

Editor's introduction: qualitative research and the epistemics of experience

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In his examination of territories of knowledge, or how knowledge is differently distributed among social members, John Heritage remarks that *the relationship between knowing something and having experienced it is deeply entrenched in interactional practices between knowing and evaluation*.¹ What this means is that epistemic access, or the rights to own one's own experiences *in terms* of knowledge – as for example, the experience of illness, or aging, or interaction with healthcare professionals as a patient or researcher – is never equal to that of others. Though firsthand experience of illness should correspond to its knowledge that is not always the case when experts enter the picture. When people who are ill enter medical treatment, as an example, their accounts will be transformed in terms of symptoms, diagnoses and prognoses, and therefore all health-care (as one among several helping relationships) is based on a functional asymmetry of knowledge between patients and third person knowers. Within the scope of any interactional asymmetry, the act of asking a question is at the heart of accessing another's experience. I consider the question as the most important interactional move in qualitative research, for it presumes that researchers do not already know the experiences of those they study, but rather grant them primacy to their own firsthand knowledge. As well, the questions researchers pose – at step of the research study – should be open to surprising responses and conclusions that were not part of previous

knowledge and always open to further questions down the line. The five articles in this issue are not only *deeply entrenched in interactional practices*,¹ but part of a meta-conversation about qualitative research and entitlement to experience.²

In the lead article of this issue of *QRMH*, *The role of standardized patient assessment forms in medical communication skills education*, Peters studies how communicative exchanges are subsumed in rubrics of medical knowledge.³ Her examination of how a computerized form establishes the rights and obligations of communicators in healthcare settings illustrates how the very experience of communication is transformed by the technological apparatus designed to evaluate it: be it questioning protocols, charts, or devices. Peters' analysis illustrates that patient experience is actually expert-generated, and ultimately for the purposes of expert knowledge and access, though it reformulates the experience of communication for all parties involved, and the knowledge of what counts as communication in medical practice as a whole.

In the study *Advantages and challenges of using mobile ethnography in a hospital case study: WhatsApp as a method to identify perceptions and practices*, Bjørner and Schröder are also concerned with capturing communication as experiential praxis.⁴ By taking a phenomenological approach, the authors introduce WhatsApp as a multimodal technology that nurses can use to track and reflect on their everyday interaction with doctors and patients, allowing a record of knowledge to be generated from the nurses' point of view. By way of this record, the researchers realize that nurses' knowledge is not valued in the same way as that of physicians, though it is nurses, and not physicians, who experience the day to day care of patients firsthand.

The three articles by Blix and Hamran,⁵ Anderson,⁶ and Bell *et al.*⁷ further expand on Heritage's discussion of territories of knowledge and territories of experience by delving into the asymmetries of what different parties in our society *can accountably know, how they know it, whether they have the rights to describe it and in what terms*.⁸ By troubling the very ideal of universalism on which the Norwegian social welfare system is built, Blix and Hamran's fascinating study *Assisted living in rural*

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areas: *aging in blurred landscapes* explores the experiences and practices of aging for elderly adults in assisted living facilities. By examining the dilemmas of equity – the tensions between ideals and practices – what the authors are in fact doing is to question whose experience of equity comes to represent its institutional accounts, and, if it does not include what the residents of the facilities can accountably know, whether it should be understood as equity in the first place.⁵

Similarly, Anderson's analysis of how participants in Facebook peer-to-peer support groups for metastatic cancer make sense of their own illness, points to the link between authorship and authority⁹ or being able to account for one's own embodied experience in terms of knowledge. In *It doesn't make sense, but we do: framing disease in an online metastatic breast cancer support community* Anderson's examination of Facebook threads between support group members demonstrates that when medical experts are out of the picture, women can occupy online spaces by resisting the medical metaphors of war and their entailments of winners and losers in the battle against cancer, thus allowing for the emergence of different identities, and the communicative creation of different bodies altogether.⁶

The closing article by Bell *et al.*⁷ reminds me of this remark about psychiatry by the late Thomas Szasz: *psychiatrists, he noted, are not concerned with mental illnesses and their treatments. In actual practice they deal with personal, social, and ethical problems in living.*¹⁰ In *There's just huge anxiety: ontological security, moral panic, and the decline in young people's mental health and well-being in the UK*, the authors rejoin a mounting critique of the biochemical model of mental illness as a disease of the mind or brain and locate it instead as a response to a collapse of ontological security, or what young people in the UK need to feel safe. By adapting Beck's concept of the risk society¹¹ to manifestations of mental illness, such as worry, anxiety, depression, and panic, Bell *et al.* argue that mental illness, like Beck's construct of risk, is the product of the very social and political arrangements that are in place to address it, and, in particular, the account of it as

an illness of the individual, rather than a social experience. In their five analyses of how experience can be accountably known, the authors of this issue make a powerful case for how qualitative research is always asking questions that are critical to social and political action, and creates the opening for alternative ways of accounting and knowing.

References

1. Heritage J. Territories of knowledge, territories of experience: emphatic moments in interaction. In: Stivvers T, Mondada L, Steensig J, eds. *The morality of knowledge in conversation*. Cambridge: Cambridge University Press; 2011. pp 159-183.
2. Sacks H. *Lectures on conversation, I and II*. New York: Wiley & Sons; 1992.
3. Peters G. The role of standardized patient assessment forms in medical communication skills education. *Qualit Res Med Healthc* 2019;3:8213.
4. Bjørner T, Schröder M. Advantages and challenges of using mobile ethnography in a hospital case study: WhatsApp as a method to identify perceptions and practices. *Qualit Res Med Healthc* 2019;3:7795.
5. Blix BH, Hamran T. Assisted living in rural areas: aging in blurred landscapes. *Qualit Res Med Healthc* 2019;3:7826.
6. Anderson AB. It doesn't make sense, but we do: framing disease in an online metastatic breast cancer support community. *Qualit Res Med Healthc* 2019;3:7007.
7. Bell J, Reid M, Dyson J, et al. There's just huge anxiety: ontological security, moral panic, and the decline in young people's mental health and well-being in the UK. *Qualit Res Med Healthc* 2019;3:8200.
8. Heritage J. Epistemics in action: action formation and territories of knowledge. *Res Lang Soc Interac* 2012;45:1-29.
9. Cooren F. *Action and agency in dialogue: passion, incarnation, and ventriloquism*. Philadelphia: John Benjamins; 2010.
10. Aftab A. Mental illness vs brain disorders: from Szasz to DSM-5. *Psychiatric Times* 2014;31. Available from: <https://www.psychiatrictimes.com/dsm-5/mental-illness-vs-brain-disorders-szasz-dsm-5>. Accessed: August 2019.
11. Beck U. *The risk society: towards a new modernity*. London: Sage Publications; 1992.