Revealing and explaining deep structure via *Qualitative Research in Medicine and Healthcare*

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In the previous issue of this journal (Volume 5, Issue 3), I described *Qualitative Research in Medicine & Healthcare* as a "helping journal." By that, I meant that *QRMH* welcomes manuscripts from a range of specializations, and as editor, I am glad to assist writers wherever they are within that range.

Some authors, like myself, are a combination of scholar and teacher, rarely, if ever working directly with patients or healthcare providers (HCPs). Often, we specialize in Communication or related fields in the humanities and social sciences. Teacher/scholars from R1 universities who have high research expectations generally need the least amount of writing assistance due to the high demands placed on their research output. Those from "teaching universities"—an arguably strange appellation—who are more pressed by extremely time-consuming classroom responsibilities sometimes need more assistance in developing their theoretical approaches, clarifying their methodologies, and/or explaining their findings and takeaway concepts. I am happy to help both of those types of teacher/scholars as much as I can.

Authors whom I take special pleasure in working with, however, are at the other end of the spectrum: those who are some combination of scholar and HCP. Often, these writers are new to qualitative research, and because they typically don't teach or conduct qualitative research on a daily basis, they are, understandably, writers who need the most guidance.

I particularly enjoy working with this latter group because their experiences and skills are most removed from my own. As a Communication teacher/scholar, I have so much to learn from HCPs. I marvel at the things they do every day to improve patients' lives. Their direct impact on people's quality of life, day in and day out, is something that I can only imagine from my position as more of a theorist who barely engages directly with suffering, challenges, joys, and triumphs encountered in family practice, emergency medical service, or among hospital wards.

In a way, *QRMH* is a meeting place of complementary professional cultures represented by these two different groups of writers. For teacher/scholars, people are often conceived of as target audiences, communities, or representations of larger populations—i.e., fairly abstract conceptions. The focus, or at least the inspiration, for the HCP/scholars' research, however, tends more often to be people who they know as individuals, sometimes as patients and sometimes as colleagues.

This is not to say there is a firm line between the two groups, of course; rather, I am thinking in terms of general patterns that I have witnessed over my past ten months as editor of *QRMH* and having reviewed several times for *QRMH* previously. Being in the middle of this crossroads is one of the greatest pleasures of my career to date, now going on 25 years.

Recently, I had the pleasure of helping an HCP/scholar think about how to best approach his research. In a way, I felt absurd offering advice to a person who makes life-and-death decisions every day, but the author really wanted to learn how to best improve his approach to qualitative research. He listened intently to what I had to say, and the fact that this person respected my opinion and wanted to learn from my experience affirmed the *value* of

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Key words: Editorial; helping journal; methodologies.

Received for publication: 31 May 2022.
Accepted for publication: 31 May 2022.

Licensee PAGEPress, Italy
Qualitative Research in Medicine & Healthcare 2022; 6:10654
doi:10.4081/qrmh.2022.10654

what we on the teacher/scholar side do all the time. I was able to help the author communicate the significance of day-to-day human experience that he witnessed on a micro level and to share that significance with fellow writers and readers of *QRMH*. During the conversation, we created a middle ground where we were able to share our respective knowledge and skills, merging Communication theory and medical practice. This sort of continual recreation of a discursive space is what *QRMH* is all about. It illustrates what we in the Communication field call the "transactional model of communication."

Prior to our Zoom chat, the author had emailed me a few times, and I could see that he was struggling with understanding the phenomenological core of qualitative research. The author had made the common mistake of thinking that phenomenology is trying to get inside other people's heads and then explaining things from their perspectives, but I think it is more than that. Trying to explain things from another person's point of view is always doomed to failure because we are not that person. We can never truly represent another person's experience because i) we have not lived all of their lives that condition their reactions to that experience and ii) because no matter how well we describe another person's perspective, our description is always conditioned by our own lived experiences.

As an undergraduate Anthropology student way back in the 1980s, I was fortunate to have had teachers who assigned difficult reading material, and lots of it. The reading that had the most impact on me, and to which I return again and again in thinking about my work, is Clifford Geertz's classic description of a Balinese cockfight.[1] For Geertz, the cockfight was much more than a means of gambling via what we now consider a cruel abuse of animals; it was a way of addressing longstanding tensions and rivalries among extended families. This is the way a lot of things in life are so that behaviors that might seem superficial have much more profound "deep structures" resonating within cultures and framing people's lives. The job of the interpretive researcher is to bring that deep structure out and explain it, using the theoretical and methodological tools at our disposal.

The older I get, the more I find myself explaining complex concepts through metaphor, so the night before my scheduled Zoom meeting with the author, I tried to think of an apt metaphor for how to take a phenomenological approach to research on patients' experiences, attitudes, and worldviews. The metaphor that I eventually thought of was that of a sculptor working with a huge chunk of rock. I explained that the rock that the sculptor works with is the data we have before us as researchers. It is a thing in itself with its own form. The job of the sculptor is to bring a new form from the raw stone, just as the job of the researcher is to find and draw out form from the data. The sculptor's tools are hammers and chisels of different sizes, shapes, and weights, each for their own purpose. Our tools are the theoretical models and various methods used to find and explain patterns (and exceptions to those patterns) in our data. And just as no two artists will make the exact same sculpture—because their experience, skills, and tools are different—so, too, different researchers can interpret the same situation, even the same data, in different ways.

In varying degrees, using different approaches, each of the articles in this issue of *QRMH* succeeds at touching upon deep structure with regard to their respective research settings. Mike Alvarez brings out the deep structure of discourse among people who consider or who have considered suicide in "'Life is about Trying to Find a Better Place to Live:' Discourses of Dwelling in a Pro-Recovery Suicide Forum."[2] Alvarez looks at over 2,000 posts on a pro-recovery, online suicide forum, and using cultural discourse analysis, recognizes a common theme regarding space—and its human dimension, community. Space and community are not always positive experiences, as Alvarez reveals in his discussion of opposing notions of entrapment, on one hand, and safety, on the other. Discourse on a pro-recovery suicide forum thus works in multiple dimensions simultaneously: as a source of shared information and encouragement and as an ongoing discussion about the world we inhabit. Indeed, even those dimensions are only two ways of thinking about SuicideForum.com, and other interpretive scholars could draw forth many other dimensions within its deep structure.

While Alvarez is writing primarily from a theoretical perspective as a teacher/scholar, Claudine Tshiama, Gédéon Bongo, Oscar Nsutier, and Mukandu Basua Babinto approach their article, "Lay Knowledge Regarding the Prevention of Complications Related to Childbirth: Perceptions of Congolese Pregnant Women,"[3] from more of a clinical point of view. Their study of how pregnant women weigh the value of lay vs. professional medical knowledge is descriptive at one level, demonstrating patterns in beliefs about traditional ways of avoiding complications in pregnancy, but there is more beneath the surface. Their analysis reveals an ongoing frustration among participants about how traditional forms of healthcare during pregnancy are largely ignored by medical staff and how this causes some degree of cognitive dissonance among pregnant patients. Significantly, participants express eagerness to share lay customs with medical staff so that the staff, in turn, can build respect and appreciation for applicable traditional practices into their prenatal workshops. The takeaway for practitioners is that the transactional model of communication can be a reality in prenatal training so that lay and professional practices can be shared in mutually beneficial ways.

Similarly, Luke Hughes, Lisa Alderton, and Rachel M. Taylor offer practical takeaway lessons from their analysis ("Evaluation of the Family Liaison Officer Role during the COVID-19 Pandemic"),[4] although instead of patients, Hughes et al. examine interviews of professional HCPs who were temporarily placed into a newly created role

during a time of immediate crisis. As with Tshiama et al., Hughes and his colleagues dig deeply among their transcripts to reveal patterns in the ways that the family liaison officer (FLO) position functioned well during initial implementation at the start of COVID-19 and to suggest where improvements are needed. Given that the FLO role was developed on the spot during a crisis, Hughes, et al. use uncertainty reduction theory as a conceptual tool to reveal and explain how FLOs dealt with unpredictable circumstances in different ways, depending on their respective professional training. Hughes and his colleagues also leverage their data and analysis to make a closing argument for developing the FLO role into a permanent, full-time, professional position.

Taken together, these articles illustrate the range of professional perspectives, traditions, and expectations comprising the community of researchers here at *QRMH*. Readers will find among each article a combination of theoretical and methodological tools used to reveal, demonstrate, and examine lessons learned from everyday experiences lived by the people who are served by and who serve in the medical professions.

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