

## Editor's Introduction

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As I welcome you to another issue of *Qualitative Research in Medicine and Healthcare (QRMH)*, I am truly grateful to the authors, the dedicated reviewers, our tireless Managing Editor, Francesca Baccino and, most especially, to our growing readership, for supporting this journal and for continuing to raise its profile as a theoretically articulate, methodologically diverse and impactful publication for scholars-practitioners (for the two are rarely separated; as research is inherently a practice). I am pleased to announce that Jay Baglia, Ph.D., Associate Professor of Communication Studies at De Paul University has accepted my invitation to join our Editorial Board. Dr. Baglia, whose research foci are health communication, performance studies and gender studies, is the author of *The Viagra Ad Venture: Masculinity, Media, & the Performance of Sexual Health* (2005) and co-editor of *Communicating Pregnancy Loss: Narrative as a method for Change*.

Thus far, *QRMH* has published diverse scholarship, ranging in topics from reproduction counseling in sub-Saharan Africa, action research teams in Sweden, rural elders in Ghana, and the identity challenges of physician burnout and anorexia in young women in the United States (just to name a few) and showcasing a variety of qualitative approaches such as interviews, critical theory, ethnography, grounded theory, narrative analysis, dialogue theory, autoethnography, personal narrative and mixed methods.

The six original research articles in this issue continue

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to demonstrate the versatility, sophistication and rigor of qualitative methodologies in tackling the tensions and complexities present in what Elliott Mishler<sup>1</sup> called the voices of the life-world: the multiply embedded accounts of health care users and providers.

In the opening article, *The introduction of the medicinal partner in direct-to-consumer advertising: Viagra's contribution to pharmaceutical fetishism and patient-as-consumer discourse in healthcare*, Applequist's compelling multimodal health communication study of advertising strategies examines the ideological underpinnings of Viagra's *ask your doctor* appeals and how the photography in Viagra ads combines semiotic resources to recruit both men and women into (a heteronormative) pharmaceutical fetishism. Atkinson, Gathright, Clardy, Thrush, and Messias' close lexical analysis of a corpus of accounts by the staff in a medical center in their study *Perspectives of meaningful work in a high-burnout academic medical center: a discourse analysis* problematizes the very discourse of burnout qua psychological condition, demonstrating instead that physicians, nurses and basic scientists find meaning (and are able to communicate how they do so, if we actually study communication carefully as the authors do) in their work in spite of its challenges. Similarly, Ottewell's *A qualitative study of illness identity: schizophrenia and depression*, an analysis of accounts of Japanese interviewees diagnosed with depression and schizophrenia, sheds light about how identities in healthcare are negotiable by those who claim them and are so identified, even when the possibilities for doing so seem restricted – as is the case of stigmatizing and isolating psychiatric diagnoses, or, for that matter, limiting and poorly examined classifiers like burnout. Ottewell's argument that illness identity, or one's self-understanding of being both object and subject to one's own medical diagnosis is not a binary between being well or ill, but rather an ongoing both/and negotiation between normalcy and the social stigma of illness is both astute and highly consequential to psychiatric patients and practitioners.

In *A qualitative study of urban hospital transitional care*, Feinglass, Wein, Teter, Schaeffer, and Rogers note how interviews are often the best, most efficient, and most meaningful way to shed light on healthcare delivery system change and innovation.<sup>2</sup>

Indeed, the authors practice interviewing as a way to not only *go beyond expected clinical narratives* but as *efficient* collaborative engagement in the very conversations that will affect the improvement that the study is designed to investigate. For what could be more efficient than actually understanding the experiences of those who must make sense of how to go about accomplishing complicated and stressful transitions as part of their workday? In this way qualitative research *about* healthcare is already transformative *of* healthcare practices for staff and patients alike: it allows for better practices to emerge from those that are currently experiences as less than ideal.

The articles by Spence, Smith and Wong and Meluch, further demonstrate the rich explanations that qualitative interviews yield for healthcare theory and effective practice. What is interesting is that both studies deal with social support, and as I see it, reveal that research interviews and focus groups are social support in (methodological) action. In *Stress and burnout in anesthesia residency: a case study of peer support groups* Spence and her co-authors return us to the topic of burnout, which has been prominently featured by research journal, as much as medical research and social discourse at large. By way of focus group interviews with medical residents in an anesthesia program—whom the authors tell us is the medical specialty at greatest risk of suicide—the study reveals that the peer support groups in which the residents participate are not what relieves their stress. Instead, the key to reducing burnout would be more time with their families and friends.

Finally, Meluch's *Above and beyond: an exploratory study of breast cancer patient accounts of healthcare*

*provider information-giving practices and informational support* adopts a constructivist grounded theory approach, which holds the researcher accountable in interpreting the data, to advance three consequential insights. The first two are theoretical, for Meluch demonstrates that physicians' clear delivery of information about breast cancer treatment is inextricable from communicating support, therefore allowing patients to feel secure with their treatment plans; the second is that uncertainty is not always a drawback—as it uncertainty theory would have it—for ambiguity can be a source of hope for patients.

The last insight is actually a proposal as to how we might conceive of interviewing itself as a form of research as social engagement, if not actual social support. When researchers ask healthcare consumers and staff for experiential accounts they not only entitle interviewees to author their own versions of how things are and should be<sup>3</sup> for publication and organizational change, but first of all listen and record these versions, which may have never been attended to before. The active co-creation of healthcare practices in qualitative research is nothing if not *supportive* and thus constitutive of change as it starts from the premise of listening and paying close attention.

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## References

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