Viewing the taken-for-granted from under a different aspect: A video-based method in pursuit of patient safety

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ABSTRACT
Contemporary clinical work involves the collaboration of different health care practitioners to provide safe, effective, and high quality services. Yet practitioner collaboration is often fraught with political, professional and ideological divergences. For these reasons opportunities for health care practitioners to come together and develop a shared meaning of practice is often constrained by organizational and professional agendas. The methodology reported on here has allowed health care practitioners to critically engage with their own practice, and the practice of their colleagues, in a way that enables them to negotiate and mitigate their differences and divergent opinions and practices. Through the use of video reflexive methods health care practitioners were able to articulate systematizing or ‘meta discursive’ solutions to address previously taken-as-given organizational and clinical (handover) practices.

Keywords: Video reflexivity, clinical handover, meta-discourse
INTRODUCTION

The provision of safe and effective health care service within contemporary clinical environments requires the collaboration of different health care professionals. This collaboration becomes critical during the handover of patient-related tasks and responsibilities. Research has revealed that clinical handover is often the weak link in the trajectory of clinical care (Australian Commission on Safety and Quality in Health Care 2008; World Health Organization 2008). This is not surprising, as clinical handover represents the intersection between shifts, units, organizations, professions, ranks, and different professional functions including teaching, caring and curing. For many, clinical handover is the hub of contemporary health care. It is during handover that clinicians’ knowledge, memory and insights are mobilized alongside complex combinations of medical chart documentation, technological readings and diagnostic information. It is all the more surprising, given the centrality of handover to the continuity of clinical care, that so little research exists into the complexities that constitute it (Australian Commission on Safety and Quality in Health Care 2008; Jorm et al. 2009).

Extant research into handover focuses on clinicians’ compliance with established handover formats such as ‘SBAR’ (Haig et al. 2006), the inter-professional tensions between nursing and medicine (Manias and Street 2001), and clinicians’ uses of technology (Ryan et al. 2008) and checklists (Lingard et al. 2005). What is less prominent in this body of literature is engagement with the complexities of clinical work as a way of understanding why clinicians structure their handovers in the ways they do (Iedema et al. 2009) and why it is so challenging to devise practical procedures for handover, particularly in high-risk contexts such as Emergency and Intensive Care (Carroll et al. 2008). While much attention has been paid to ‘pathwaying’ clinical treatment trajectories in ways that ensure multidisciplinary professionals have opportunities for sharing information (Atwal & Caldwell 2002), the systematization of clinical handover to date has not engaged with specialty complexity in the same way, leading to often simplistic and mechanistic handover procedures and guidelines being imposed on frontline staff. While such handover solutions may be important for some specialties, and are of particular importance to inducting junior staff into appropriate knowledge sharing and information transfer processes, the complexity of clinical work generally does not permit adherence to these solutions.

Workplace complexity comes to the fore the closer we get to frontline practice. Ethnographic methods have revealed the tensions and contradictions that arise for clinicians working in modern hospitals in particular (Seymour 2001; Strauss, Schatzman et al. 1963; Zussman 1992). These methods have yielded important insights into the difficulties clinical staff have negotiating challenging matters such as dying (Glaser and Strauss 1965), medical error (Bosk 2003 [1979]) and grief in the face of treatment failure (Ofri 2003). While ethnography reaches deep into the existing practices of workplace personnel, this method tends to stop at the point where participatory, collaborative and appreciative kinds of enquiry begin: collaborating with practitioners on creating new meanings, new ways of working, and new practical opportunities (Cooperrider & Whitney 1999; Reason 1999; Reason & Bradbury 2008). In participatory research, new knowledge about practice is produced and shared with the practitioners themselves.

The present paper reports on participatory video-based research that engages frontline clinical staff in confronting the complexities of their everyday work. This research is formulated collaboratively at several levels: at the level of practice problematization, data identification, gathering and interpretation, and the publication and presentation of conclusions, findings and arguments (Wicks et al. 2008). This research is presented here in an effort to accrue value to the knowledge generation or ‘knowing’ dynamic that
ensues when researchers engage as ‘outsiders’ with clinical practitioners as ‘insiders’ (Collins & Evans 2002). This paper reports on such boundary-crossing engagement to argue that it can create an environment in which questions can be asked that clinicians have forgotten or never learned to ask, and which researchers have not known and are learning to ask.

The paper is structured as follows. The background section overviews patient safety research approaches to the challenge of understanding how practice creates safety. The middle section reports on a recent video-based clinical handover project as part of which clinicians were able to codesign their communication practices and engender a meta-discourse about handover, leading them to initiate discussions and even debates about how to best structure handover in their units. The subsequent discussion picks up where the literature overview left off: what contribution can research make to handover redesign and, through that, to patient safety. We conclude that the visualization of hospital practices provides a significant impetus, not so much for ‘taming’ clinical complexity (Woods et al. 2007), but for enabling clinicians to illuminate existing complexity and engender meta-discourses that afford complexity-friendly interventions.

BACKGROUND

By and large, the paradigm of practice improvement in health care focuses on producing decontextualized knowledge, formalized evidence and generalized policies, at the expense of in-depth attention to local complexities of knowing and doing. The knowledge, evidence and policies that are favoured in health reform circles and health services research lay claim representing ‘what works’. This occurs in the expectation that such knowledge about ‘what works’ can be rolled out – ‘implemented’ – across any site in health care and that what practitioners in those sites themselves know and do is subservient, as well as sufficiently amenable, to change as dictated from above (Zuiderend-Jerak 2007).

In cases where adapting practice to ‘what works’ fails, the problem is not attributed to the limited relevance of such generalized knowledge for frontline staff. Rather, the problem is seen to be inappropriate team culture (Hackett et al. 1999), lack of staff compliance (Creedon 2005), or an excess of personal discretion and autonomy (Harrison 1999). Likewise, formal rules rather than complexity of practice are made the benchmark against which to measure change.

But organizational change is inevitably contingent on where frontline staff work and what that means for what they do and say. For Barley and Kunda, this means that any attempt to change practice puts existing understandings and relationships under pressure:

Any modification of an organization’s structure must be grounded in changes that occur at the level of [ordinary] encounters. Alterations in [ordinary] relations may induce such structural changes as the reformulation of cliques … or the re-differentiation of statuses. Such changes may occur because new forms of work reduce or create dependencies, because they require interactions among people who previously did not interact, or because they alter the tenor of supervision, collaboration and other social relationships.

(Barley & Kunda 2001: 90)

Barley and Kunda’s argument is that ‘situated interaction’ among clinicians is critical to how new knowledge, evidence or policies are responded to, how they are taken up, and what their effect on outcomes might be. But to date, health services and patient safety research have framed in situ practice primarily as an object that must display conformity to established guidelines and protocols. With regard to video methods, for instance, these have been deployed mostly to test clinicians’ compliance with established practical procedures (Michaelson and Levi 1997; Santora et al. 1996).

Admittedly, recent calls for methods of enquiry other than large scale epidemiological
studies acknowledge the importance of coming to terms with local complexity (Berwick 2007; Grol et al. 2008). Debate in the domain of patient safety has thereby begun to engage with the methodological implications of choosing a particular data collection approach, and the different kinds of learning that are possible by varying one’s approach (Berwick 2008). Overall, however, the main impetus behind this research is to develop pre-determined systems of practice bolstered by scientific evidence. The net effect of this is that the complexity of clinical work is kept invisible and therefore continues to be positioned as arbitrary to how staff respond to emerging knowledge, evidence and policies.

Its newly emerging methodological concerns notwithstanding, this conventional patient safety research paradigm differs substantially from one that regards what frontline staff do as central to how the system works, what the system is and how the system is to be defined. To regard the clinical system of work practices as a fixed structure credits rules, regulations and procedures with the power to comprehensively shape practice. In contrast, to regard the system as also emerging from what staff do and say is to accept that practice is inherently complex rather than linear and rule-oriented. To accept that practice is complex means to accept that it cannot be fully pre-determined. The system apprehended in this second sense embodies the complex realm of what clinicians do and say in situ, upon which the formal realm of rules, regulations and forcing functions remain contingent (Jensen 2008).

One way of approximating this complexity is by video-filming it. Frequently, when clinicians watch footage of their practices they come to two contrasting realizations. First, they realize the extent to which their practices embody their own peculiar logic – a logic they have often learned no longer to see. This logic harbours a regularity that has become second nature, thereby slipping from conscious view. Second, the footage reveals for them the complexity and indeterminacy of what they do. It reveals their practical wisdom, or phronesis, which they had equally come to take for granted (Dreyfus 1979). They observe themselves making on-the-spot decisions, acting on hints and intuitions, sharing tasks with colleagues in ways they could not have described beforehand nor afterwards, displaying knowledge they gained in unexplainable ways, and so forth.

It is the tension between the first and the second realization that makes it possible for clinicians to apprehend their practice ‘from under a different aspect’ (Wittgenstein 1953). Critically, this renders practice malleable, in that viewing effects “a continuous displacement of the subject, the object and their general relation … it is an opening onto a space of transformation” (Massumi 2002: 51). Besides focusing here on this process of transformation, the present article also maps a critical transformation that was accomplished: the ‘meta-discursive’ talk that clinicians began to produce about their handover process, evidencing their reflection-in-action (Schön 1983).

**METHODS**

The video-based method used here emphasizes and operationalizes practitioner knowledge, expertise, and insight into the dynamics of their own work processes (Carroll et al. 2008; Iedema et al. 2009; Iedema et al. 2006). This was achieved by first arranging discussions between researchers and health care practitioners about the peculiarities of handover in the clinical environment. Occurring on four different occasions of between one and two hours, involving 50 to 80 clinicians in total, these initial discussions served to elicit comments about the environmental, inter-professional and organizational contingencies that enable and constrain practice.

These initial discussions achieved two things. First, the engagement allowed health care practitioners to discuss their practice giving researchers insight into those areas of practice that might benefit from codesign. Second, this engagement established a strong relationship between the researcher and the practitioners which was central to the video-reflexive dynamic. By ensuring that
practitioners were aware of their pivotal role in the methodology and their ‘ownership’ of the data, trust was established between the researcher and the practitioners.

Subsequently, the researcher observed handover practices focusing on both areas of practice identified by practitioners during the initial focus groups and areas of practice that emerged from our critically observing the clinical work process flow. The duration of observation at the clinical sites reported was around two days, including night shifts. Following observation, relevant aspects of handover practices were filmed. Filming was targeted at both the handovers identified by clinicians during engagement and at the instances of clinical communication that the researcher saw as important. In the Intensive Care Service reported on here, filming occurred over a three-week period and sought to capture handover practice at all times of clinical activity, in total over fifteen hours of footage was collected capturing the handover practices of more than 50 clinicians. The resulting video footage was digitally compiled and exemplars of handover practice were selected in reference to the issues identified by health care practitioners and issues that became apparent for the researchers.

The researchers then arranged a series of seven reflexive meetings with health care practitioners to allow them to watch the compiled footage. A researcher was present at these meetings to facilitate the discussion, answer questions and point to issues identified through non-participant observation. In the majority of cases the researcher was able to let the discussion take its own course. Upon viewing the footage, practitioners were generally very interested and inspired to address the strengths and weaknesses of their handover practice. To capture the potential solutions that were proposed and the plans for implementation that were proposed, each of these reflexive meetings was also filmed, providing the researchers with an important record of the impact of the reflexive viewing and subsequent discussion.

Finally, ethical approval for this research was obtained from the University of Technology Sydney Human Research Ethics Committee and the appropriate Area Health Service Human Research Ethics Committee. Site-specific ethical approval was subsequently obtained from each of the individual hospital ethics committees.

RESULTS

In this section we present data derived from this research. The data are drawn from field notes and video-film records and focus on practitioners’ trajectory towards constructing new conversations about the organization of their handovers. To situate the outcomes of this research, we will begin with presenting our observations at the start of the project. Vignette 1 captures some of our initial observations shortly after negotiating entry into the intensive care unit. (The participants featured in the photos have consented to the shots rendering them identifiable.)

On the one hand, this first vignette describes from the researcher’s perspective how the handover practices in the unit appeared to lack cohesiveness. There was limited evidence of handover being shared across levels of seniority and across professional group. Then, when asked a question about this, the Nurse Unit Manager confirmed our observations by expressing concern about these gaps in handover communication himself. Moreover, his concerns were articulated in terms that suggested that change was going to be a challenge: “And that’s a culture I think we need to sort of like change and improve”. Here, use of terms like ‘culture’ hints at a view that the behaviours in question are not very amenable to being questioned. Initial focus group discussions with other staff revealed similar language and related concerns: ‘this is the way we work (and will continue to work) around here’.

Some time after this, we arranged feedback sessions during which staff viewed footage of their own practices. These sessions produced a rather different type of discussion. People talked about what was wrong with the ways in which handover was conducted in quite specific terms...
Handover processes in this unit are regular, frequent and complex. There is a nurse-to-nurse handover in the morning, followed by a general medical handover occurring at the staff desk (about 07:30am), and then there is the formal medical handover involving the staff specialist between about 8am and 10am. Several issues with how handovers are done stand out. First, handovers do not seem to connect well from one handover event to the next. Second, there appears to be limited communication between senior and junior staff, and between nursing and medicine. When I interviewed [name Nurse Unit Manager] about this he was aware of the tendency of time-pressured nursing staff to use medical handovers as an opportunity to go for a tea break. When I interviewed him he commented, “of course the timing as well comes with the nursing staff usually having their breaks half way through the medical rounds so quite often they’ve disappeared for their breaks before the medical team have come there so, although again there is a minor handover process between the nurse babysitting the patient and the one gone to the break there is… little knowledge of what really has been going on with that patient to be able to give input to the medical team. And that’s a culture I think we need to sort of like change and improve and bring it back to there being a far better interaction and communication between medical and nursing staff at that point of the day”. (Filmed interview, Nurse Unit Manager of Intensive Care Services)

Staff begin to discuss the use of electronic patient records and how these affect practice. During this discussion a junior nurse (F) comments that there is no clear way to graph changes in vital signs over time. This prompts considerable discussion regarding the limitations and strengths of the current electronic patient record. A senior nurse (M) disagrees with the junior nurse’s view that the electronic record is not amenable for graphing vital signs. She points out it has a special facility for this.

F: Clear, multi-coloured, transparent.
M: What you mean...?
[Everyone interrupting]
F: Yeah – It is available; we don’t tend to use it.
M: That’s different, if people turn it off then that’s different from the fact that it’s not there and not useful.
F: People don’t tend to use it, that’s the thing, they’re very used to the care use system now that they don’t tend to use the visual reference.

After more discussion, staff agrees that there is a need to orientate new staff to the use of electronic resources for recording and organizing patient information.

The significance of this vignette is that handover communication (here, mediated electronically) is analysed at both a specific level and at a systemic level. In this case the specific focus is, can you use the electronic patient record for graphing vital signs? The systemic focus that this connects to is, how do staff commonly communicate vital signs? This raises further questions for those present: How do staff use the electronic patient record, and how are they inducted into using it?
Critical here is that footage of a nursing handover led the junior nurse to pick up on something specific that concerned her. The footage enabled her to express concern about ‘how staff communicate vital signs’, and ‘how staff use the electronic record’. As the subsequent discussion unfolds, her seniors realize that there is confusion about the electronic record’s graphing function, and that they need to induct staff better so they do know about that function. As such, the discussion is at once specific (‘what this junior nurse knows’) and systemic (‘how we communicate vital signs’, ‘how we use the electronic patient record’, ‘how we induct junior staff’). Hence, where the footage engages staff with the specifics and complexities of their work, the discourse that this process enables clinicians to produce is a ‘meta’ discourse: a discourse that takes us ‘beyond’ the ordinary everyday experience of specific individuals and specific situations. The power of this meta discourse is that it reframes another practice (clinical handover in this case) by drawing out the general, systemic implications of what specific people know, do and say.

Now that this ‘meta’ discourse has begun to be articulated, it begins to inform the way that clinicians engage with their own practices back in the unit. The next vignette (Vignette 3) captures a situation three weeks after the video-reflexive session was held. It describes how staff on the ward discussed ideas about how to change their handover practices.

In the course of this interaction, the discussion at the patient’s bedside shifts from addressing clinical-procedural details to articulating systemic issues: why do staff do handover in one way rather than another? How can ideas generated by staff be embedded and maintained in practice? The discussion becomes somewhat tense when the nurse challenges the doctors, pointing to reasons behind existing ways of doing handover. At this time, the discussion does not proceed or reach a satisfactory conclusion. It appears staff are grappling with issues for which they need a new way of talking, a new discourse.

Then, another three weeks on, the researcher notes the following situation unfolding in the unit (Vignette 4).

If nothing else, this last vignette demonstrates that staff in the unit have developed an interest in and an ability around discussing handover as process. They do this in meta-discursive terms. Meta discourse refers to language that abstracts away from the here-and-now. Unlike the term ‘culture’ that reifies norms and relationships, meta-discourse reframes aspects of the in situ work and creates new common ground. Where handover had remained part of the taken-as-given domain of everyday work experience with staff conducting their handover roles without special attention, meta-discourse enables staff to address
and reinvent how they conduct handover and what are their roles in it.

Our description suggests that engaging with handover footage can enable health care practitioners to develop a meta-discourse about a domain of workplace experience that otherwise remains ‘under the radar’: how handover is done in this unit, how it can be done differently, how changes can be embedded, and how changes can be evaluated and revisited.

**DISCUSSION**

In health, video methods have been deployed in multiple ways, but predominantly to extend the reach of trainers’, assessors’ and managers’ surveillance (e.g. Deveugele et al. 2005; Leggat 2000). The work reported in this article is not in the first instance about using video for the purpose of surveilling how effectively or appropriately tasks are being conducted. Rather, our use of video footage centres on enabling practitioners to reframe the processes that they are part of on a day-to-day basis. The principle that underpins this approach is that by re-apprehending and reframing work processes, practitioners gain the opportunity to recreate those processes and redesign them in everyday practice.

The focus of the present article has been on data that shows how practitioners, by viewing the video footage, begin to generate meta discourse about their work. The important point of this analysis is not that particular bits of footage are necessary for staff to begin conversations about what is shown, but that the principle of viewing one’s work on the screen is enabling in and for itself and taking viewers well beyond what is shown. That is, viewing work process footage puts practitioners in a new space from where they can engage with their work, or what Massumi refers to as “a space of transformation” (Massumi 2002: 51).

Massumi’s narrative about the transformative potential of the visual moving image differs from the narrative of reflection that is often invoked to explain the effect of visual feedback. For example, Dale’s analysis of self reflection using visual media privileges the control that viewers are supposed to derive from viewing themselves as others do: “this sense of self reflection, of being able to see oneself as others do and of looking at the self from ‘out-
side’ owes much to the metaphor of the mirror. Once the self is aware of its own existence, control of self becomes possible” (Dale 1997: 103). In Dale’s analysis, “the mirror becomes a tool of the normalizing principle. It reflects back, not unique images of the individual, but replicated copies of the norm” (Dale 1997: 106). Visualizing and reviewing self in/and practice, according to this analysis, are part of the modernist drive towards surveillance and control. Dale characterizes this process, following Benjamin, as “mechanical reproduction [involving] the mass production of the identical mirror image” (Dale 1997: 106).

Our analysis above has shown that visualizing ourselves for ourselves does not necessarily reduce to strengthening existing norms and replicating dominant conducts. In that regard, our analysis confirms Massumi’s insight that the moving image has a transformative potential. This is thanks to video’s “continuous displacement of the subject, the object and their general relation” (Massumi 2002: 51). The subject (the practitioner) and the object (the clinical unit, handover practice, the patient) are removed from their usual relation, in that the footage ‘de-subjectifies’ the viewer and ‘de-objectifies’ her context and her practice. Here, viewing video footage creates a space where “[t]he objectness of the object is attenuated as the subject, seeing itself as others see it, comes to occupy the object’s place as well as its own. Simultaneously occupying its place and the object’s, the subject departs from itself” (Massumi 2002: 50). In direct contrast with Dale’s account, then, we are led to conclude that viewing footage of oneself and one’s own practice means that “the subject–object symmetry of mirror-vision is broken” (Massumi 2002: 50).

Of course, Dale’s point about the normalizing impact of viewing video footage of one’s own ways of working cannot just be ignored. Viewers may invest their work practices with awareness of how they and their work appear in the footage, and seek to change this appearance according to what is considered socially and organizationally desirable. But viewing video footage, besides confirming existing normative discourses, also affords new or ‘emergent’ discourses of the kind seen and heard above. It is this latter potential that the present paper seeks to move to the fore, not just as an important aspect of viewing video footage as such, but also as an element that is critical to clinical practitioners’ creating a safe working environment for themselves and for their patients.

On that score, patient safety research to date has set greater store by producing knowledge about best practice than by enabling practitioners to enter ‘a space of transformation’. Given the problems with implementing new evidence (Zuiderend-Jerak 2007), translating research and policy into practice (Walshe & Boaden 2006), and ensuring that frontline staff adopt best practice (McGlynn et al. 2003), policy makers are now concerned for patient safety research to show practical impact (US Institute of Medicine 2001). While critical to reforming the patient safety research agenda, this concern is in conflict with the ‘quest for evidence’ discourse in which it remains framed. Even Berwick, who publishes quite radical views on patient safety research methodology (Berwick 2008), reverts to ‘naïve rationalism’ (Russell et al. 2008) when he attests that safety will emerge incrementally, from the accumulation of evidence following planning, experimentation and knowledge building: “A central idea in improvement is to make changes incrementally, learning from experience while doing so: plan-do-study-act.” (Berwick 2008: 1184). In this regard, it seems that patient safety research remains beholden to the strengthening of an evidence base, not to the transformation and capacity building of frontline practitioners.

Our video work and our analysis of how practitioners capitalise on viewing their own practices leads us to a different conclusion. To be sure, the safety of health care is inscribed into clear procedures and guidelines. This is particularly the case for emergency situations (Vincent 2006). But for these formal devices to gain practical relevance,
practitioners need to engage with the complexities that characterize their day-to-day practices. Further, alongside ‘taming’ these complexities and designing them out as much as possible (Woods et al. 2007), we acknowledge that complexities harbour opportunities for staff to negotiate aspects of practice that otherwise remain invisible. This was evident from the junior nurse commenting above on the difficulty of using the electronic record for graphing vital signs.

Our final point is that the specifics and complexities of practice are of critical concern to those focusing on improving health care practice ‘from above’. In contrast to merely embodying local relevance and solving site-specific issues, video-based research and the ‘transformation’ it can entrain have important implications at a number of levels. The new meta-discourse that clinicians in the unit described above are now wielding to address their handovers may also apply to how they conduct the discharge of patients; it may impact on the explanations junior staff receive about how the work is done in this unit, and it may have relevance for clinicians who need to explain to patients how things will unfold for them, or why and how care did not eventuate as planned in the case of adverse event disclosure. Paradoxically, and in a non-trivial way, this research reveals how engaging with local practice in-depth affords insights that have systemic as well as policy relevance.

CONCLUSION
This paper has addressed the way in which clinicians in a local intensive care unit responded to footage of their handover practices. We described how their discussions appeared to shift from objectifying their own ways of working towards engaging with local specifics in a way that led to important and generalizable discussions, or what we termed meta-discourse. In our analysis, this meta-discourse became possible when practitioners viewed their own footage and thereby became unhinged from being embedded in the taken-as-given temporal unfolding of practice. In essence, the footage enabled practitioners to gain a view of the broader system of practice, of the systemic space within which it operates, and of the opportunities for change that this systemic perspective brings into view.

The second part of our argument has been that practitioners’ creative engagement with their own practices is a dynamic that is integral to enacting safety. This creativity is critical in our view, because safety is not created once and for all, but ensues from clinicians’ communicative acumen, their interactive intensity, and their mutual attentiveness (Gherardi & Nicolini 2002; Weick & Roberts 1993). This point is not merely about insisting that clinicians communicate accurate information to the right people at the right time. Nor are we merely confirming that safety emerges from the ‘resilience’ of staff towards unexpected events (Hollnagel et al. 2006), or from their ‘error wisdom’ in the face of volatile situations (Reason 2004). Our point, rather, links in with the critical role of practitioners’ ability to produce and maintain meta-discourse about their general ways of working. This meta-discourse places practitioners in an analytical space with regard to themselves and their work, bringing into view whether and how their actions hang together, and whether and how their intentions relate to outcomes.

In this work, video plays the role of catalyst. The footage cannot be seen to harbour a more truthful or more accurate view of what happens. Video introduces a different view on what happens. As noted, it enables practitioners to apprehend their work ‘from under a different aspect’ (Wittgenstein 1953). Outweighing resilience, heedfulness and error wisdom in scale and effect, this capacity to apprehend self and practice from under a different aspect is what enables practitioners to reframe the day-to-day unfolding of their work within the broader picture of ‘how the work is done’. In the final analysis, it is this transformation towards a meta-discursive perspective on practice that forms the precondition for workplace safety.
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