical in the production of the research results, while being immersed among our participants and try to approach the position of insider. For other contributors, the external perspective was also an opportunity to deconstruct positions, wishes and understandings associated with the moral framework of the participants. An external position may help to critically analyse unquestioned values and positions that may appear 'natural', 'rightful' and therefore legitimate to groups, or individuals, although potentially neglecting the interests of others (e.g. other groups, the society at large, or even people being attributed a lower social status within the group of participants itself).

However, contributors described conflicts when working in close proximity with their participants, which could provoke feelings of betrayal due to the difficulty of wearing the multiple hats that qualitative research requires. Such anxiety shows the moral dimension that fieldwork creates when ties develop with participants. Issues with integrity emerge when researchers struggle to sustain this commitment to participants throughout the research and production of outcomes. Contributors, when considering these issues emphasized the importance of research to be non-exploitative. Participants also mentioned that coproduction of findings with participants should not be tokenistic. Overall, such concerns with integrity and independence of the research are testimonies of the fact that creating or influencing change in itself is not a neutral process and requires continuous reflection upon modes of engagement with participants and stakeholders. It may appear to be controversial and can sometimes have a substantial impact on people's lives.

Power and positionality

Undertaking ethical research was therefore an important challenge for contributors when implementing change. Some mentioned the tensions they faced when acknowledging the

concerns and positions of their participants on one side and being bounded to stakeholders and standardized ethical guidelines on the other. It was therefore a complex equilibrium that contributors tried to maintain between these standards of institutional ethics, commitments to research participants' perspectives, the increasing demand for 'impact', and the requirements dictated by stakeholders. Qualitative research is therefore caught in a web of political intricacies.

Contributors discussed several of these intricacies and the need to account for their positions. Furthermore, those who were also clinicians or service users articulated other pressures, personal and professional. Contributors also described challenges they encountered as they strove within their own careers, often moving between short-term contracts, and the future prospects of employment and research grants. The key concerns here were therefore about power and positionality, meaning the influence that the position and values of the researcher has on the research itself. To this regard, contributors highlighted the challenge linked to divergent agendas between researchers, funding bodies, and/or other institutions.

Roles can be conflicting, and there is always a need within qualitative research to position oneself regarding change, especially when change is controversial. Solutions to these tensions and demands is, some participants argue, to speak a 'language of value' to stakeholders and holding onto this position with conviction. Although we did not report further on this last idea from the workshop, we suggest the contributor may have meant that we should build an argument emphasizing values attached to human rights when engaging with stakeholders and the public in relation to the conclusions of our research. Several contributors argued that we should not be apologetic about our role as researchers. It therefore relates to a sort of *ethos* of engagement that we should be ready to take as researchers – a continuum between being an activist researcher aligned to a cause and attempts to keep a certain detachment.

Negotiating critique

When facing the difficulty to engage directly with stakeholders, participants mentioned other possibilities for engagement, and enacting change. In these diffuse forms of engagement,

researchers cited the possibility of being flexible in terms of the type of contribution that we make, taking alternative, creative modes of influencing transformative forces. For instance, the power of storytelling, or pragmatic forms of engagement which avoid being overcritical with the risk of offsetting other stakeholders. Such approach would help mitigate an important concern when engaging with politically sensitive topics. Other participants mentioned co-production, or participatory action research as a mode of engagement that may help resolve some of the dilemma associated with the political nature of engagement.

Accounting for time

The inescapable dimension of time was another major tension for contributors, with several specific challenges discussed. For many, capturing "change" in the real time and understanding its many causes meant being present long enough to discern the differences entailed and spending time at the sources of change. Yet, this desire for longer term fieldwork was often incommensurable with the structural realities of short-term contract work, the rapidly changing healthcare contexts where we work and the need to provide results quickly. We believe it would be relevant to study whether such pressures could eventually compromise the accumulation of knowledge and the development of in-depth expertise. Indeed, for many contributors, less time "in the field" meant less familiarity with research settings and participants. It also limited opportunities for gathering rich situational data and the possibilities to witness critical moments of change which might arise serendipitously. It is relevant to point out that the wish to engage in long-term research, and the understanding that we have of what constitutes an adequate length of time in the field may vary depending on the discipline and its mode of engagement with participants. Those working ethnographically particularly felt these tensions. Studying change in "naturalistic" settings and developing terms of engagement in which the researcher becomes an actor in the lifeworlds of his or her informants, perhaps even taking sides, was felt an inevitability for some workshop participants who engaged in long-term research. Despite these limitations, other researchers pointed to new developments in the field of rapid qualitative research, which could help address some of the challenges outlined above.

Session 2: Methodological reflections on studying and responding to change

In this session, contributors discussed ways of using and enhancing qualitative methods to study change at the level of individuals and populations and across multiple kinds, rates and degrees of change, such as broader societal change, policy, and individual attitudes. They also offered reflections on the timely dissemination of research in rapidly changing research environments. Broadly, contributors agreed that these research environments shape the production of methods and their theoretical underpinnings. Aside from issues around the limits set by institutional ethics (which has been discussed at length elsewhere in this report (See pg. 7-8)), contributors outlined a number of key and difficult questions specific to qualitative studies of change. These included: How can qualitative methods be more sensitive to capturing change? What periods and aspects of change are available to which kinds of qualitative inquiry? How can depth and rigour of research be balanced with timely dissemination of findings?

Conceptualizing change within the research method(s)

Attempting to conceptualize the nature of change today and select methodologies that could optimally grasp its complexities, was a main topic of discussion among contributors. Firstly, this conversation within the group appeared useful to review the plurality of methods that qualitative research encompasses. Contributors mentioned methods ranging from cross-cultural, prospective and comparative approaches, to the expedience of methods like rapid ethnography. Members also looked at the salient role that the process of analysis takes into understanding change.

Imagining change

Regarding analysis, points were made about rethinking the role of *imagination* in understanding complex, multi-layered and all-encompassing phenomena such as change. One contributor mentioned how *imagining the future* could be inspiring, and likewise

understanding historical changes could be valuable. Another point discussed by the group related to the role that imagination plays in understanding change, more specifically relating to the *untold dimensions of change.* Such argument reminded researchers looking at change to pay attention to what people do not talk about, or the actions that they do not make, rather than solely focusing on what they *do* say about change, and about the acts they *do* perform during interviews and observations. In a way, underlining the importance of imagination recalled aspects of Catherine Pope's keynote introduction and her mention of *The sociological imagination* (1959) attempting to connect 'society, history, and biography' in our explanations of the world, as C. Wright Mills explained in this seminal work.

Many of these concerns, as said, come from our attempts to understand the nature of change and how to approach it. It could therefore be useful to explain some of the attempts that were made on the day to define our understanding of the *'nature of change'*. Change can be understood as a social construct in the sense that it appears to be in large part a result of human activities and their variation across time. Some of the participants characterised change today as *relentless*, often perceived as intensifying within a world currently more intertwined due to globalization and technologically induced transformations.

There is also the dizzying impression that researchers encounter when trying to grasp change across scales. Indeed, one could speak of a *mise en abîme*—an infinite recursion or image within an image—when realising that research trying to study and act upon change is itself part of a changing landscape. Here we face again the conundrum between observer of change, and agent of change. Again, this might be more felt by those engaged and embedded within the communities they study.

Considering stability

Another key point and a possible resolution to the difficulties of managing flux, was a consideration of stability or stasis as a counterpart to change. Contributors recalled that change is a social phenomenon that can operate at a changing pace across time, allowing us to rest our analysis upon moments of stasis and slowdown. Indeed, not everything changes with the same intensity and there may still be a certain level of inertia within changing

societies, for instance with the continuous existence and resistance of certain ideas and institutions. Such inertia can constitute a highly relevant object of study for qualitative research looking at current social transformations.

Imagination may here again play a role as a response to the relentlessness of change. Some asked during the day: Should we actually slow down the pace of research to study sites and places where the speed and/or intensity of change is increasing? Participants suggested for instance the interest of 'watching and waiting', and of considering change in hindsight, rather than 'in the moment.' The point presented here relates to our ability to interpret the intense, rapid transformations that we confront without being submerged by them. Taking plenty of time to deeply reflect on rapid changes might appear more beneficial to understand what really matters in these transformations, rather than trying to increase the speed of research to embrace situations of intense and rapid change which may appear overwhelming for the researcher.

However, there are potential pitfalls in this judicious approach of slowing the research process. Researchers face a challenging dualism today. They should integrate the requirements of timeliness in the research design on one side, while performing the time-consuming depth of analysis, introspection, imagination and use of social theory required to deepen the social analysis on the other. While these two poles are not exclusive, they illustrate concerns felt by our contributors and many in the broader community of qualitative health researchers.

Change and perspective

A view of change is never a view from nowhere. It can be viewed from multiple perspectives and considered constructive or destructive, good or bad. In this way, considering change is intrinsically moral. It is also political given the difficulties of extricating change from the political landscape in which it exists, a landscape from which we, as researchers, also cannot escape. Contributors therefore noted two things: 1) the need to account for multiple experiences and perspectives of change, and 2) the need to reflect on our own perspectives.

Regarding the latter, contributors emphasised the importance of reflecting on our assumptions and research practice and how these might impose a particular moral framework on the change phenomena studied. Some spoke about the origin of change as a marker that might enable us to calibrate, or at least be aware of, our own moral compasses.

Regarding the former, contributors emphasised the need to examine power, which could be understood here in a 'Foucauldian' sense. Distinguishing between changes mandated in top-down initiatives and those given in grass roots movements was a critical consideration. Questions which might support such considerations included: To whom does change belong? What are its intended purposes and for whom? What are the social consequences of change, intended and unintended? To better tackle these complex questions, contributors critically examined the strengths and weaknesses of qualitative methodologies.

Reflexivity

Reflexivity was advocated as a particular strength enabling us to situate ourselves within an open system and query our influence on the production of knowledge about change. And yet, contributors also remarked on its cost—practically and emotionally. On the one hand, reflexivity carries many implications regarding the negotiation of being in-between research participants and stakeholders, leading sometimes to a serious questioning of identity and allegiance. On the other, and at a more personal level, reflexivity might lead researchers to expose themselves to the many emotional aspects of human interactions with participants, and the difficulty of navigating across various moral dilemmas. Again, peer support and qualitative research networks were seen to offer safe spaces to voice concerns and resolve such issues.

Methodology and its influence on outcomes

How *methodology* determines *outcome* was a major concern for contributors when considering studies of change. This was particularly salient when considering the *researcher as observer of change/agent of change* dynamic described in session one. Here, the choice of method was acknowledged to be a critical factor in shaping this dynamic and enabling new

possibilities for *actualising* change. The idea 'radical change-oriented research' was discussed, in which various forms of participatory research are used to engage 'marginalized voices'. Again, contributors emphasised the political dimensions of enacting change, in recognition that sources of change are very often multiple. Contributors also cautioned against tokenism in collaboration and highlighted opportunities to strengthen genuine partnership.

Dissemination and impact

Dissemination of research plays an essential role in affecting or provoking change, with different modes of dissemination appropriate to different audiences. Beyond considerations of *audience*, contributors made insightful comments on the *timing of dissemination*. Here, the issue was about matching the pace of dissemination with the pace of change. The key challenge is to balance depth and rigour in the research process with the mobilisation of knowledge necessary for its continued relevance. Examples of rapid and overwhelming change were given, such as the Ebola epidemic or the sudden introduction of new medical technologies. Such phenomena seriously challenge established norms of qualitative health research and impacts all phases of research. Contributors mentioned the difficulty to keep up with change whilst writing and disseminating. Ideas and approaches such as rapid ethnography were offered as means to capture change in the moment and disseminate knowledge in a timely way.

Underpinning the question of dissemination is therefore *impact*—an arguably more evasive concept. One contributor noted the schism between actual change (impact), and the sheer amount of research in healthcare. Another concern was the unpredictability of impact. Discussions over this theme covered the fact that researchers cannot anticipate the changes brought by their results during dissemination, which may differ from the impact they wished for.

How to implement *sustainable* change was also a matter of concern for the contributors. In many ways, uncertainty has a substantial effect on the sustainability of change triggered by research. How does the research design therefore accommodate uncertainty and ensure sustainability?

Session 3: Theorising change and its processes

In this final session, we discussed concepts and mechanisms of change. Contributors offered theoretical perspectives on studying change, its processes and accounting for social context. A key concern was how to theoretically integrate different levels of change (e.g., micro, meso, macro) and how change occurs across multiple temporalities (kinds and rates of change). Papers also offered reflections on the dynamics of change and its relationships to continuity, as well as the structural conditions and contexts (e.g. funding, policy, governance imperatives), which bear upon how we can think about and study change. Together, we attempted to discuss issues related to the following questions: How can qualitative research help us conceptualise change? How can concepts of change help us study change more effectively? How can we take account of multiple levels of change and temporalities, conceptually? How can social theory help us to study change? What structural conditions shape how we think about change and study it?

Understanding theory and method

A series of discussions on the day illustrated a general concern about theory within qualitative health research and what it should achieve. The scope of the discussions was vast and there were divergences among the contributors' perspectives. We attempt to translate aspects of these discussions below.

First, there was the issue of terminology and academic discipline. Theorising change should be more than a codification of "reality" based on simply mimicking the conceptual terms of a discipline – the idea of 'common sense wrapped in jargon'. It should constitute an explanatory framework which attempts to move beyond disciplinary jargon and micro-description. Only then, can it fulfil its role of suggesting explanations for the transformation of institutions, ideas and human groups associated with health.

Second, theory in qualitative health research cannot be isolated from methodology or indeed the structural constraints mentioned in session one. There was broad consensus that research design and epistemology affect the kind of evidence and interpretation that researchers ultimately integrate into their theoretical accounts. Regarding other constraints, researchers mentioned the interests of funders as often being more about discreet practical outcomes and rapid fixes than deeper accounts of change and complexity.

Third, researchers discussed the importance for theory to be holistic when it attempts to interpret reality, for instance by looking at particular situations without neglecting elements of context. An holistic approach can help build explanatory frameworks covering questions about generation, ethnicity, class, gender, professional role and their repercussions at a local and societal level. Such explanatory frameworks are also a means to guide data coding. The interpretation of interviews and field notes in dialogue with existing theory could equally help qualitative research to 'see' beyond a set of observed variables. Here again, contributors mentioned the role of imagination as a means of intuiting meaning and developing relationships between self, society and history as pertaining to change. Although there was not really a proposed definition for this idea of 'imagination' on the day, we could understand it as the capacity to establish complex and rich interpretations of observations of society, culture and social interactions (and their meanings) which attempt to encompass a wide range of research material in creative manners.

Towards interdisciplinarity

Contributors aspired to develop roles and forms of theory to improve the qualitative study of change and wished specifically for theory to be more interdisciplinary. It was hoped that this might encourage more dialogue and collaboration between disciplines and schools of thought. This point seems to logically emerge from the fact that many different disciplinary backgrounds are represented among members of the network and in attendance at the workshop. It is also the result of an understanding about the importance of being aware of our *positionality* regarding theory. Hence, scrutinising the impacts our various disciplines and backgrounds on the constitution of theory would be central to fulfilling this wish. While

contributors also recognised this objective of interdisciplinarity, they were cautious about the set of challenges that would emerge in regard to epistemology for instance. What constitutes knowledge differs between disciplines and promoting interdisciplinarity will come through reflexivity and the construction of consensus, or at least some agreed common grounds on such questions of epistemology. This latter statement applies even more when engaging with scientific disciplines that fall outside the realm of qualitative research and may have very different understandings or limited use of theory. The role of the qualitative researcher in interdisciplinary endeavours, therefore, changes toward the one of an advocate promoting the use of theory. Some contributors mentioned for instance the importance to anchor quantitative findings often focused on individual behaviours into societal, historical and political contexts thanks to theory.

Epistemology and the scope of theory

Following the contributors' points, theory was discussed as both the available arguments/ideas within a particular discipline – the available scientific literature – and the newly constituted analyses and interpretations of the researcher throughout his/her fieldwork/empirical research.

As for the theory resulting from the interpretative and analytical activity of research, contributors reminded us that it remains dependent upon the epistemology associated with the discipline to which the researcher belongs. This is one of the characteristics mentioned in the previous section regarding the challenges associated with achieving actual interdisciplinarity (e.g. incompatibility of paradigms, etc.).

That said, some contributors discussed possible ways to enrich theory construction beyond these challenges. Some of them spoke about the interest to more thoroughly include the study of emotions within research. For instance, we could evaluate the operation of change, and the appropriateness of decisions influencing change by looking at their impact on the creation of anxiety, hope, and other social phenomena deeply influenced by emotions within society. Such indicators may then be analysed and can feed into other theoretical frameworks.

Scales of change

The question of *scale* was a regular theme of discussion. Some researchers spoke about scale in regard to methodology (see section two) and discussed the range of scales which might be taken into account (micro, meso, macro). Researchers discussed these aspects within theory in a similar fashion by considering the importance to explore and interpret social phenomena and their interrelations across 'scales'. Some researchers discussed whether we should build theories on the *micro*- solely or extend the inquiries to include *macro*-processes as well. At least some agreed that we should locate small studies into the larger social and political context. That is, for a richer analysis of local change, we must consider how it relates to larger scale healthcare transformations.

Dealing with uncertainty in outcomes

Finally, some contributors briefly discussed the importance of being aware that actions aiming to create change do not always lead to the desired results. This simply means that there is always a certain level of uncertainty and speculation about the outcomes of actions. The discussion did not go beyond that point on the day, yet we think that it might be interesting to keep in mind that *uncertainty*—here meaning unintended consequences—should be considered while doing research aiming at a change. This might be done by reflecting upon uncertainty in relation to the dissemination of the research for instance, or in relation to the research design and the kind of data gathered, while considering the impact of the general context of the research at the same time. Ultimately, we may simply remember that the quality, richness and scope of our interpretation of the reality in research will help in reducing the amplitude of uncertainty built in the achievement of the desired outcomes.

Conclusion: Responding to change

Studying change within contemporary society has brought up novel challenges and reinforced previously encountered challenges within qualitative health research. The aim of the *Responding to Change* workshop was to contemplate these challenges and interrogate how qualitative approaches can be deployed in studying change in health, illness and care. The papers submitted, together with the discussions during the workshop, provided rich and varied perspectives on this theme. In this report, we have not attempted to simplify these perspectives into consensus, but record the many questions, provocations and challenges offered by contributors. Our thematic headings are simply a way of ordering key concerns around tensions and opportunities, methodological reflections, and the theorisation of change. Far from discreet arenas of thought and practice, these are intrinsically related and mutually constitutive.

Throughout this report, we have emphasised the open and unfolding nature of the world(s) we study and our inescapable positions therein. We have also emphasised the imperative to account for the particularities of our positions when studying change – how we are differently located as observers and participants in change; how we are located within academia; how we are located in structural conditions which imply certain sets of conduct and norms around output. Finally, we have attempted to capture something of the particular character of change itself – its capacity to move in unexpected ways, across multiple sites, scales and temporalities, and often at unfathomable pace. All these things come to bear on the methodological and theoretical orientations we assume and reject as we approach change. They call into question what we mean by the categories of expertise, experience and engagement and their relationships to how communities imagine and try to enact alternative futures for health and care. Ultimately, they bear on how we make sense of, how we represent, and how we enact change.

Together, these concerns invite approaches which themselves are neither static nor formulaic. And this is what is exciting about qualitative health research: its continued capacity for self-scrutiny, reinvention and adaptation to the phenomena under study. The variety of

flexible and adaptive approaches given in this workshop is testament to this – oral history, longitudinal interview and ethnography, to name a few. Through these approaches, stories are traced as they unfold, wresting accounts of subjectivity and society from the static quality of snapshots to the more dynamic character of the moving picture.

As we look forward to our 4th symposium, we report that the pulse of qualitative health research and its investments in studying change beats strongly, supporting a body of researchers adapted and ready for radical change-oriented health research. This approach is extremely capable of producing the rich and nuanced accounts that are much needed to help patients, health and social care practitioners, policymakers, and society at large, anticipate and navigate the social consequences of change as it unfolds continuously throughout multiple arenas.

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Appendix

Keynote lecture

Catherine Pope, University of Southampton	**Groundhog Day? Or Sliding Doors? Reflecting on 30 years trying to do qualitative research to study health and healthcare systems.**

Early on in my career I published, with Nicholas Mays [1] a small piece about the role and potential of qualitative research. I spent the following decades doing health services research and, often, defending qualitative method. There have been advances - the rise of qualitative evidence synthesis which I have had a role in developing methods for, and the growth and increasing use of mixed methods research in health services evaluation, for example. But some methodological battles that I and other researchers considered won have resurfaced with depressing regularity, notably the question of the worth and utility of qualitative methods in health and health related research [2]. These debates can often feel rather like the recursive plot used in blockbuster movies (but without the accompanying romance). Surely it is time we moved forward. Can we not take our methods and use them to enrich our understanding of health and healthcare? Can we push our methodologies to deliver explanatory power as well as rich description? And in so doing perhaps we can silence the critics? I will illustrate my presentation with some examples from my own empirical research – most recently about NHS urgent and emergency care – and hope we can generate a lively discussion about some of the opportunities for qualitative health research methods in healthcare and health services that move us beyond Groundhog Day.

1. Pope Catherine, Mays Nick. Qualitative Research: Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research *BMJ* 1995; 311 :42

2. Greenhalgh Trisha, et al. An open letter to *The BMJ* editors on qualitative research *BMJ* 2016; 352 :i563

Paper titles and presenters

Session 1: Tensions and opportunities in evaluating and creating change

Lil Deverell, Swinburne University	**Bridging the clinical/functional divide with QUAL/quant assessment tools**

Orientation and mobility (O&M) specialists work in the community with people who have low vision or blindness. Low vision typically fluctuates with changes in lighting and fatigue, and clinical vision measures (e.g., visual acuity, fields) don't predict a person's functional capability in the community. Qualitative O&M assessment helps to scope clients' individual needs and tailor program design, but in the context of infinitely different, dynamic travel environments, fluctuating vision, changing personal needs and a dearth of functional O&M measures in a culture of evidence-based practice, it is difficult to account

for client competence, compare clients, prioritise their needs and evaluate training outcomes. O&M specialists in Australia are wary of standardised measures that might impinge on clients' freedom to live and move authentically. Attempting to build bridges between qualitative and quantitative approaches, we use grounded theory methodology to identify what matters to clients about their functional vision and mobility, to group elements of universal relevance while also treasuring the diverse, unique experiences with low vision that help to break down a binary understanding of sight and sightlessness. The universal elements have provided a foundation for two mixed measures of functional vision and mobility. These person-centred assessment tools are used during qualitative O&M assessment, in everyday places that matter to each client. Co-rated between assessor and client, behaviourally-anchored ordinal scales help to reduce universal data to a score out of 50, while qualitative data are recorded alongside ratings to interpret the numbers, demonstrate their individual validity, and enrich our understanding of living with low vision. This QUAL/quan priority in outcome measurement offers a fresh approach to translational research.

Robert Edward Whitley, McGill University

Responding to change or catalyzing change? Why qualitative researchers must be agents of change as well as observers of change

Quantitative approaches within health sciences such as epidemiology demand that researchers act as passive observers. Their role is to dispassionately collect and analyze data. These approaches discourage active involvement in social change during the research process. In contrast, qualitative approaches within health sciences encourage researchers to act as agents of change. This is particularly so within the Participatory Action Research (PAR) approach. This approach demands that researchers design and execute interventions in collaboration with vulnerable populations to improve health outcomes. These interventions are subsequently evaluated for health impact. This emancipatory approach has been used with considerable success by many qualitative researchers in response to injustice and inequality. For example, indigenous health researchers have successfully used PAR approaches in diabetes prevention and mental health promotion. I am presently using a PAR approach in a national project attempting to reduce mental illness stigma. In this project, groups of people with mental illness have created a series of educational documentaries, with complete editorial control over content. The workgroups are currently organizing screenings (with panel discussions) to reduce stigma in target groups. Impact on viewers and participants is being evaluated using qualitative methods. We are not merely observing and documenting stigma, but trying to reduce it and its nefarious social consequences. In short, PAR encourages qualitative researchers and vulnerable populations to work together to plan, implement and research change. I conclude that qualitative researchers should take a lead in initiating and catalyzing change through PAR, especially given growing injustices, inequality and inertia.

Roman Kislov, The University of Manchester

Going native in order to make a difference? Longitudinal qualitative participatory research in healthcare

There is a growing criticism of both 'pull' and 'push' approaches to implementing evidence-based change in healthcare, with the increasing prominence of co-production, also referred to as action research, participatory research, engaged scholarship and integrated knowledge translation.

Qualitative health services researchers can contribute to this broad family of approaches as (1) 'researchers-in-residence' embedded in healthcare organisations; (2) as members of multiprofessional implementation teams working at the interface of healthcare organisations and universities; and (3) as contributors to multidisciplinary mixed-methods research teams aiming to produce impactful research.

This paper draws on an auto-ethnography conducted over a nine-year period by a qualitative researcher embedded in a large-scale knowledge mobilisation partnership between a university and a range of local healthcare and third-sector organisations. It traces an individual journey from being a relatively disinterested observer, focusing on researching organisational change, towards becoming an enthusiast of co-production, promoting the practical impact of longitudinal research on the organisational structures and functions within the partnership.

At the same time, the paper highlights four dilemmas that longitudinal qualitative action researchers have to manage:

(1) Wearing different 'hats': being 'too academic' for practitioners and 'not academic enough' for fellow researchers;
(2) Compromising research rigour in order to quickly produce results fed back to non-academic partners;
(3) Achieving a balancing act between being critical and constructive;
(4) Maintaining your own voice while truthfully reflecting the (often conflicting) voices of multiple stakeholders.

Sarah Yardley, UCL

Can 'learning through shared endeavour' help realise the potential of qualitative health research? - methodological reflections

The ability to learn and adapt is crucial to successfully navigating change. High-quality patient care, professional learning and Qualitative Health Research (QHR) are all relationship-based; dependent on meaningful collaboration to negotiate understanding, priorities and purpose. Effective responses to change depend on people willingly engaging in mutual expansive learning1 – generating collective expertise through shared endeavours.

The need for better adaptive and sustainable responses to healthcare changes is well established and so the key challenge for QHR communities is how to ensure our work is seen as essential to guiding and fostering effective change responses. Examples achieving this include developing understanding of intentional and unintentional 'learning consequences' arising from change, and the transition of research about interpersonal dynamics into designs and implementation plans for effective complex interventions.
The QHR community should develop a message of synergy between relationship-based patient care, professional learning and the iterative use of QHR methodologies to study, respond to and manage change. Exploring what people actually do, how they decide this, and how everyone involved in healthcare learns from each other can help evidence new healthcare models, such the concept of co-dependency for improving quality and safety in both learning and practice. In this paper I will use examples from my work to explore mutual expansive learning options for QHR engagement to achieve mutual benefits for research and healthcare communities through simultaneous development of fundamental understanding and provision of real world utility.

Konstantina Poursanidou, King's College London

Exploring attempts at innovation and change in inpatient mental health care through service user-led critical ethnography: methodological, ethical and political dilemmas

Using a critical autoethnographic approach, this paper will draw on my recent experience of conducting an ethnographic process evaluation of a Quality Improvement violence reduction programme on inpatient wards in two NHS Mental Health Trusts in England to reflect on crucial methodological, ethical and political dilemmas-questions associated with exploring attempts at innovation and change in inpatient mental health care through service user-led critical ethnography. Utilising my service user-led critical ethnographic study as a case example, the paper will seek to examine the potential contribution of survivor research and knowledge on the one hand, and of 'engaged' research approaches on the other, to qualitative mental health research's meaningful exploration of change. Dilemmas – questions on methods, relational ethics and politics that will be interrogated, include:
i) How to negotiate the need to constantly oscillate between 'staying native' whilst

immersed in the ethnographic field, on the one hand, and 'making the familiar strange' by adopting a critical interpretive distance and problematising what could be taken for granted (including one's own lived experience and experiential knowledge), on the other?

ii) How can one manage the emotional labour and profound emotional cost of using one's lived experience/subjectivity as 'an instrument of knowing' in qualitative mental health research? For instance, how can one use their lived experience and experiential knowledge of coercive/violent staff practices in acute inpatient mental health care constructively in their ethnographic research work - without being overwhelmed by difficult emotions associated with this knowledge (i.e. anger, grief and terror)?

iii) How to reconcile the political and ethical standpoint of being an 'engaged' (service user) researcher and an ally of mental health service users (as research participants) with the expectation to be dispassionate, detached and critically distant in ethnographic research work in mental health?

Sohail Jannesari, King's College London

The challenge of change in forced migration and mental health

Background: The outbreak of the Syrian Civil War sparked a new wave of forced migration. This contributed to a gradual rise in UK asylum applications, with 2015 and 2016 seeing the highest number of asylum applications for a decade. The mental health care needs of this population are complex as people are likely to arrive with their own traumatic experiences, face additional stressors related to asylum application process, and face difficulties in accessing services.

Methodological challenge: Research in forced migration and mental health can be too slow to produce results and, even then, results may not make a direct change to the lives of participants or practitioners. In reality, research can sometimes prove distressing to participants, who are asked about sensitive topics. We need to move towards a model of research which is more integrated with the communities and organisations working with people who have been forced to migrate.

How can we respond: We need to be more flexible in the methods we use and the ways we gather data. My PhD uses Participatory Action Research (PAR) to help ensure that results are quickly applied to the benefit of participants. Though not all research can use PAR, its ethos is applicable to other methods. My last study used theatre transcripts of people's migration experience. Theatres, campaigns and art can provide a wealth of secondary data, thus reducing the burden on participants and linking with ongoing practical work in the area.

Viola Cassetti, University of Sheffield

Understanding change in community health promotion interventions: where qualitative research becomes important

Over the past decade, asset-based approaches (ABAs) to promote health and reduce inequalities in local communities have increasingly become important. In ABAs programmes, professionals and community members work together, strengthening and

connecting existing local resources (assets). Nonetheless, the understanding of how ABAs can promote health is still limited.
This study aims to explore what changes in health-related behaviours and changes in social determinants of health can be explained by ABAs through a cross-comparison of two similar programmes using ABAs implemented in Spain and in England. Drawing on theory-based evaluation and qualitative research methodologies, this research proposes a novel approach to study change at neighbourhood level.
Data collection has started with the development of a theory of change consulting programme managers and staff. Ethnographic methods, including observations, interviews, focus groups and interactive workshops, will be used to explore how different local stakeholders perceive the change or impact generated by the intervention.
Thematic analysis will be conducted and data will be compared within and across the two cases. This allows to explore similarities and differences in the perceived mechanisms of change associated with the programmes, while identifying data to support or refute the assumptions in the initial theory of change. These findings will be integrated with evidence from the scientific literature to develop a conceptual model that illustrates which are the mechanisms that can lead to changes in health and wellbeing and in the social determinants. The final theoretical model can contribute to the evidence base on ABAs in community health promotion.

Lorelei Jones[2], UCL; Ellen Stewart[3], The University of Edinburgh

Taking sides in qualitative research on healthcare change

This paper considers the challenge of researcher positionality in qualitative research on healthcare change. Drawing on Stewart's postdoctoral qualitative study of public involvement in major service change in Scotland, and Jones's ethnographic doctoral study of hospital planning in England, we argue that policy-relevant health research poses both risks and opportunities for researchers in contemporary academia, which shape the research process and its findings. One aspect of this shaping is that, in seeking to create 'useful' accounts of policy issues, health policy researchers risk either neglecting subordinated knowledges, or representing them only through the framing device of dominant, systemic knowledges. We describe the presence of these tensions at key stages of our research projects – framing and the search for funding, entry to the field, conduct in the field, writing up and dissemination – and demonstrate the value of key theoretical resources from wider social science in elaborating and mitigating them. We seek to explicate some of the tacit decisions around researcher standpoint in policy-relevant qualitative health research, and argue for explicit efforts towards multivocality within our findings.

[2] Co-author and presenter on the day
[3] Co-author

Session 2: Methodological reflections on studying and responding to change

Hannah Shipman, The University of Hong Kong

Taking the long view: Exemplifying a discursive historical approach to address the problem of mental health stigma in Hong Kong

Societal changes and developments in policy reshape the landscape when it comes to addressing health and illness, though often this is not fully appreciated or integrated into current practices. In situations where changes have not delivered the impact that had been promised or hoped for, it can be helpful to take the longer view. Qualitative health researchers are in a unique position to explore the issues and contribute to discussions for the benefit of societies today and tomorrow.

We present our discursive historical approach as one way of undertaking this task. It involves a free-range approach to discourse analysis, particularly drawing on the tradition of oral history, as well as other adjacent disciplines. It is well suited to studying changes within living memory, by interviewing relevant participants with particular attention to the temporal dimension. In this way the approach can shed light on framings and ideologies, and where the tensions lie in going forward.

We present our application of this method to our project addressing stigma related to mental illness in Hong Kong. We showcase how the method can open up new avenues to address issues as entrenched in society as mental illness stigma and questioning the ideological underpinnings of attempts at destigmatisation. Exploring the discursive constructions of those who have lived through the changes allows the topics to be addressed in culturally sensitive ways, vital to the qualitative health research of today.

Sarah Jasim, UCL

Challenges of undertaking qualitative research studying change in inpatient mental health services

During my PhD, I undertook a mixed methods realist evaluation studying how changes occurs in peer review networks and accreditation schemes, in the context of inpatient and community-based mental health services. Available evidence had suggested that although membership of external peer review programmes can bring about changes that help improve the quality of health care services; very little was known about how this was achieved and what key mechanisms and contexts were essential for change. Informed by a systematic literature review, I collected qualitative data from coordinators (four focus groups) and participants (122 interviews) of external peer review programmes. I also collected quantitative data from 178 community-based memory clinics and 33 inpatient mental health services to examine whether organisational readiness for change influenced service quality.

This study was particularly challenging, as qualitative research in the field of forensic mental health services was not widely recognised. Access to undertake rigorous qualitative research in these environments was difficult, and it was not feasible to include voices of service users, due to issues surrounding capacity and consent – which are common hindrances in this field.

I seek to further explore the challenge of undertaking in-depth qualitative research in challenging environments, where studying change could benefit these under-researched health services; who face a future of increased competition from both the private and public sector. Without further developing qualitative research methods, there is a risk of limiting opportunities from programmes such as external peer review, which bring about change leading to improvements in service quality.

Jayne Webster, London School of Hygiene and Tropical Medicine

Mainstreaming qualitative longitudinal research and re-visiting causality in a global health context

As a rich and flexible methodology for discerning dynamic processes, Qualitative Longitudinal (QL) research follows the same individuals or small collectives prospectively, in 'real' time, as lives unfold. It has the power to mirror real world processes, to investigate how and why changes occur, and to discern the mechanisms that shape these processes (Neale 2018). This capacity is vital where people are required or encouraged to change their practices or otherwise adapt to changing circumstances or environments over time. In recent years this approach has been used increasingly in health services research (Calman, Brunton and Molassiotis 2013; Grossoehme and Lipstein 2016). However, there have been few attempts in this field to document its use or explore its theoretical underpinnings.
This presentation will outline the design and development of an ambitious programme of QL research, the Health Utilisation Dynamics Study, directed by PATH. This is a qualitative 'add on' to a large-scale evaluation of the Malaria Vaccine Implementation Programme in Ghana, Kenya and Malawi (World Health Organisation, 2018-22). QL enquiry is uniquely placed to investigate health and illness biographies, changing health policies, the delivery, uptake and sustainability of new treatments, and to produce dynamic case studies of local health care systems. These are central themes in this study. In particular, we will explore innovative ways to discern causal mechanisms across the micro-macro plane. Our aim is to reflect the dynamic, open-ended and fluid nature of social actions, reactions, effects and counter effects in complex systems of change.

Linda Thomson, UCL

Museums on prescription: Mixed methods evaluation of wellbeing and social inclusion for older adults at risk of social isolation referred to museum-based programmes

As a large-scale social prescribing scheme, 'Museums on Prescription' addressed the considerable public health issue of loneliness. Using best practices derived from an extensive review of social prescribing, objectives were to evaluate wellbeing and inclusion in older adults (65-94) at risk of social isolation referred to museum-based programmes. Referrers, including health and social care, and third sector organisations, used inclusion (e.g. capacity to function in a group, ability to give consent) and exclusion criteria (e.g.

inability to complete questionnaires, moderate-to-severe dementia). Twelve programmes comprising ten, weekly two-hour sessions for c.10 participants, conducted by seven museums in central London and Kent, offered curator talks, behind-the-scenes tours, object-handing and collections-inspired creative activities. In a repeated measures design, wellbeing and social inclusion scales were completed pre-, mid- and post-programme. Participants (n=115) kept weekly diaries and took part in programme-end, and 3- and 6-month follow-up interviews. Measures showed significant psychological wellbeing improvements. Thematic analysis revealed feelings of belonging, renewed interest in learning, increased social interaction and continued museum visits. Findings have implications for policy and practice in that disadvantaged adults might benefit from non-clinical, psycho-social museum interventions; Museums on Prescription could be scaled up across the UK with partnerships between researchers, artists, museums and the voluntary sector. 'On prescription' schemes align with the Health & Social Care Act focusing on multi-agency approaches and preventative treatments; NHS Five Year Forward View advocating 'a new range of approaches' and the UK Government's Sustainability and Transformation Plans suggesting more care provision will be determined at local level.

Cecilia Vindrola, UCL

Responding to change: Is rapid qualitative research the answer?

Timeliness has been highlighted as a factor influencing the utility of research and evaluation findings in healthcare. Only findings shared at time points when they are able to inform decision-making will be able to produce improvements in care. This has prompted the development of rapid research approaches that aim to make findings available when they are most needed. The field of rapid research has advanced considerably in the last few decades, but concerns have been raised in relation to the validity of rapid research and quality of reporting.

In this paper, I explore the main challenges of conducting rapid qualitative research in healthcare identified in the literature. These challenges include the tensions between the breadth and depth of data, which might raise questions regarding the validity of data. Rapid research might not be able to capture changes over time, understand all relevant socio-cultural factors at stake or document conflicts and contradictions in finding, thus potentially leading to unfounded interpretations and conclusions. Shorter fieldwork periods also raise questions in relation to the representativeness of samples as researchers may need to rely on the participants who are most accessible, losing diversity in experiences and points of view. Periods of data analysis might need to be compressed, affording little time for critical reflection. This paper will describe each challenge, present examples of how these are experienced in practice and provide potential strategies for addressing them.

Tarek Younis, UCL

The Hippocratic Oath in a pre-criminal space: Exploring the evolving roles of practitioners

As part of the Prevent statutory duty, the UK government now designates healthcare settings as a 'pre-criminal space'. NHS staff must now identify and report individuals they

suspect may be vulnerable to radicalisation. This presupposes novel ethical dilemmas for practitioners, who may have to breach patient confidentiality prior to any obvious threats of violence to self or others. The politically-loaded responsibility of anti-radicalisation may also introduce a racialized element in healthcare roles. The goal of this submission is to reflect on this supplementary policing role of practitioners, and provide methodological thoughts on researching this change qualitatively. In my research, I found taking an experiential, narrative-based approach centered on mandatory Prevent training both necessary and enlightening. By emphasizing practitioner agency as active recipients of health policy, as well as the context in which emotional experiences are embedded, this narrative approach allows for unique expressions that may otherwise go untold. Through their emotions, practitioners recount experiences of racialized prejudice and/or ethical dilemmas through this change in safeguarding roles, yet reveal simultaneously an apprehension to voice their feelings with staff for fear of repercussions. Furthermore, the perceived incapacity to take a critical stance on Prevent, which many believe unfairly targets British Muslims, has provoked sentiments of helplessness and frustration. My findings beg the question to what extent practitioner experiences may be dismissed in healthcare settings, and how qualitative research can amplify their voices in return.

Jenevieve Mannell, UCL

Innovative qualitative methods for randomised controlled trials

Our study aims to identify the innovative qualitative methods being used alongside randomised controlled trials (RCTs) and highlight their value as tools for evaluating interventions. Qualitative methodologies are ideally suited for considering the multifaceted social changes that occurs during complex health interventions, however only 13% of RCTs use qualitative methods. To encourage better uptake of qualitative tools, we are undertaking a modified Delphi study to explore the innovative methods currently being used alongside RCTs of complex health interventions. The modified Delphi process consists of a round of semi-structured interviews with 20 experts, followed by two surveys for validation and consolidation. Participants include scholars with extensive experience in trials of complex health intervention and expertise in innovative qualitative methodologies, examples of which include participatory mapping exercises, “spiral walks”, and photovoice. The study will establish expert consensus on the most valuable innovations in qualitative methods currently being used, their benefits and feasibility and how they should be situated within RCT design. Preliminary findings indicate the ability of these methods to decipher the complexities of social change brought about by an intervention and to engender high levels of engagement with the research by its participants and researchers. Delphi participants placed emphasis on the importance of choosing methods that answer the specific research question and that maintain rigour and integrity of data. The usefulness of mobile technology as a tool for qualitative data collection also emerged, particularly in remote contexts. This study emphasises the importance of using qualitative methods alongside RCTs and highlights current innovations being used to improve understanding of social change within complex health interventions.

Session 3: Theorising change and its processes

Priscilla Alderson, UCL

Researching transformative change over time in neonatal units

There are several reasons for the limited capacity of current qualitative health (social) research (QHSR) to inform policy and practice, which are related to its marginalised status within biomedical, policy and public communities. Qualitative medical and scientific health research (such as embryology or genetics) are highly valued as valid and trustworthy in being demonstrable, replicable, and useful when identifying causes of problems and potential remedies.

However, QHSR tends to be seen as making non-validated, non-demonstrable, non-replicable, non-generalisable claims, with little attention to causes of problems or to remedies. Positivist and interpretive QHSR approaches both attend to 'downstream' and diverse correlations, symptoms, effects and observable evidence, as if they are somewhat fixed. They tend to neglect unseen, more unified 'upstream' causal mechanisms, critical comparisons, potential remedies, and alternatives, and interactive processes over time in open systems.

To research these latter phenomena, ways are needed for QHSR to theorise and recognise the following: absence that allows space and time for change; emergence, alternatives and transformation; realities of suffering and healing beyond empirical observations and accounts; causal mechanisms in closed and open medical and social systems; social interactions between staff and families being as valid and relevant as the babies' clinical care.

These theories will be illustrated in a critical review (2018) of our research in 2002-2004 in four neonatal units, to examine how critical realism could inform a more enriched, innovative, valid take on the study of change in relation to health and healthcare.

Rosie Perkins, Royal College of Music/Imperial College London

Arts-in-health: Developing arts-based qualitative methods to study change

Arts-in-health interventions, distinct from arts therapies, are increasingly utilised within healthcare, with evidence that they can contribute to positive health change at individual and population levels. A form of 'complex' intervention, artistic activities – such as music making – are inherently messy and experiential, co-constructed in a specific moment of time with a specific person or group. This poses challenges regarding the focus and priorities of research as while the 'outcome' of an arts intervention can be captured through experimental designs and qualitative methods such as interviews, the processes of change, as they happen during an arts intervention, are methodologically more slippery to grasp. This is problematic because we need to understand mechanisms and processes of change if we are to make attempts at meaningful generalisability or upscaling of interventions.

An arts-in-health intervention can of course be described, but how much of its essence is lost in this process? How much of the change such an intervention may elicit is inextricably

tied up within the artistic process itself? While we have made attempts in previous work to analyse mechanisms of change, these are restricted by a reliance on retrospective perceptions and experiences. Indeed, we are certainly not the first to critique outcome-based interventional research in this way and many researchers have taken a qualitative approach to understanding the impact of the arts on health. However, it is also useful to consider what arts-based methods could contribute to begin unravelling processes of health change, using art forms as methods instead of, or alongside, more traditional qualitative approaches. There are, to date, relatively few attempts to use arts-based methods to scrutinise the artistic change processes within arts-in-health interventions. We posit that fore fronting the artistic process itself within interventional designs, perhaps through arts-elicitation methods, may pave the way for evidence-based upscaling and commissioning that not only acknowledges key outcomes but also the key artistic ingredients of change.

Clare Coultas, King's College London — **'Capturing' process and the complex contextualisations of change; A social psychological approach**

Interpretations and operationalisations of 'capturing' process in health institutions/interventions remains highly varied in the literature: from atomistic indicators, to interviews, or ethnographies, with focusses ranging from accessing 'insider' perspectives, ascertaining 'fidelity to design', to identifying 'mechanisms' of change. A common challenge that remains however is capturing the complexities of contexts in their shaping of change. A social psychological conceptualisation of context, viewed as dynamic interconnecting material, relational, and temporo-symbolic aspects (Campbell and Cornish 2010), highlights how the marking out of context, is no easy task, in that an inappropriate severing of objects, connections, or histories of meaning-making, runs the risk of misrepresenting the object of study. In this paper, I propose that dialogical analyses of observed communicative activities in health institutions and interventions cannot only provide insights into the dynamics of implementation processes, but too, to the dynamic contexts which situate them, being identified through interactions. I outline how Linell's (2009) 'communicative activity types' (CATs) concept provides an analytical frame for organising and unpacking observed interactions through their 'double dialogicality', which places analytical focus on exploring how specific interactional accomplishments in CATs are embedded in wider contexts, yet too emphasises that those contexts can only be fully understood through the CAT interactional patterns. Through this process, the shaping of gaps between 'intentions and actuality' in implementation can be mapped out and interrogated, with an emphasis on the porosity of institutions, and the complexities of change, borne out of strategized engagements between people in continual interaction with their dynamic contexts.

Andy Guise, King's College London — **Anticipating change in qualitative global health research**

In this paper I will draw on specific projects to examine the potential for studying change in qualitative health research (QHR) in the context of global health.

Collaborative study of harm reduction services in Kenya reveals dynamics that limit the potential for QHR. As framing: 'global health` research is often misnamed, being focused on low and middle income settings and dominated by researchers, funding and agendas set in high income settings. This limits QHR in its depth and long-term engagement. In studying Kenyan services we developed policy recommendations and theoretical conclusions for documenting change processes in health care services, drawing on ideas from Mol and actor-network perspectives. However, the analytical depth of this work and its impacts are potentially limited. Comparison of this Kenya project to other work just starting in the UK to explore the introduction and effects of Universal Credit will be used to draw out theoretical, methodological and institutional lessons for QHR engagement with change, drawing also on broader literature.
In discussion, I will reflect on structural constraints to qualitatively studying change in global health, and then how global health regimes might themselves change to support QHR. Building on the comparison above, I'll also explore the potential for comparative qualitative analysis between low, middle and high income settings as an institutional and methodological focus for (and marker of) an equitable global health research regime for QHR. Such approaches could address theoretical and policy goals, and in particular aid study of processes of change.

Sébastien Libert, UCL

Bridging the gap between qualitative health research and social theory: New modes of engagement with health, technologies and social change

Recently, technologies have been heavily promoted as the most adequate responses to various challenges associated with dementia. From the start of my anthropological research on this matter, I emphasized the fact that technologies are not neutral, yet strongly bounded to the ideas of their makers and users. I argued that our society's emphasis on individualized technical solutions to complex conditions such as dementia was historically and culturally located, and emerged from broader social, political and economic changes. I was concerned that many qualitative studies I came across scarcely questioned the impact that macrosocial changes have on the experience of dementia through the intermediary of technology. A knowledge of social theory's extensive exploration of social change could have helped in establishing this relationship. Indeed, the systematic study of social change has been at the hearth of social theory for more than a hundred years now, from the Chicago School of Sociology, to the Manchester School of Anthropology, and the Frankfurt School of philosophy. I believe insights from these major academic endeavours and their most recent ramifications could be of great support to qualitative health research's ability to critically address the intensification of technological change in healthcare today. I hope that my engagement in this workshop through my knowledge of these existing theories will help my colleagues to approach their own research in novel ways. Furthermore, references to such theories of change could help the group to optimally respond to current transformations of our political economy and their impact on health.

Anna Dowrick, Queen Mary University of London

Changing by staying the same: how boundary objects help understanding of transformation in health care

Change in healthcare is often characterised by external structural movements that unsettle organisation. Tsoukas and Chia (2002) remind us of the change that is inherent in staying the same, encouraging an analytical focus on becoming.
Qualitative approaches that take social practice as their focus have been exploring the process of change and becoming for many decades. In the field of science and technology studies (STS), researchers seek to understand stability as temporary, where uncertainty is momentarily resolved through networks of people, things and processes.
The study of what Star (1989, 2010) has term 'boundary objects', which are flexible working arrangements and actions that allow for the solution of multiple local problems in different communities of practice, has opened up productive avenues for the study of change. It allows for examination of how boundary objects enable change to happen in a way that feels to actors like continuity.
I have applied this concept to the study of change in the responsibilities of primary care in the UK with regard to identifying domestic violence and abuse (DVA) and referring patients to specialist support services. I propose that positive changes have been facilitated by boundary objects which forge connections between practitioners, patients, specialist domestic violence workers and commissioners, simultaneously allowing continuity and transformation. This case study offers theoretical insights for how changes in the organisation of healthcare can be understood more broadly.

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Tsoukas, H., & Chia, R. (2002). On Organizational Becoming: Rethinking Organizational Change. Organization Science, 13(5), 567–582. http://doi.org/10.1287/orsc.13.5.567.7810

Alec Fraser, London School of Hygiene and Tropical Medicine

Towards a sociology of large-scale healthcare change

Forms of large-scale healthcare change, such as the regional re-distribution of services, are an enduring reform orthodoxy in health systems of high income countries. The topic is of relevance and importance to sociology in the way that large-scale healthcare change significantly disrupts and transforms therapeutic landscapes, relationships and practices, yet it has received relatively little attention from sociologists. In this paper we review the literature on large-scale healthcare change. We find that the literature is dominated by competing forms of knowledge, such as health services research, and show how sociology

can contribute new and critical perspectives and insights on what is for many people a troubling issue.

Nicola Morant, UCL

Qualitative research to understand how change occurs in service improvement initiatives

Qualitative methods are often used in randomised research trials to study processes and mechanisms of change associated with a clinical intervention. When the intervention is targeted at the level of the healthcare service (rather than at individuals), how intervention-derived changes occur is often shaped or limited by broader and pre-existing change processes occurring simultaneously in healthcare organisations. This can pose significant implementation and methodological challenges. In this paper I reflect on how qualitative health research can respond to these challenges. I will draw on a recent example of research conducted by myself and colleagues in mental health, a systemic context experiencing on-going resource-related changes and challenges. This work focussed on crisis resolution teams, which provide short-term home-based support for people experiencing severe mental health crises who might otherwise be admitted to hospital. A large trial of a multi-faceted Service Improvement Programme designed to improve the effectiveness of services over a 12 month period was conducted. Within this, we used qualitative methods to understand the varieties of ways that change was implemented across six case-study services, drawing on and integrating the perspective of service managers, participating staff teams and facilitators of the improvement programme. As well as enabling the research team to understand which elements of their service improvement programme had proved successful and unsuccessful, and how they had been used by facilitators and received by clinical teams, this work also enabled a better understanding of how changes initiated as part of the intervention interfaced with existing organisational change processes.

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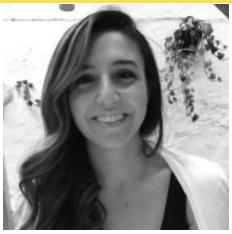

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