Editor's Introduction

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There's a crack in everything.
That's how the light gets in.
Get after that light.
This is your assignment.[1]

I take this mandate from the quotation in Erin Castelloe's beautiful opening piece to welcome our readers, authors and reviewers to the third issue of *Qualitative Research in Medicine and Healthcare:* the first issue of 2018. I am thankful to have gotten this far, with seven great articles in the issue, and already look forward to publishing even more analyses of the cracks and light that are the assignment of qualitative researchers. As I see it, the articles in this issue are woven together by a common thread, which is the notion of cultural context. Culture in this case is not static or homogenous, or even a variable and divisible quantity, as in the construct of subcultures; rather, it is systems, processes, and often fraught dynamics of and in communication.

In *Tincture of Time*, the second piece by Castelloe in her two-part reflection on her positioning within the medical profession and her decision to leave clinical practice, the author searches for a definition of burnout that may capture her own experience. Castelloe locates multiple meanings generated by multiple stakeholders, somewhere in the schism between the relationship of healing and the demands of (managed) healthcare. She notices that though many physicians' and patients' lives are deeply affected by the burnout of health care providers, analyses and explanations of burnout go no further than individualist accounts, thus completely neglecting the systemic culture of burnout that isolates physicians from each other as well as those they wish they could take care of. The empirical work in this issue shows equal commitment to explicating cultural contexts by first, attention to participants' lived experiences and, second, suggestions for transformation of current cultural understanding of healthcare praxis.

By way of their thick participation[2] in the culture of resident physicians, Foster, Defenbaugh, Biery and Dostal take a grounded theory approach to analyze the activities of a Resident Assessment Facilitation Team (RAFT). In *Resident assessment facilitation team: collaborative support for activated learning*, the authors begin by attending to interactional terms by which residents account for their own engagement in learning, and move from there to theorize that residents' ability to fully participate in physician-patient communication can only happen by means of active, co-participatory learning, supported by teaching faculty. For this to happen, the authors recommend that the time dedicated to the facilitation of activated learning allow for self-reflection and self-assessment on the residents' part.

In *Mandates of maternity at a science museum,* a fascinating study of how a museum exhibit – where information is seemingly transmitted to the public, under the guise of neutrality and education – is in fact an agent of cultural socialization, Lee also attests to the communicative complexity of learning environments. Lee's argument about communication is particularly compelling, for it speaks to its material and consequential power – speech is action, it does what is says. Thus, an exhibit of motherhood performs cultural norms and prescriptions of what motherhood should and could be like, placing women in asymmetries of knowledge vis-à-vis the exhibitors, and ultimately making them solely accountable (and subject to blame) for motherhood as an individual responsibility. It is nice to see how, in their own empirical investigations, Davis et al., Drummond, Colvin et al. and Sworonski et al. pick up and elaborate on the ways in which communication is the key to culture-making.

In *Patient-centered outcomes: a qualitative exploration patient experience with encephalograms in the ED*, Davis, Beverly, Hernandez-Nino, Wyman and Asimos allow us to listen to the voices of patients dealing with

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seizures in the emergency department (ED). What is interesting to me reading their work is to find out that what matters most to patients is not so much whether they receive an encephalogram or that a particular plan of care be undertaken by the medical team, but that physicians validate patients' experiences with seizures by carefully explaining exactly which treatment they will be receiving. By attending to the patients' accounts of their experiences in the ED, the authors' unique insight is that patients want to trust their doctors! What they need to do so is clear, two-way communication in order to feel safe and taken seriously.

By offering a nuanced and complex narrative of the patient experience, Drummond's piece continues in this vein to explore the culture of uncertainty surrounding cholesterol and statins. *If my cholesterol is…then I foresee: patient accounts of uncertainty*, constructs a picture of patients as conflicted as to whether to take statins at all, largely due to a misunderstanding of how these drugs work and what benefits they have. This, even though statins are prescribed to them by their physicians. Issues of noncompliance (as they are characterized) on the part of patients are of course a bane of physician's existence, and yet understanding patients in terms of compliance misses the point of how they account for their reasons for not taking medications. Drummond's article is therefore an important move in changing the culture of the patient-physician relationship.

In her close analysis of communication strategies employed by members of an emergency response team, Colvin takes up the concep of knotworking. *Knotworking in an emergency response team: understanding team communication and process* is a study of how team members understand their work in multiple and overlapping systemic terms, constantly responding to the moment to moment requirements of crisis, as well as repositioning themselves with respect to each other. The author does a fine job of examining the complexities, dilemmas and tensions of the work of knotworking, which is never homogenous and involves members' orientation to multiple asymmetries. What I find particularly insightful and refreshing about this work is the author's discussion of power as both a matter for negotiation and a (cultural) resource for the team to find new ways of doing things.

The final article in this issue explicitly addresses communication, change and cultural context by taking us to Norway. In *The significance of cultural norms and clinical logics for the perception of possible relapse in rural Northern Norway: sensing symptoms of cancer*, Sworonski, Risør and Foss present findings from ethnographic fieldwork and in depth interviews to argue that sensory experiences – as is pain, for example – are not natural, but symbolic, and culturally mediated. Because we can never be in another person's body, the incarnate is always mediated by communication, and symptoms are therefore not ontologically fixed, but contingent on sensemaking. What the authors' insightful analysis helps us realize is that, in order to be realized as symptoms for the patient, sensory experiences need to be legitimated by healthcare providers.

Whether we acknowledge it or not, cultural contexts are always performed collaboratively, always (multi)systemic, as well as complex, dilemmatic, and tensional. Qualitative research – which cannot but engage researchers in the universe they study – helps us appreciate just how much, and opens the door to changing the practices that conceal how communication works and could work.

References

1. https://www.brainpickings.org/2017/05/15/focus-wendy-macnaughton-courtney-martinposter/53.
2. A phrase coined by Srikant Sarangi, to argue for the importance of an analyst's membership and ability to belong in the world she is studying.