Opinion Paper

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Diagnosis as a social process: benefits of classic ethnographic practices and some practical considerations

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Abstract: Reducing diagnostic error and understanding how to prevent it remain critical goals of medical research. While diagnostic error has been studied through a variety of approaches, recent scholarship has increasingly highlighted the value of social science perspectives, particularly ethnographic methods. Chopra (2020) introduced "focused ethnography" as a valuable and efficient method for studying diagnostic errors in healthcare settings. We extend this conversation by arguing that more traditional ethnographic practices – especially open-ended and iterative research design, extended fieldwork, and researcher immersion in clinical communities – remain essential for examining the complexity of medical diagnosis. Diagnosis is now widely understood as a team-based process involving physicians, nurses, patients and families, and other healthcare professionals who exchange information and distribute tasks to reach a diagnosis (Graber 2017). We argue that only deep immersion in this fundamentally social process allows researchers to identify the subtle barriers and facilitators shaping diagnostic work and assess how diagnosis unfolds in practice as teamwork. In this article, we illustrate how classic ethnographic practices can be implemented to gain a deeper understanding of diagnostic processes and highlight some key methodological considerations when planning an ethnography in a healthcare setting.

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Introduction

Diagnostic decision-making is a complex, iterative, team-based activity prone to errors [1]. Up to 15 % of diagnoses are incorrect, delayed, or missed – contributing to increased mortality, prolonged hospital stays, and a substantial financial burden on healthcare systems [2–4]. In 2015, the National Academy of Medicine identified the facilitation of teamwork among diagnostic team members as a key driver of improving diagnostic quality [1]. Successful diagnosis depends on communication and coordination among physicians, nurses, patients and their families, and other healthcare professionals, who collaborate at different stages and then dissolve [5–7]. Diagnosis can thus be seen as a cognitive and a social process that occurs within a broader context shaped by environmental, patient, and physician factors as well as culture, healthcare systems, and time [7–12]. The emergency room illustrates this complexity, where clinicians rotate across shifts and patients continuously transition through care.

Despite increasing recognition that improving diagnosis requires attention to both cognitive and collaborative dimensions of teamwork [1, 7, 13–15], empirical insights into how diagnostic teams function in practice remain limited [12, 16]. To address gaps in research on dynamic teaming, Tannenbaum and colleagues [6] identified several priorities for future research, including understanding the barriers and breakdowns that arise during diagnostic teamwork, examining how clinicians and patients experience teaming processes, and identifying which specific teaming behaviors most strongly influence clinical outcomes. They further emphasized the need for longitudinal, qualitative, and mixed-methods approaches capable of capturing the evolving nature of diagnostic work.

Against this background, methods from the social sciences are increasingly used to study diagnostic processes in medicine. One such method is ethnography, in which

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researchers immerse themselves in clinical settings and generate insights through observation, interviews, informal interactions, and other qualitative techniques, such as the collection and analysis of documents and artifacts, digital and photographic methods, and mapping of spatial attributes, pathways, or chains of interaction. In a recent publication in this journal, Chopra [17] highlighted the value of focused ethnography – as distinct from classic ethnographic approaches – for studying diagnostic error and argued that this approach is particularly well suited to healthcare settings. While we agree that focused ethnography offers important advantages, we argue that classic ethnography also has unique strengths for understanding the complexity of diagnostic teamwork. Our aim is explicitly not to pit focused and classic ethnographic approaches against each other or to suggest that one is inherently superior. Rather, we seek to complement Chopra's introduction of focused ethnographic methods to the readers of this journal by highlighting the benefits of classic ethnography, which we believe should not be so readily dismissed. Ideally, the choice between focused and classic ethnographic approaches should be guided by the research question, timeframe, and intended outcomes of a study, rather than by dogmatic preferences for one method over another. In this article, we therefore discuss key aspects of classic ethnographic methods and illustrate how they can uniquely reveal and disentangle the underlying social complexities of medical settings. We thereby draw on the research experience of authors MI (sociologist) and JEK (psychologist), who previously conducted an ethnographic study in two emergency departments, and combine it with the practical experience of authors WEH and SG (emergency physicians).

Emergency departments are a particular well-suited site to study how diagnostic processes unfold. Emergency medicine is characterized by highly variable demands, constantly changing team compositions, and a broad range of diagnostic challenges spanning the full spectrum of possible diseases. Many diagnoses in emergency medicine are made under time pressure without prior acquaintance with the patient and staff often attend to several different patients simultaneously, often in distinct, patient-specific teams. Unlike scheduled outpatient care, emergency clinicians cannot anticipate the complaints, languages, medical histories, or medication regimens they will encounter. Patients may also present in pain, distress, or anxiety, limiting their ability to communicate clearly. Together, these conditions create a highly complex diagnostic environment in which error rates are high and consequences may be severe [2]. Classic ethnographic methods zoom into these complexities and facilitate our understanding of how the various actors involved in the diagnostic process – physicians, nurses, patients, and their families – navigate this highly dynamic and complex environment.

Why medical ethnography?

Lab experiments, surveys, and intervention studies are valuable for testing hypotheses and identifying effects, such as that of stereotypes [17], timing of teamwork [14], and team training [18]. These methods are limited, however, in generating new hypotheses and capturing context-specific, real-world dynamics. Ethnographic methods are designed to do exactly that.

Ethnography has a long tradition in cultural anthropology and sociology. At its core, ethnographic research involves studying people and groups as they carry out their everyday activities. To do so, ethnographers enter a social setting ("the field"), often unfamiliar, and participate in its routines while developing relationships and observing interactions. Simultaneously, they systematically and meticulously document observations and experiences, creating a detailed account of the activities and interactions within the setting. Through this process, ethnography captures both everyday practices and the meanings attached to them, offering a rich understanding of "the field" under study [19].

Ethnographic methods are increasingly used in medical research to get a deeper understanding of the dynamics and dependencies in healthcare settings. They have been used to examine medical team dynamics and performance [20, 21], how hierarchical structures shape communication [22, 23], clinical decision-making [12, 24], and patient and family involvement [25, 26]. Together, these studies highlight ethnography's value in revealing both explicit and subtle dynamics of medical teamwork, including relational, communicative, and institutional factors that ultimately also affect diagnostic processes.

Recently, Chopra [27] presented "focused ethnography" as an approach particularly well suited for studying diagnostic processes in medical settings, and specifically for investigating diagnostic errors in healthcare. According to Chopra and earlier proponents [28–31], focused ethnography is more problem-oriented, time-efficient, and narrowly focused than classic ethnographic methods, which seek a broad cultural understanding. It relies on targeted sampling of relevant groups, shorter and episodic observations timed to capture critical clinical interactions, and multiple data sources such as interviews, documents, and electronic records. The validity of the distinction between focused ethnography – practiced primarily by health professionals – and classic, "traditional" ethnography – practiced primarily by social scientists – has since been critically examined [32]. We do not aim to resolve

this debate here, nor do we seek to advocate for one ethnographic approach over the other. Instead, following Chopra's argument that focused ethnography can illuminate diagnostic processes, we emphasize three traditional tenets of classic ethnographic approaches that – in our view – remain valuable in medical research, namely 1) an open-ended and iterative research design, 2) extended (though not indefinite) fieldwork, and 3) researcher immersion in clinical communities. These practices can enable researchers to uncover the broader social dynamics and contextual complexities that shape diagnostic teamwork – dimensions that may be difficult to capture through a more focused and time-limited ethnographic approach.

In what follows, we discuss key aspects of classic ethnographic fieldwork and the challenges of conducting ethnographic research in clinical settings. We illustrate these issues through a recent ethnographic study by MI and JEK of the diagnostic process in emergency medicine, highlighting how ethnographic research can be conducted in clinical settings and the key methodological considerations involved.

An example ethnographic study in emergency medicine

Ethnographers aim to capture the inside perspective of the people within the social setting they wish to understand. To approximate this inside perspective, ethnographers using classic rather than focused ethnographic methods ask open-ended research questions, apply an iterative research design, conduct extended fieldwork and immerse themselves as much as they can into the communities whose routines, interactions, and relationships they seek to understand. In this section, we illustrate these core classic ethnographic practices (Figure 1) through a study conducted by MI and JEK on the diagnostic process in emergency medicine (analysis ongoing). Before discussing these practices in greater detail, we briefly outline the design of this example study.

Study design

In the example study conducted by MI and JEK, three ethnographers investigated how diagnostic processes unfold and are experienced in emergency medicine. The study examined who participates in diagnosis, how and when collaboration occurs, and how patients and families are involved. To capture these perspectives, participants included physicians, nurses, patients, and family members. A particular focus was placed on patient involvement in diagnosis, which required participants to be conscious and cognitively able to engage in communication and provide informed consent. The study therefore included only patients who were physically, cognitively, and emotionally capable of participation. Ethnographers further focused on patients presenting with diffuse symptoms requiring diagnostic workup – such as headache, nausea, or abdominal pain – rather than straightforward complaints like isolated forearm trauma.

Data collection ("fieldwork") consisted of three main activities: participant observation, fieldnote writing, and

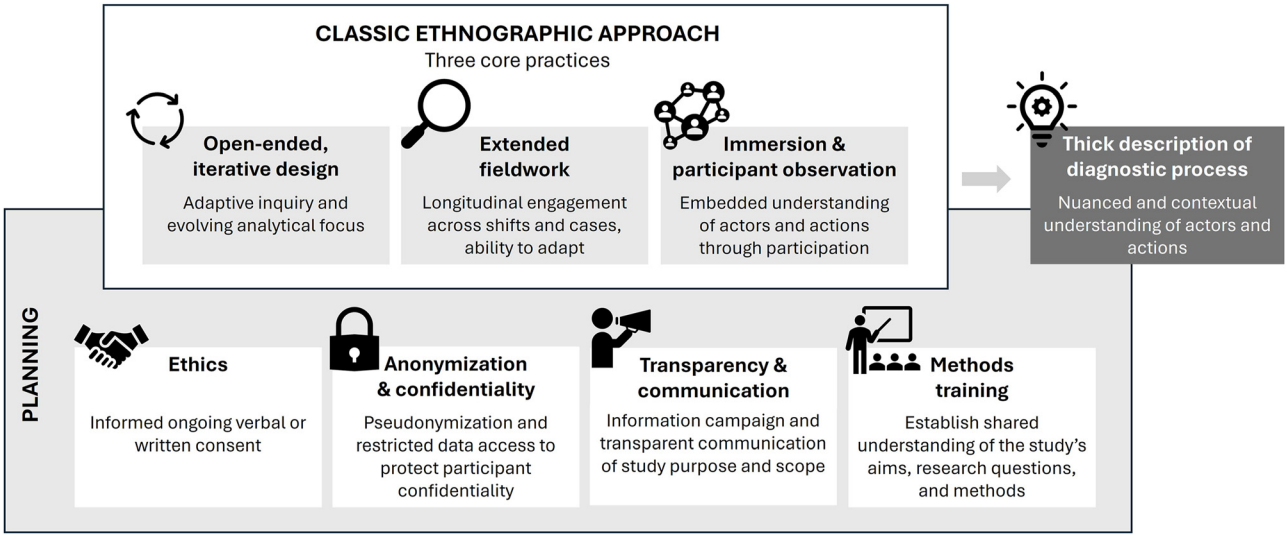


Figure 1: At a glance: three classic ethnographic practices and considerations when planning an ethnography.

interviews with clinical staff and patients. During participant observation, ethnographers accompanied and interacted with physicians, nurses, patients, and families throughout shifts or emergency department stays while jotting hand-written notes whenever possible. On different days, they focused either on physicians (residents or attendings) or nurses to understand their work routines, diagnostic practices, and case management under time and resource constraints. Ethnographers also followed selected patients from triage through discharge or admission to examine how diagnoses and patients' involvement evolved over time. Within 36 h after each observation day, handwritten notes were expanded into detailed fieldnotes capturing interactions, dialogues, behaviors, and impressions from the field. Semi-structured interviews were subsequently conducted with physicians, nurses, patients, and their families to explore participants' experiences and their perceptions of their roles, the diagnostic process, and the observations of the researcher.

Open-ended and iterative research design

Classic ethnographic research begins with broad, open-ended questions that do not presuppose specific outcomes. Rather than testing predefined hypotheses, this approach encourages discovery and allows unexpected themes and perspectives to emerge from the field. MI and JEK, for example, started with the intentionally broad question: How is the diagnostic process done and experienced in emergency medicine? This enabled the researchers to capture diverse practices and experiences among physicians, nurses, patients, and families through their actions, interactions, and expressed perspectives.

Throughout the nine months of fieldwork, MI and JEK continuously revisited their research questions, interview guides, and follow-up questions in response to emerging observations and relevant literature. Early observations, for instance, showed that many emergency department encounters ended without a definitive diagnosis, prompting the additional question: "What is a diagnosis in emergency medicine, for whom, and why?" The researchers subsequently explored how clinicians defined diagnosis in this context and what patients expected from the diagnostic process. Other observations generated further lines of inquiry. Some patients emphasized or minimized aspects of their medical history as their cases evolved, leading researchers to examine these communicative practices more closely. Similarly, ethnographers observed that physicians often withheld aspects of the diagnostic process, such as differential diagnoses, from patients. This prompted further exploration of how clinicians manage patients' knowledge about potential medical conditions and what this practice reveals about the patient's role within the diagnostic team.

Extended fieldwork

Iteration requires time and sustained engagement in the field. Extended fieldwork allows researchers to observe a wide range of events, interactions, and social processes that shorter studies may overlook. In ethnography, fieldwork and analysis are closely intertwined, with data generation through observations and interviews accompanied by ongoing analytical reflection. In the study conducted by MI and JEK, ethnographers completed nine months of fieldwork across three iterative cycles. Although shorter than classic ethnography, this duration exceeded that typical of focused ethnography and enabled observation across different shifts, patient cases, and clinical situations. After each observation day, ethnographers produced detailed fieldnotes describing actors and interactions while reflecting on questions such as: What did I learn? What surprised me? How do these observations relate to existing literature on teamwork and medical decision-making? These reflections were documented in analytic memos, integrating analysis directly into the ongoing research process. In this way, extended fieldwork supported a rigorous and analytically responsive research process.

Immersion and participant observation

Ethnographic researchers engage deeply with the communities they study by participating in daily routines and social interactions, enabling them to experience events firsthand and better understand participants' perspectives. Rather than remaining detached observers, the ethnographers sought to participate as actively as possible in the two emergency departments. As social scientists, their involvement was limited to non-medical tasks – such as cleaning empty cubicles, fetching equipment, accompanying patients to the toilet, or helping patients complete forms – but these activities demonstrated their commitment to understanding everyday clinical work and becoming part of the team environment. Immersion also involved building relationships through ongoing interaction, creating opportunities for informal and unfiltered conversations about workplace dynamics, roles, and challenges. Through this sustained engagement, the ethnographers generated rich, contextually grounded insights into emergency medicine that are difficult to capture through other methods.

Importantly, the ethnographers' own presence became part of the data and was incorporated into the analysis, as is characteristic of classic ethnographic approaches [33]. Rather than assuming that observations provide direct access to an objective reality unaffected by the researcher's presence, ethnographers acknowledge that data are shaped by their relationships and interactions in the field. Attending to this intersubjective production of knowledge by documenting the researcher's behavior, questions, relationships, and interactions in fieldnotes, and reflecting with participants on how their presence may have influenced what participants said and did, can strengthen the transparency and interpretability of findings. For example, in the study by MI and JEK, the ethnographers documented interactions with patients, including questions about the diagnostic process during waiting times and their responses, such as providing information about waiting times or how CT scans may unfold logistically. They also supported patients practically by asking medical staff whether they could eat or drink and bringing tea or sandwiches to their cubicles. In later interviews, some patients reflected on how the researchers had positively influenced their experience of care, providing insights into patients' needs for communication, attention, and information during their diagnostic journey.

Planning an ethnographic study in hospital settings

What needs to be considered when planning an ethnographic study on diagnostic decision making? Conducting ethnographic research in sensitive and dynamic clinical environments requires careful planning to build trust and protect participants' identities, irrespective of whether classic or focused methods are applied. When multiple ethnographers are involved, adequate preparation is essential so they can work effectively both as individual researchers – developing relationships and insights – and as members of a coordinated research team. In this section, we outline key considerations for implementing an ethnographic study, again using the study of MI and JEK as a concrete example.

Ethics

Because ethnographic researchers document dialogues and interactions and ask follow-up questions, informed consent is essential, even when healthcare research regulations do not formally require it. Ideally, written consent is obtained from participants who are observed over extended periods or play a central role in the study. However, verbal consent may be more appropriate when written consent would disrupt clinical workflows or burden patients, such as those who are bedridden. In some situations, particularly during observations of broader interactions, explicit introduction at every moment may not be feasible. This situational approach is consistent with Heibges' [34] pragmatic critique of formalized research ethics in ethnography. She argues that the ethical principle of self-determination should not be equated with a fixed requirement for written informed consent; rather, it should be operationalized by respecting participants' situation-specific expectations of autonomy and privacy. It is therefore important to establish clear guidelines regarding when written, verbal, or no immediate consent is appropriate. More broadly, consent should particularly in classic ethnographic studies be understood as an ongoing process rather than a one-time agreement [34, 35]. In practice, this involves clearly introducing oneself and the study, reintroducing oneself after absences, remaining transparent about one's role – for example by visibly taking notes – and staying attentive to situational cues when engaging with patients and staff.

Anonymization and confidentiality

Ethnographers must recognize that richly detailed fieldnotes cannot be fully anonymized. This is particularly the case in classic ethnographic studies, where fieldnotes contain detailed descriptions of participants, including their dialogue, gestures, and mannerisms. To reduce risks to confidentiality, MI and JEK conducted fieldwork in two similarly sized emergency departments, making individuals and situations less identifiable later. They also established strict boundaries around data access: clinicians facilitating the study have no access to fieldnotes, interview transcripts, consent forms, or participant lists. Consequently, they are excluded from data analysis and from authorship on publications presenting empirical findings from the study. Maintaining this separation is essential for preserving participants' trust in the independence of the research. More broadly, ethnographers should anonymize participants as far as possible through pseudonyms and carefully crafted descriptions. It is equally important to communicate clearly with institutional gatekeepers, such as clinic directors, that they will not have access to identifiable data or findings traceable to individual staff members.

Transparency and communication

MI and JEK developed a comprehensive information campaign in collaboration with senior attendings and chiefs

of nursing to ensure that staff in both emergency departments were informed about the study's aims, data management procedures, and the consent process before data collection began. Multiple communication channels were used to reach clinicians, patients, and families. A dedicated website provided information about the study purpose, research team, timeline, data handling procedures, dissemination plans, a Q&A section, and downloadable consent forms (www.teams-notfall.org). Ethnographers also attended staff meetings to introduce the study and answer questions. Posters were displayed throughout the emergency departments, and informational slides appeared on patient-facing screens in waiting areas so that patients could learn about the study before direct contact with researchers. During observation days, ethnographers wore clinical attire with visible researcher identification and carried business cards linking to the study website via QR code. Together, these measures promoted transparency, informed participation, and trust within the clinical community.

Methods training

Three researchers were involved in data collection. The lead researcher (MI), a sociologist with prior experience in ethnographic research in healthcare settings, conducted data collection alongside two master's students from social anthropology and psychology. All ethnographers underwent rigorous methods training led by the lead researcher. This training was designed to establish a shared understanding of the study's aims, research questions, and scope, as well as its epistemological and methodological foundations. It also covered best practices in participant observation, writing detailed fieldnotes, conducting ethnographic interviews, recruiting participants, and managing data in accordance with data protection regulations. The methods training also included a conversation about emotional support mechanisms and services available to the ethnographers, recognizing that they would – inevitably – witness severe injury, illness, and death during their fieldwork in emergency medicine.

Limitations

Like all methodological approaches, classic ethnographic methods entail limitations that should be considered when designing studies and interpreting findings. Conducting classic ethnographic fieldwork is time-intensive and requires a high degree of flexibility, while the production of detailed fieldnotes demands considerable time, training, patience, and strong writing skills. Furthermore, ethnographic findings, those that are produced in classic *and* in focused ethnographic study designs, are inherently context-specific and cannot be replicated in the same way as experimental studies. The value of ethnographic data therefore lies in the extent to which readers can transfer findings to other settings. This transfer is facilitated by providing sufficiently detailed descriptions of the research setting, participants, interactions, and social and institutional context, allowing readers to determine the extent to which the findings may be relevant to contexts with similar characteristics. Thus, rather than seeking statistical generalizability, ethnographic research supports a context-sensitive form of knowledge transfer in which the applicability of findings is judged in relation to the similarities and differences between the original and potential new setting. For these reasons, ethnography is best understood as complementing rather than replacing methods such as laboratory experiments or randomized controlled trials. Its particular strength lies in generating novel hypotheses and uncovering mechanisms that can subsequently be examined using other methodological approaches.

Ethnographic findings are also shaped by the researcher's positionality and presence in the field. This is true for both classic and focused ethnographic methods. Researchers' social identities, professional backgrounds, relationships with participants, and interactions within the field can influence what they are able to observe, how participants respond to them, and how they interpret and represent their observations. While reflexive practices can help identify and critically examine these influences, researchers must acknowledge that their own positionality inevitably shapes the research process. Similarly, access to the field may be uneven, as researchers often rely on gatekeepers and established relationships to enter particular settings. Institutional structures, professional hierarchies, and participants' willingness or ability to engage may therefore shape which people, interactions, and perspectives become visible in the ethnographic record. This may result in some experiences or perspectives being over- or underrepresented in the analysis.

Conclusions

While classic ethnographic methods cannot directly detect diagnostic errors – a limitation they share with focused ethnographic techniques – they are uniquely suited to developing an understanding of the cultural, relational, and organizational contexts in which such errors occur. Researchers should therefore consider classic ethnographic research methods when the aim is not only to assess outcomes, but also

to uncover the underlying social, communicative, and organizational processes that produce them.

The ethnographic study presented here illustrates how classic ethnographic practices – particularly open-ended and iterative research design, extended fieldwork, and researcher immersion – can be applied to the study of diagnostic processes and medical teams in emergency medicine. An open-ended and iterative design allows researchers to identify and follow unexpected but theoretically relevant insights, such as how clinicians define "diagnosis" in emergency medicine or how patients manage the presentation of their symptoms. The integration of analysis with ongoing data collection further supports the development of additional research questions. Extended fieldwork enables observation of variation across cases and actor constellations, capturing the situational complexity of diagnostic work. Immersion and participant observation provide access to the subtle, often implicit dynamics of teamwork, communication, and knowledge management that are difficult to capture through more structured methods. Together, these practices support an understanding of diagnosis as it is enacted and experienced in practice. By revealing how diagnostic processes are shaped by everyday interactions, hierarchies, and institutional constraints, classic ethnographic approaches can contribute to a more comprehensive understanding of diagnostic quality in healthcare.

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Use of Large Language Models, AI and Machine Learning Tools: None declared.
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