

# **Ethnographic Practice within Public Health: Hierarchies of Evidence, the Political Economy of Practice and the Possibilities of Transdisciplinarity**

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The call for greater consideration to be paid to “slow research” in the field of “global health” (Adams *et al.* 2014) highlights the need for dialogue regarding the position of ethnographic practice within public health research generally. In this blog, I reflect on the establishment of five Centres of Excellence for Public Health Research by the UK Clinical Research Council (UKCRC) through my own personal observations (2011-15) of: a) having received PhD funding from a UKCRC Centre of Excellence; b) having attended three UKCRC Public Health conferences (at which I presented research findings, posters, and facilitated workshops; and, c) worked on a multi-disciplinary public health research project.

I outline the marginalised position of ethnography within modern public health practice. This marginality is related to an institutionalised hierarchy of evidence as well as the multi-disciplinary approach and inter-disciplinary research agenda adopted by the UKCRC’s Centres of Excellence. I highlight how a transdisciplinary ethos offers the potential to involve ethnographers meaningfully within public health research. Despite epistemological challenges and bureaucratic barriers, I argue that a transdisciplinary public health agenda has the potential to reconfigure the gaze of public health researchers away from unhealthy individual behaviours and towards critical reflection of the political economy of modern public health practice. Ultimately, this would contextualise the complex public health problems of modernity and support the development of public health interventions that are historically situated, culturally nuanced, socially specific, and politically aware.

## *Setting the scene: UKCRC Centres of excellence*

In 2005, the main UK health research funding bodies, health departments, academia, the National Health Service (NHS), regulators, industry and patients established the Public Health Research Strategic Planning Group. Its aims, which were laid out in a UKCRC report (2008a), were to streamline public health research funding within the UK, generate synergy between policy-makers, civil society, and public health researchers and to improve the health of the nation.

In 2007, following an evidence-based review of available information and consultation with stakeholders, a competition was launched to establish five Public Health Research Centres of Excellence that would have “a significant impact on the health of the nation” (UKCRC 2008b: 2). In 2008 these Centres were awarded an initial £5m for five years and, following a review by an international panel of experts, in 2013 each was awarded a further £4m for another five

years. The Centres of Excellence link twenty universities across the UK, including University of Cambridge, Queen's University Belfast, Newcastle University, Cardiff University and University of Nottingham. The initiative has thus created a web of public health staff and students who are interconnected to one another as well as to innumerable actors in the public, private and charitable sectors through the annual UKCRC Public Health Centres of Excellence (PHRCoE) Conference (2015 will be the 6<sup>th</sup>).

The £36m that has been invested in the creation of the Centres of Excellence was considered by the coalition of public-private funders to be the most efficient manner to make public health research “effective” and “world leading” (UKCRC 2008a). This strategy, with its focus on efficiency, synergy and cost-effectiveness, is reflexive of the core logic underpinning the neoliberal ideology that has shaped British politics and policies since their introduction by Margret Thatcher in the 1980s. The pumping prime of public health “laboratories” (Latour 1987) has, through a focus on career development (see UKCRC 2008b), aimed to enhance the institutional authority of public health power/knowledge (Foucault 1991).

The allocation of significant levels of funding and the promise of enhanced institutional stature, however, came with conditions. For example, research within the Centres of Excellence are expected to focus on the following priority areas: diet and nutrition; physical activity; and addictions (alcohol, tobacco and drugs) (UKCRC 2008a, see Image 1). These research foci reflect how the Centres of Excellence have been explicitly directed to focus their gaze on individual health behaviours and the development of effective “technologies of the self” (Rose 2000), i.e. processes and practices of regulation aimed at normalising deviant individuals. The streamlining of capital has therefore positioned public health researchers as a powerful professional class with the authoritative power/knowledge to achieve population-wide (healthy) behaviour change.

### *Evidence-based policy, cost-effectiveness and the evidence hierarchy*

Since the turn of the 21<sup>st</sup> century the British Government has promoted the concept of “evidence based policy” (Solesbury 2001), which has evolved from the concept of evidence based medicine. Evidence-based policy promotes the notion that Government policy should be data driven and decision-making based on scientific facts rather than political ideology (see HM Government 2012). This is reflected in the UKCRC report (2008a), which outlines the expectation that the Centres of Excellence would conduct more research into interventions and policies. Following this, an overarching research focus of the Centres of Excellence has been to determine whether or not an intervention/policy is cost-effective in reducing the social and economic burden posed by an identified public health problem, e.g. morbidity and mortality linked to diet and nutrition, physical activity and addictions.

The UKCRC's (2008a) report directs the Centres of Excellence to develop and standardise the use of evaluative methods that economically appraise the benefits of public health interventions. The quality of public health evidence is judged against an evidence hierarchy, which has its

historical roots in the medical sciences. Research methodologies that are supposed to be unbiased, systematic and replicable are positioned at the apex of the hierarchy (see image 2). Hypothesis driven and deductive in orientation, public health research generally aims to identify “what works at the lowest cost”. Typically large in scale and seeking to produce generalizable outcomes, there is less of a concern with questions of “why” and “how”. Consequently, research that is observational, interpretative and case specific or exploratory and inductive is situated at the base of the hierarchy.

Together, the dictum of evidence based policy, the aim of cost-effectiveness and the evidence hierarchy strengthen the bond between funding, political imperatives and research agendas, which is embodied by the Centres of Excellence. From a critically reflexive perspective, however, this bond can be seen to be based on two inherent discursive fallacies. The first is the belief that policies based on research evidence render government healthcare decision-making apolitical, accountable and more effective. This fallacy is easily discernable in the current era of austerity in the UK: currently, all healthcare decisions are made second to the £81b public spending cuts that are being implemented by the Coalition government (HM Treasury 2010). The second fallacy is the high value placed on allegedly unbiased research methods. All research disciplines are the product and producers of ideology (Cheal 2005); and thus represent a theoretical gaze that is ontologically and epistemologically biased (Bourdieu 1988). One of the effects of these discursive fallacies is to have rendered reflexive practice obsolete within the discipline of public health.

### *Multi-disciplinarity, complexity and qualitative methods in public health*

A further expectation placed on the Centres of Excellence is that they foster a multi-disciplinary research environment (UKCRC 2008a). The hundreds of researchers affiliated to the Centres of Excellence thus represent a range of disciplines: epidemiology, health economics, genetics, immunology, nutrition, sociology, etc. This multi-disciplinary ethos is, in part, an extension of the multi-disciplinary model that has become prominent in healthcare delivery of interventions that are considered “complex” within the UK (see Medical Research Council 2000, 2008). An explicit aim of the Centres for Excellences’ multi-disciplinary approach has been to stimulate interdisciplinary research that is translational and applicable in practice (UKCRC 2008a).

My personal observations have revealed that the multi-disciplinary ethos of the Centres of Excellence is dominated by researchers who share a world view that is more positivistic and realist rather than radically constructionist. This is reflected in the fact that four of the original five directors of the Centres of Excellence are epidemiologists; with Professor Laurence Moore, of the University of Glasgow, standing out as the only social scientist (but also a statistician). The effect of this has been that the inter-disciplinary research agenda of the Centres of Excellence has been dominated by quantitative research methods. For example, in 2014 QUB’s Centre of Excellence published a booklet outlining the research interests of academics affiliated to the Centre. Of the approx. 108 researchers profiled in the document, nine self-identified as using qualitative research methods.

Although there is qualitative research conducted within the Centres of Excellence, e.g. Cardiff University's Centre for Development and Evaluation of Complex Interventions for Public Health (DECIPHER), the minority status of qualitative researchers has, ultimately, diminished the practice of qualitative methods. Subsequently, qualitative methods (typically in-depth interviews and focus groups) are typically incorporated within larger mix-method studies in order to define the components of an intervention, tailor interventions to specific settings and during evaluation (Padgett 2011).

For example, following completion of my PhD I was employed to conduct the qualitative phase of a public health research project investigating the cost-effectiveness of using financial incentives to encourage increased physical activity in the workplace. My role was to conduct focus groups with potential participants in order to ensure the intervention was tailored to the local context. This amounted to asking participants: their perceptions of the project's aims, their current levels and forms of physical activity, and their views on the proposed financial rewards. My subjective experience was that this qualitative phase was more akin to market research (where the focus group method was developed to obtain consumer feedback) than the engaged and participatory practice of my PhD research (see Brown/McBride 2015).

The trend towards conducting mix-method research reveals a recognition that the effectiveness of a public health intervention is enhanced when it is contextualised (Padgett 2011). It is therefore surprising that ethnography – a methodology that involves a combination of participant-observation, interviewing and text analysis in order to produce empirical knowledge that is situated historically, culturally, socially, and politically – remains a rarity within the field of public health (Reeves *et al.* 2008). The absence of ethnographic practice from the discipline of public health has been linked to a lack of knowledge about what ethnography actually is among policy makers, funders and public health researchers.

Limited knowledge about what ethnographic practice entails becomes problematic in relation to participant-observation and the issue of ongoing informed consent from research participants (Caprara/Landim 2008). A major challenge facing ethnographers of public health is presented by medical research ethics committees, which were established in the 20<sup>th</sup> century following atrocities associated with medical experimental research, and their concern with consent. For example, I was required to undergo NHS ethical review for my PhD research (investigating mental health policy and practice in prisons). I found this process hegemonically geared towards deductive experimental research to the disadvantage of my intentions to conduct an inductive ethnographic investigation. Receiving an unfavourable review would have rendered completion of my PhD within my three year funding period impossible. It was therefore an anxious process that significantly structured my agency. Ultimately, I “chose” to omit ethnographic methods from my “research design” (a concept alien to many ethnographers) and conduct semi-structured interviews instead (a method that is much easier to gain informed consent). Consequently, the participant-observation I practiced, e.g. co-facilitating a prison art project, became framed as a means of gaining access to research participants rather than as a form of data collection. The sum result of this ethical erasure was the omission of empirical data regarding the lived reality of prison life from my final analysis.

## *Transdisciplinary research and ethnographic research of public health*

Ethnographers entering the discipline of public health encounter, I would argue, a stifling paradox: complex public health interventions are considered to work best when tailored to a given social setting yet research that poses “why” and “how” questions is not considered as important as that which asks “what works cheapest”? My experience as an ethnographer working within a multi-disciplinary environment left me with the sense that ethnography is a subordinate method of research. Consequently, I encountered communication barriers, intellectual ethnocentrism and bureaucratic hurdles that structured my research in line with the dominant values, interests and power of public health. A consequence of which was the eclipse of empirical “evidence” of everyday lived realities; “evidence” that is central to the contextualisation of public health research. It is my belief that ethnography has the potential to improve public health projects aimed at addressing health inequalities, protecting health and promoting wellbeing. However, to be able to do so greater awareness is needed of ethnographic methods. One way to achieve this is to move towards a transdisciplinary research framework.

Transdisciplinarity seeks to integrate diverse forms of research. It is related to, but distinct from, multi- and inter-disciplinary research in that it seeks to move beyond a disciplinary framework (Nicolescu 2002). For example, the establishment of five Centres of Excellence has been an attempt to reassert the institutional authority of “public health” as a discipline. A transdisciplinary approach would require instead open dialogue between the medical and social sciences regarding the nature of the public health problems. By bringing a diversity of perspectives together from across and beyond individual disciplines on an equal basis (Nicolescu 2008), the transdisciplinary approach would attempt to determine: 1) what the cause of present problems are and how they may develop in the future; 2) how values and norms shape current research goals; and, 3) how problematic situations can be transformed and improved.

Applying this approach retrospectively to a public health intervention that financially incentivised workplace physical activity (discussed above) highlights its potential benefits. Including ethnographic practice could have:

1) added to our understanding of the problem of low levels of physical activity among workers, switching the focus from unhealthy behavioural choices (not doing exercise during work) to structural factors (the time pressures of modern sedentary occupations);

2) highlighted how the values of neoliberalism combine with the norms of economic modelling and epidemiological practice to place the research focus on determining the cost-effectiveness of incentivising individual behaviour rather than the social benefits of ameliorating pathological working conditions; and,

3) led the solution to be re-focused towards significantly reducing working hours of sedentary employees and re-consideration of the emphasis placed on maximising productivity and

efficiency in the workplace.

Such a transdisciplinary project, however, is perhaps easier in text than it is in practice (Ramadier 2004). First, transdisciplinarity requires researchers to have knowledge of a range of disciplines, shun intellectual ethnocentrism and be skilled in mediation and knowledge transfer. Second, it entails equal collaboration not only between researchers but also between researchers and the researched. Finally, and perhaps most challenging, a transdisciplinary approach in public health research would have to overcome the considerable epistemological and ontological schisms that exists within and between medical and social sciences.

### *Conclusion*

Modern nation states, international bodies and private actors now invest significant capital into funding academic public health research. Within the UK, a public-private funding partnership has led to the development of five Centres of Excellence, which have created a network of hundreds of experts. This professional network is explicitly expected to contribute to Government decision-making, enhance accountability and drive efficiency. In practice, the gaze of public health researchers has been directed onto “lifestyle diseases” and the individual health choices of citizens; obfuscating historical and political determinants of poor health. Just as anthropologists have had to reflect on the colonial roots of their discipline, public health practitioners would do well to consider: their positionality as authoritative professionals engaged in social regulation; the power/knowledge invested in the evidence they produce; as well as the political economy surrounding public health practice. Such reflection would reveal, for example, how evaluating the cost-effectiveness of an intervention that financially motivates individual behaviour change is far from unbiased but the product of a “bio-political gaze” imbued with the principles of neoliberalism and supportive of the globalised capitalist economic order.

A transdisciplinary approach could further a reflexive agenda among public health researchers and should have the ultimate aim of normalising the historical and political contextualisation of public health research. Involving ethnographers meaningfully in this process would foster culturally sensitive approaches, help develop interventions that are socially nuanced and promote practice that is critically aware. Ethnographers who produce evidence from the bottom-up, in turn, have the potential to foster the principles of social justice within public health research (Beauchamp 1976), which is morally imperative in this unprecedented era of global inequality (see Seery and Caistor Arendar 2014). Ultimately, ethnographers have the potential to further public health research by deconstructing the objects of investigation, examining the moral order that shapes practice as well as supporting the re-imagination of public health solutions.

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