Guidance on Performing Focused Ethnographies with an Emphasis on Healthcare Research

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Focused ethnographies can have meaningful and useful application in primary care, community, or hospital healthcare practice, and are often used to determine ways to improve care and care processes. They can be pragmatic and efficient ways to capture data on a specific topic of importance to individual clinicians or clinical specialities. While many examples of focused ethnographies are available in the literature, there is a limited availability of guidance documents for conducting this research. This paper defines focused ethnographies, locates them within the ethnographic genre, justifies their use in healthcare research, and outlines the methodological processes including those related to sampling, data collection and maintaining rigour. It also identifies and provides a summary of some recent focused ethnographies conducted in healthcare research. While the emphasis is placed on healthcare research, focused ethnographies can be applicable to any discipline whenever there is a desire to explore specific cultural perspectives held by sub-groups of people within a context-specific and problem-focused framework. Keywords: Focused Ethnography, Healthcare Research, Qualitative Methodology, Guidance

Introduction

Within an ever-increasing number of qualitative research genres (e.g., classical or anthropological ethnography, ethnography, grounded theory, phenomenology, narrative inquiry), focused ethnographies (FE) are very suitable for healthcare research as they can be pragmatic and efficient ways to capture data on a specific topic of importance to individual clinicians or clinical specialities, and to determine ways to improve care and care processes. They are able "to address specific aspects of fields in highly differentiated organisations" (Knoblauch, 2005). This paper defines focused ethnographies, locates them within the ethnographic genre, justifies their use in healthcare research, and outlines the methodological processes including those related to sampling, data collection and maintaining rigour. It also identifies and provides a summary of some recent FE conducted in healthcare research. While the emphasis is placed on healthcare research, FE can be applicable to any discipline whenever there is a desire to explore specific cultural perspectives held by sub-groups of people within a context-specific and problem-focused framework.

What is Ethnography?

Ethnography is "the work of describing culture" (Spradley, 1979) using a "process of learning *about* people by learning *from* them" (Roper & Shapira, 2000). Ethnographers essentially study situations in real-time, thus as they occur in their natural setting, to gain an in-depth perspective. This includes the overt or explicit dimensions of culture that are known and cognitively salient to members of that culture or subculture, and covert or tacit dimensions that may not be articulated by members of the culture or subculture, but nevertheless shared (Fetterman, 2010). What most clearly distinguishes ethnography from

other qualitative research genres and makes it valuable for researching healthcare issues, is its link between the macro and micro, thus between everyday interactions and wider cultural formations through its emphasis on context (Savage, 2006).

The depth of comprehension sought with ethnographies typically requires multiple data collection methods including participant observation, with "cultural immersion" over an extended period of time, interviews and documentary analysis (Fetterman, 2010). Ethnographic research is shaped by the nature of the relationship between the researched and the researcher, taking into account both emic (insider view) and etic (outsider view) perspectives and therefore acknowledging the existence of multiple realities (Fetterman, 2010). In as such, the reflexive and contextual dimensions are pivotal (Atkinson & Hammersley, 1998; Savage, 2000; Fetterman, 2010). Key characteristics that all ethnographies share include (Atkinson & Hammersley, 1998, p.110):

- Scrutiny of specific social phenomena, as opposed to deductive research that tests out hypotheses;
- A propensity to elicit unstructured data as opposed to pre-coded data;
- Small sample sizes which may include just one case;
- Narrative description as the product of analysis that includes an unequivocal acknowledgement of interpretation of the significance and purpose of human behaviour; and,
- No quantification of data.

While ethnographers may have originally studied whole communities or cultures, there is wide agreement that the methodology is eminently suitable for exploring sub-cultures or groups of people within complex, pluralistic societies (Atkinson & Hammersley, 1998; Higginbottom, 2004b; Fetterman, 2010). Moreover, a discrete field studied by numerous disciplines, considered *medical* or *health sciences* ethnography, focuses on describing the relationships between cultural beliefs and health behaviours.

Focused Ethnographies for Clinically-Orientated Research

Medical ethnography has at times studied the cultural perspective of an illness rather than that of groups themselves. When investigating specific beliefs and practices of particular illnesses, or particular healthcare processes, as held by patients and practitioners, the ethnography is considered focused (Magilvy, McMahon, Bachman, Roark, & Evenson, 1987; Morse, 1987). The focus on cultures and sub-cultures remains but is framed within a discrete community or phenomenon and context, whereby participants have specific knowledge about an identified problem. With FE, the findings are anticipated to have meaningful and useful application in community or hospital healthcare practice (Knoblauch, 2005). The genre originated with various ethnographers generating understandings in rural (Brink, 1982; Morse, 1984) and urban settings (Carr, 1996) related to the ways in which cultural beliefs determine health practices, such that culturally relevant practices can be planned and delivered. The genre is now used in many health-related fields, including nursing where the goal is often to enhance and understand practice by studying specific phenomena within distinct client or professional cultures and sub-cultures (Cruz & Higginbottom, in press; Roper & Shapira, 2000). Remaining a qualitative genre using an inductive paradigm to gain in-depth understandings, FE offer a different approach to deductive observational studies (e.g. case series, cohort studies) which may fail to capture a holistic perspective. These forms of ethnography have also been termed rapid appraisals, or micro (Spradley, 1980) or mini (Leininger, 1985) ethnographies, but the term focused best describes their problem-focused

and context-specific attributes (Morse, 1987). Moreover, there is a method of rapid assessment process which seems similar although requires intense, team-based fieldwork and does not answer specific questions (Beebe, 2001).

Characteristics and Methods of Focused Ethnographies

Figure 1. Characteristics of focused ethnographies (adapted from Muecke, 1994).

Conceptual orientation of a single researcher

Focus on a discrete community or organisation or social phenomena

Used in academia as well as for development in healthcare services

Involvement of a limited number of participants

Problem-focused and context-specific

Episodic participation observation

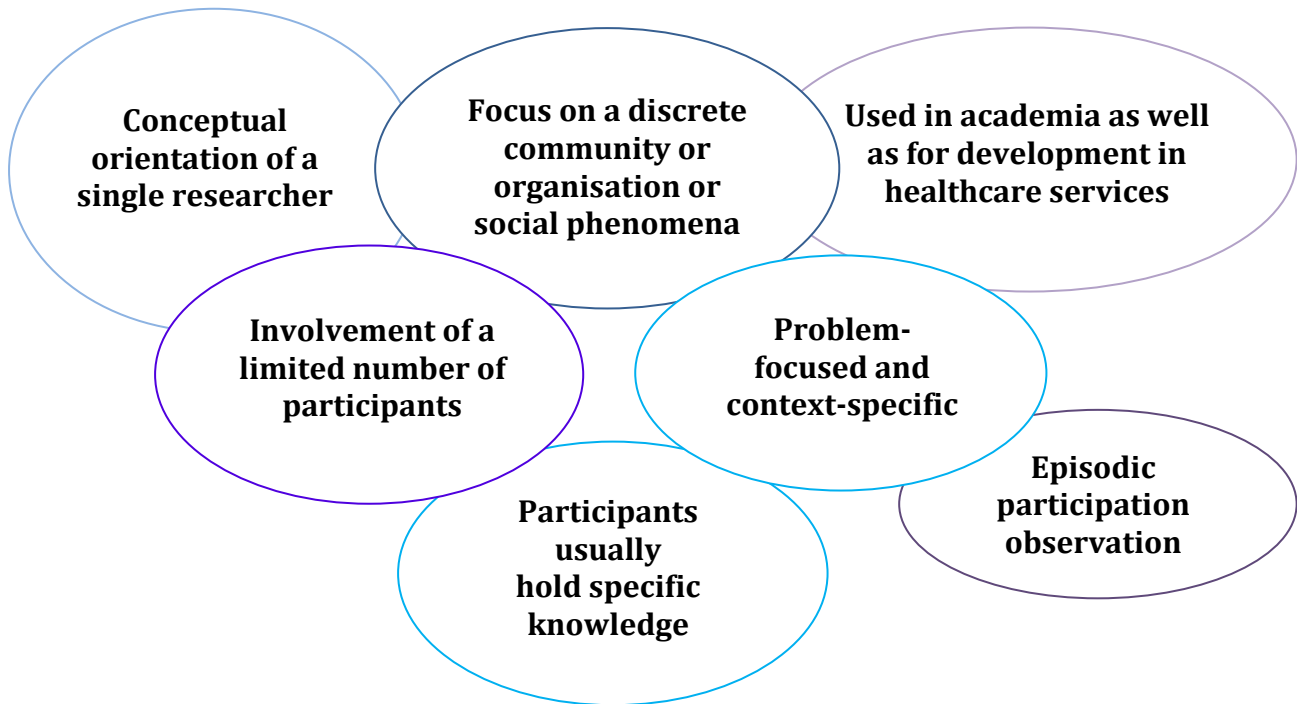Participants usually hold specific knowledge

Figure 1 illustrates the main characteristics of FE as described by Muecke (1994). **Table 1** differentiates between FE and anthropologic ethnographies in terms of their characteristics and data collection methods. With FE, topics of inquiry are pre-selected, participant observation is discrete (within specific timeframes) and can be limited or sometimes deleted (Morse, 2007) and interviews are at times highly structured around the issues. Participant observation might be in effect replaced by hypothetical scenarios, or structured vignettes, which are used to elicit views within interviews especially on sensitive topics when personal experiences may be hard to reveal (Higginbottom, 2006). Participants are often informants with in-depth knowledge and experience of the topic, rather than individuals with whom the researcher has developed a close relationship over time. Observation can include the principal subjects as well as "significant others", such as the elderly patient's child, to gain greater insight. Many FE have been performed by various disciplines, with some of those explicitly performed within a healthcare setting summarised in **Table 2**.

Table 1. Comparison of focused ethnographies to traditional anthropologic ethnographies**.**

Focused ethnography	Anthropologic ethnographies
Specific aspect of field studied with purpose.	Entire social field studied.
Closed field of investigation as per research question.	Open field of investigation as determined through time.
Background knowledge usually informs research question.	Researcher gains insider knowledge from participatory engagement in field.
Informants serve as key participants with their knowledge and experience.	Participants are often those with whom the researcher has developed a close relationship.
Intermittent and purposeful field visits using particular timeframes or events, or may eliminate observation.	Immersion during long-term, experiential-intense fieldwork.
Data analysis intensity often with numerous recording devices including video cameras, tape recorders and photo-cameras.	Narrative intensity.
Data sessions with a gathering of researchers knowledgeable of the research goals may be extensively useful for providing heightened perspective to the data analysis particularly of recorded data.	Individual data analysis.

Conducting Focused Ethnographies

Research Questions

The questions in FE relate to describing experiences within cultural contexts or specific groups/sub-groups. They tend to take the form of first-level questions focused on the "what", such as "what are the shared beliefs, values, and practice patterns (of a specific population) in a specific setting (or who have a specific condition)?" Other key phrases are "what are the characteristics", "what is the relationship between", or "what is it like to." Secondary questions may relate to ideas such as "what facilitates, constrains or sustains", or "how did (particular group) engage with (particular group)" (Walsh, 2009). Knowledge of what is known in the literature or in clinical practice will help determine an appropriate question to generate new findings that are relevant and useful for the service environment.

Sampling and Sample Sizes

Qualitative research generally uses non-probability sampling, wherein generalisability is not usually sought and a preference exists for information-rich data applicable to a specific population. Critique of qualitative research's lack of usefulness and transparency can be diminished by clearly describing the sampling processes and characteristics of the sample (Higginbottom, 2004a). For FE, the most common type of sampling technique is purposive sampling, with complimentary strategies including snowballing (also referred to as opportunistic or nominated sampling) and solicitation. Purposive sampling stems from the fact that the participants have specific knowledge or experience which is judged to be of interest to the investigation (Crookes & Davies, 1980). Often key informants are invited to

participate, with the hope that they will act as gate keepers and thus enable access to the study population. Snowballing occurs when participants act as recruitment or referral agents for further participation, while solicitation requires "cold call invitation" to individuals in relevant positions within the community or relevant organisations.

In times of economic constraint in respect of healthcare research funding, collecting data from the whole population of a group will usually be far too extensive except in those cases where the group works in or frequents a small hospital unit or clinic rather than, for instance, a population of patients with a particular disease. Often, a method of sampling within case is undertaken, whereby individuals are chosen as determined by their contributing to the achievement of maximum phenomenon variation such that the full range and extent of a phenomenon are represented (Miles & Huberman, 1994; Atkinson & Hammersley, 1998). Nevertheless, the method of sampling will be undermined by the number of participants in the subculture or group being investigated, and the number of participants will not usually be predetermined. Data saturation often dictates the sample size, such that participants are recruited until the topic has been fully investigated and no new interpretations are generated from additional participation (Guest, Bunce, & Johnson, 2006).

Data Collection

Interviews will help validate observations (if undertaken) and provide directions for future observations, collect data on issues that cannot or have not been observed, and collect data on non-observable phenomena including feelings (Roper & Shapira, 2000). They can be formal or informal and usually incorporate open answered questions. Often semi-structured interviews will be performed, with the use of a topic guide containing themes or questions relevant to the research question(s). Moving from general to specific is often appropriate, with descriptive, structural and contrast questions complemented by probes (e.g., "could you tell me more about that?", or "what do other practitioners do?") to gain depth of exploration (Spradley, 1979). It is important that the interview be started after an informal opening, to put the participant at ease and establish their trust, and ends after a formal closing, or "sign off", after the participant has been asked if they have anything else they would like to contribute. The interviews are usually tape-recorded and transcribed verbatim when consent is provided, although in-depth field notes may be written or digitally voice-recorded and transcribed especially when consent for recording is not granted, as has been the case in one of the author's experience when studying migrants with precarious legal status.

There is a continuum of observation between acting as participant, participant-as-observer, observer-as-participant, and observer (Byerly, 1969). Focused ethnography will typically use the observer-as-participant role which is not as time-intensive as that of the participant-as-observer. This role often serves for collecting specific information in settings where active participation is not allowed, thus making this well-suited for this research. While some intimacy is important to gain trust and close relations for sharing, researchers must not lose their objectivity. Examples of observation locations might be at hospital wards or clinics, or at social events of participants, such as at an ethnocultural dinner to learn about food choices. Often observations may move from descriptive to focused to selective, the latter of which may make use of checklists. The use of recording equipment may leave the researcher in a highly observant role (Knoblauch, 2005).

A variety of documents can be consulted including policies, procedural documents, epidemiological and census data, maps, photographs, patient records, test results, and biographical materials. These can be used to confirm or contrast interview and observation findings. Focused ethnographies often use a variety of recording equipment such as video-recorders, tape recorders, or cameras. When observations with or without recordings are

incorporated, field notes or reflective journals (largely providing contextual observations including those related to non-verbal communications) will often be used to offer a heightened perspective of the data particularly when multiple individuals are interpreting and analysing the data. Respectively, these means of data collection can be highly amenable to data sessions (Table 1) whereby a gathering of researchers may assess the data and provide intersubjectivity to the data analysis thus prompting different perspectives than if the data was analysed individually (Knoblauch, 2005).

Data Analysis

Analysing data from FE demands the researcher engage in an iterative, cyclic, and self-reflective process, as preliminary interpretations are challenged and data are continually revisited to plan for further data collection to generate new insights into the data (Pope, Ziebland, & Mays, 2000; Higginbottom, 2004b). The process of analysing FE is also characterised by the identification and classification of the data, which then progresses to abstract generalisations and explanation of patterns. A systematic approach for analysing ethnographic data, as expounded by Roper and Shapira (2000), can be followed and is highly compatible with computer-assisted qualitative data analysis software such as Atlas.ti (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany) or NiVivo (QRS International, Victoria, Australia). Analytical steps include, (a) coding for descriptive labels, (b) sorting for patterns, (c) identification of outliers or negative cases, (d) generalising with constructs and theories, and (e) memoing including reflective remarks. The analytical steps are focused on creation of answers to specific problem-orientated research questions and consequentially the creation of concrete recommendations.

Maintenance and Evaluation of Rigour

Determining the methodological and analytical rigour of ethnographies is difficult and may largely depend upon the setting and purpose. Rigour and robustness in qualitative research are to some extent established via a self-conscious and reflective approach, but they are also accompanied by an explicit methodological framework (Higginbottom, 2004b). The conventional criteria for evaluating logical positivist approaches are not suitable for qualitative constructivist approaches where the stability (reliability) and wide applicability (external validity) are not always possible or desired (Lincoln & Guba, 1985). The field of evaluation in qualitative research is evolving constantly; it may therefore be considered inappropriate to suggest one approach to evaluate all qualitative research in a generic fashion. Focused ethnographies could be equally evaluated by the criteria of one of many variations listed in Box 1. Much of the terminology can be different, such as that defined in the foundational work by Lincoln and Guba (1985), who postulated that assessment of rigour (quality, trustworthiness) can be performed using the criteria of credibility, transferability, confirmability, and dependability.

In qualitative research the investigators are relied upon to represent the data with integrity, such that one can consider the researcher characteristics when evaluating their conclusions. Additionally, data collection tends to include "triangulation," with multiple means of data collection (e.g., supporting open-ended or semi-structured interviews with observation) to compare data and confirm findings (Muecke, 1994). Moreover, the depth of understanding can be enhanced by contextualising the participants adequately and accurately in their local environments. The context of the study must be explained with differences and similarities to other similar contexts examined, often using theory or other empirical study (Mays & Pope, 1995).

The Ethnographer's Role and Reflexivity

Fetterman (2010) states that the ethnographer is a human instrument. In this respect, the role of the ethnographer is to eliminate all personal biases and preconceptions prior to entering the study domain. The extent to which this is truly achievable is open to challenge, as our deeply held, internalised beliefs and values may be impossible to disregard (Higginbottom, 2004b). Focused ethnographies are often performed within the researcher's own working environment whereby patients, or participants, are conveniently available. During examinations of patient healthcare experiences and perceptions regarding quality of care, which may largely depend on the patient-provider relationship, the concept of reflexivity is crucial during interpretation of the data and when drawing conclusions. Moreover, within this context there becomes a heightened need for ensuring maintenance of respect for human dignity, through gaining full informed consent from both patients and practitioners (emphasising the voluntary and confidential nature of the research) and for demonstrating genuine concern for their welfare and justice.

Box 1. Additional resources related to maintaining and assessing rigour in qualitative research

1. Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal of Qualitative Health Care, 19,* 349-357. Retrieved from http://intqhc.oxfordjournals.org/content/19/6/349.full
2. Kuper, A., Lingard, L., & Levinson, W. (2008). Critically appraising qualitative research. *BMJ, 337,* 687-689. Retrieved from http://www.bmj.com/content/337/bmj.a1035.long
3. Mays, N., & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *BMJ,* 320, 50-52. Retrieved from http://www.bmj.com/content/320/7226/50.1.full
4. Cohen, D. J., & Crabtree, B. F. (2008). Evaluative criteria for qualitative research in healthcare: controversies and recommendations. *Annals of Family Medicine,* 6, 331-339. Retrieved from http://www.annfammed.org/cgi/reprint/6/4/331
5. Hannes, K., Lockwood, C., & Pearson, A. (2010). A comparative analysis of three online appraisal instruments' ability to assess validity in qualitative research. *Qualitative Health Research,* 20, 1736-1743. Retrieved from http://qhr.sagepub.com/content/20/12/1736.long
6. Mays, N., & Pope, C. (1995). Qualitative research: Rigour and qualitative research. *BMJ*, 311, 109. Retrieved from http://www.bmj.com/content/311/6997/109.full
7. Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.

Conclusion

In healthcare research, many times the methods need to reflect the unique situations in which we are collecting data. Reflecting on the many divergences health researchers have taken with various patient groups, Morse (2007) states that "the methods inherent in qualitative health research are different enough and require enough skill to be considered a subspecialty of qualitative inquiry".

Table 2: Some recent (2008 – present) examples of focused ethnographies in healthcare

Reference	Setting & sample	Study aim	Data collection & analysis methods	Conclusions
Daack-Hirsch & Gamboa (2010)	Eighty purposefully selected individuals in four cities of the Negros Occidental Province in the Philippines, with a cleft lip with or without cleft palate (CL+/- P), or who have children with either or both conditions; controls; and local health care workers.	To describe beliefs about the cause, prevention, and treatment of cleft lip with or without cleft palate, among working class people in the Philippines.	Individual and group informant interviews, using a topic guide. Content analysis of interview transcripts.	By eliciting and comparing patients' explanations for CL+/- P with biomedical explanatory models, clinicians can better understand patients' care seeking/ treatment behavior. This knowledge is useful to improve health outcomes, and for the design of health campaigns regarding CL+/- P in the Philippines.
Green et al. (2009)	Eleven parents of children aged 6-12 years who had undergone heart transplant two+ years prior, at a heart transplant clinic at a large children's hospital in mid-South USA.	To describe parents' experiences of parenting a school-aged child after heart transplant.	Demographic questionnaires elicited patients' racial/ethnic background, family composition and income, and transplant history. Topic guided in-depth qualitative interviews, with parents of the children at private locations of their choice. Recorded field notes were based on contextual observations during	One of few studies to document parenting experiences with child heart transplant patients. Calls for targeted attention to assist parents with: - integrating their child's medical care into their daily lives - obtaining peer support - seeking continuous education to accurately appraise the risk of

			interviews. Content analysis and constant comparison. Documentation of theoretical notes during analysis, served as an audit trail for conceptual decisions.	infectious disease associated with activities appropriate for their child's development.
Higginbottom (2008)	Thirty-six adult African-Caribbeans, mostly long-term economic migrants to England.	To understand the meanings and consequences of hypertension to persons of African – Caribbean origin; and, To describe how these individuals perceive primary health care services.	Two focus group interviews, 21 semi-structured individual interviews and 5 vignette interviews. Ethnographic data analysis was guided by the framework outlined by Roper and Shapira (2000). Data management and coding processes were facilitated using Atlas.ti software. Interpretation of findings used Kleinman's Explanatory Model of Illness.	It is incumbent upon primary health care nurses to recognize and take account of lay explanations of health and illness held by patients and/or their families. Failure to do so may compromise effective care giving.
Kelley et al. (2011)	Sixty-seven seniors, 13 proxy decision-makers, 61 staff members and 8 key community informants, in the Emergency	To assess the environment of an ED, and its impact on adult care, using a "senior-friendly" conceptual	Multiple methods including interviews with seniors or their proxy decision-makers, staff and key community informants;	The ED is an important part of seniors' healthcare. Changes to policy and practice, and enhanced

	department (ED) of a regional acute care hospital in Ontario, Canada.	framework.	on-site observations; a staff survey; and hospital administrative data. Individual analyses was conducted on the various data sets; - descriptive and inferential statistical analyses of quantitative (hospital administrative) data; - coding and systematic inductive analysis of qualitative (interview and observational data) as outlined by Huberman and Miles (1998). Findings of individual analyses were integrated and synthesized to formulate recommendations for policy, practice, and education.	education are needed to better serve the complex health care needs of seniors in this environment.
Kilian et al. (2008)	Purposive sampling using a 'chain-referral' process, of eight older adults who were "fallers" and their six of their	To examine the perceptions of risk regarding falling held by older adults and their adult children; and to	Open-ended interviews using a semi-structured interview guide, elicited insider perspectives (the elder adult's or	Research on injury prevention among older adults must take into account in multiple family perspectives when

	adult children living in urban Toronto, Canada.	examine the similarities and differences in these perceptions.	their child's);

Field notes provided the outsider (researcher's) perspective to allow reflexive data analysis of both perspectives; and reflexive journaling during data collection and analysis facilitated examination of assumptions and evolving themes.

Thematic analysis, used coded sections of data and examination of emerging themes (Fetterman, 1998).

Participant checking provide elaboration, instead of verification of data.

Data analysis was concurrent with collection, and continued until maximum phenomenal variation was achieved. | taking action to prevent falls.

This will inform the development of strategies that respect iseniors' independence, to encourage better adoption of these measures by the seniors. |
| Smallwood (2009) | Nurses in a cardiac assessment (CA) team in an acute hospital trust in | To explore, describe and interpret the roles of nurses in the culture | Seven semi-structured interviews, 5 participant observation | Four main roles were played by nurses on the team. These were the gatekeeper, |

	the UK.	established on the CA team.	sessions, (observer-as-participant) and reflective field journal. Analysis followed the framework outlined by Miles and Huberman (1998).	specialist consultancy practice, catalyst and diplomat. There is a necessary interlinking of roles among team members in order to facilitate care in the unsteady organizational culture of a managed care environment.
Spiers & Wood (2010)	Convenience and theoretical sampling of community mental health nurses who had been providing brief therapy (10 sessions or less) or were involved in consulting practice for 3+ years in Alberta, Canada.	To describe the experiences, perceptions and actions of community health nurses in building a therapeutic alliance in the context of brief therapy;and to identify factors that facilitate or impede its development.	Focus groups and individual interviews, verification interview, and methodological journal writing. Thematic data analysis was modeled after the frameworks of Bunard (1991), and Morse and Richards (2002). .	Findings contributed to the empirical understanding of alliance-building actions of nurses in brief therapy. Building an alliance consisted of three non-linear overlapping phases: establishing mutuality, finding the fit in reciprocal exchange, and activating the power of the client. Inhibitions to alliance-building were related to patient history, environment (e.g., workload) and experience. Recommendations are made to enhance intentional

				alliance-building.
Wilkinson & Callister (2010)	Snowball sampling of 24 women at a pre-natal health care clinic in Ghana, West Africa.	To describe the perceptions of childbirth among child-bearing Ghanaian women.	Intensive participant observation, with field notes to record observations, impressions and insights. Using the Health Belief Model was as conceptual framework.24 women were interviewed individually during outreach clinic days. Content analysis involved comparison of interview and observational data to enhance the quality of findings (Roper and Shapira, 2000).	Seven themes were identified and several clinical implications were tabulated. Major conclusions were of many fears (including superstitions) related to maternity and birth and the holistic approach including respect of spirituality which must be respected.

References

Atkinson, P., & Hammersley, M. (1998). Ethnography and participant observation. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 110-136). London: Sage.

Beebe, J. (2001). *Rapid assessment process: An introduction*. Walnut Creek, CA: Altamira Press.

Brink, P. J. (1982). Traditional birth attendants among the Annang of Nigeria. *Social Science & Medicine, 16,* 1883-1892.

Byerly, E. L. (1969). The nurse researcher as participant-observer in a nursing setting. *Nursing Research, 18,* 230-236.

Carr, G. (1996). Ethnography of an HIV hotel. *Journal of Nurses in AIDS Care, 7,* 35-42.

Crookes, P., & Davies, S. (Eds). (1998). *Research into practice: Essentials skills for reading and applying research*. London: Balliere Tindall.

Cruz, E., & Higginbottom, G. M. (in press). The use of focused ethnography in nursing research. *Nurse Researcher*.

Daack-Hirsch, S., & Gamboa, H. (2010). Filipino explanatory models of cleft lip with or without cleft palate. *Cleft Palate Craniofacial Journal, 47,* 122-133.

Fetterman, D. M. (2010). *Ethnography: Step by step* (3rd ed). Thousand Oaks, CA: Sage Publications.

Green, A., Meaux, J., Huett, A., & Ainley, K. (2009). Constantly responsible, constantly worried, constantly blessed: Parenting after pediatric heart transplant. *Progress in Transplantation, 19*, 122-127.

Guest, G., Bunce, A, & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Method, 18,* 59–82.

Higginbottom, G. M. A. (2006). "Pressure of life": Ethnicity as a mediating factor in mid-life and older peoples' experience of high blood pressure. *Sociology of Health & Illness, 28,* 583-610.

Higginbottom, G. M. A. (2004a). Sampling issues in qualitative research. *Nurse Researcher, 12,* 7-19.

Higginbottom, G. M. A. (2004b). *The meaning and consequences of hypertension for individuals of African Caribbean origin: Perceptions of primary health care service.* Unpublished PhD Thesis.

Higginbottom, G. M. A. (2008). "I didn't tell them. Well, they never ask": Lay understandings of hypertension and their impact on chronic disease management: Implications for nursing practice in primary care. *Journal of Research in Nursing, 13,* 89-99.

Kelley, M. L., Parke, B., Jokinen, N., Stones, M., & Renaud, D. (2011). Senior-friendly emergency department care: An environmental assessment. *Journal of Health Services Research & Policy, 16*, 6-12.

Kilian, C., Salmoni, A., Ward-Griffin, C., & Kloseck, M. (2008). Perceiving falls within a family context: a focused ethnographic approach. *Canadian Journal on Aging, 27*, 331-345.

Knoblauch, H. (2005). Focused ethnography. *Forum: Qualitative Sozialforschung / Forum: Qualitative Social Research,* 6, Art.44.

Leininger, M. M. (1985). *Qualitative research methods in nursing*. Philadelphia: W.B. Saunders.

Lincoln, Y. S., & Guba, E. G., (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.

Magilvy, J., McMahon, M., Bachman, M., Roark, S., & Evenson, C. (1987). The health of teenagers: A focused ethnographic study. *Public Health Nursing, 4,* 35-42.

Mays, N., & Pope, C. (1995). Qualitative research: Rigour and qualitative research. *BMJ, 311,* 109.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis*. Thousand Oaks, CA: Sage Publications.

Morse, J. M. (1984). The cultural context of infant feeding in Fiji. *Ecology of Food and Nutrition, 14*, 287-296.

Morse, J. M. (1987). Qualitative nursing research: A free for all? In J. M. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue* (pp. 14-22). Newbury Park, CA: Sage Publications.

Morse, J. M. (2007). Does health research warrant the modification of qualitative methods? *Qualitative Health Research, 17,* 863-865.

Muecke, M. A. (1994). On the evaluation of ethnographies. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 187-209). Thousand Oaks, CA: Sage Publications.

Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in healthcare. Analysing qualitative data. *BMJ, 320,* 114-116.

Roper, J. M., & Shapira, J. (2000). *Ethnography in nursing research*. Thousand Oaks, CA: Sage Publications.

Savage, J. (2006). Ethnographic evidence: The value of applied ethnography in healthcare. *Journal of Research in Nursing, 11,* 383-393.

Savage, J. (2000). Ethnography and health care. *BMJ, 321,* 1400-1402.

Smallwood, A. (2009). Cardiac assessment teams: A focused ethnography of nurses' roles. *British Journal of Cardiac Nursing, 4*, 132-139.

Spiers, J. A., & Wood, A. (2010). Building a therapeutic alliance in brief therapy: The experience of community mental health nurses. *Archives of Psychiatric Nursing, 24,* 373-386.

Spradley, J. P. (1979). *The ethnographic interview*. New York, NY: Holt, Rinehart, and Winston.

Spradley, J. P. (1980). *Participant observation*. New York, NY: Holt, Rinehart and Winston, Inc.

Walsh, K. M. (2009). Disciplined silence: A focused ethnography of exemplary emergency nursing practice (Doctoral dissertation). ISBN: 978-110-928-0708708.

Wilkinson, S. E., & Callister, L. C. (2010). Giving birth: The voices of Ghanaian women. *Health Care for Women International, 31*, 201-220.

Author Note

Since 2007, Gina Marie Awoko Higginbottom PhD, MA, Postgradip (Ed Studies), RN has held a Tier II Canada Research Chair in Ethnicity and Health and served the role of Associate Professor in the Faculty of Nursing at the University of Alberta, Canada. Prior to this Dr. Higginbottom was Principal Research Fellow and Senior Lecturer in Sheffield, England. She has twenty years clinical experience has a nurse, midwife and health visitor. Dr. Higginbottom's research portfolio focuses on ethnic minority populations and immigrant health using participatory models of research and her ultimate goal is to improve healthcare access, delivery, and outcomes for vulnerable populations. Specific topics of investigation have included lay understandings of health and illness, chronic disease management in primary care, self-care strategies, the cultural congruence of primary health care services, access and utilization of primary health care services, and ethnic and cultural diversity in care giving. A dominant focus has been maternal health and well-being including parenting issues, healthcare access, perinatal food choices, and early parenthood and postnatal depression in different ethnic minority groups. Dr. Higginbottom has employed focused ethnography methodology in several of her research studies and appreciates its allowance for incorporating various perspectives which helps to increase the comprehensiveness of the findings. Dr. Higginbottom is Affiliated Associate Professor of Nursing at the Karolinska Institute, Stockholm, Sweden, Visiting Professor at Sheffield Hallam University, and Assistant Editor of *Ethnicity and Health*.

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