

Editorial

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In her final editorial for *Qualitative Research in Medicine and Healthcare*, Mariaelena Bartesaghi described how her health condition prevented her from continuing as Editor-in-Chief. Dr. Bartesaghi described herself as a character in the type of stories that we research and report about in this very journal. Like so many people whose stories have been told and reflected upon in *QRMH* since Dr. Bartesaghi founded the journal in 2017, her story “is one about the burdens of being a patient as well as a human being who suffers” (p. vi).¹

I am honored to carry the journal forward as the new editor, but I wish that it could have come to me through different circumstances. In a way, I am experiencing a facet of health narrative that I have never considered before. When our family, friends, and colleagues become unable to do the things that they love because of illness, what does it mean when we take their place? What are we to feel inside about assuming the role of another who left their position, not because they wanted to, but because illness had left them unable to proceed any further?

I am fortunate in that Dr. Bartesaghi graciously reminded everyone participating in this journal about what it means to keep on with the work that she initially envisioned and pursued through four volumes. “Another body,” she wrote, “will continue my work, your work, the work of *Qualitative Research in Medicine and Healthcare* in examining, validating, and ultimately speaking of the experiences of those [who experience illness] in these pages” (p. vi).¹

As I write these words, I can’t help thinking that Dr. Bartesaghi’s mention of “another body” is an apt phrase indeed. The body that is me writing these words has already spent much of the summer and well into the fall in the role of Editor-in-Chief (such a lofty title!). On the other hand, “body” is also a collective term. All of us who work on this

journal as writers, reviewers, editorial board members, publishers, copyrighters, and, of course, readers, inhabit our singular bodies, yet we also constitute a communal body with shared interests in the intersectionality among qualitative research, health, illness, and the human condition(s). This is our journal, and I look forward to working with you all in keeping Dr. Bartesaghi’s vision of what *QRMH* the vibrant journal that it is.

like anyone who has conducted qualitative research knows, our chosen method of scholarship is highly iterative. Moving forward almost always requires simultaneously looking backward to where we have come from and ascertaining how we ended up where we are in this moment. In that iterative spirit, I have taken the opportunity to read with deep appreciation the editorial that Dr. Bartesaghi provided for the first issue of *QRMH* (2017).² In that brief essay, Dr. Bartesaghi provided the foundation for what it means to do qualitative research with respect to communication, health, and medicine:

As many of you already know, qualitative research is not for the faint of heart. It is reflexive, positioned and like life itself, often messy and focused not on producing easy answers but on the very process of questioning. It is, at best, acutely aware [of] its ontological consequentiality. Unlike research studies under positivist or post-positivist auspices, true qualitative research does not separate the observer from the lived experience of those whom she observes. Rather, it is by understanding the ways in which our own research practices bring forth the very world in which we live that qualitative researchers have a stake in understanding the very reflexive dynamics of how we constitute the world...(p. i)²

Mindfully positioned and messily bent on questioning our own assumptions about health, illness, patients, providers, the medical industry, government policies, and the ways that all those things are embedded in cultural systems shaped by history, economics, epistemology, and many other factors, we move forward, backwards, and sideways following our winding, twisting, circular, and sometimes overlapping paths.

It is not hard to place each of the articles featured in this edition into Dr. Bartesaghi’s vision of what we do as researchers and how *QRMH* serves as an important platform for sharing our work with other scholars and with the world at large. Sylvie Lafrenaye and her co-authors illustrate the value of qualitative research with respect to healthcare in multiple ways.³ First, they stress the particular value that qualitative research proffers to our understanding of the ex-

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Received for publication: 5 October 2021.

Accepted for publication: 5 October 2021.

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Qualitative Research in Medicine & Healthcare 2021; 5:10168

doi:10.4081/qrmh.2021.10168

perience of illness, experienced not just by patients, but also by their caregivers:

Questions of meaning and of “why me?” inevitably arise. Medical science is interested in the “how?” of the disease (biological and genetic explanations), while parents wonder about the “why?”. Unfortunately, too often, the discourses on the “how” and the “why” do not overlap.

Furthermore, the combination of content and rigorous methodology provided by Lafrenaye et al. are a model of how qualitative research can be done. Data collection is meticulous and clearly explained, but the content of the stories is what really hits hardest as parents try to make sense of and garner meaning from the imminent deaths of the children. Words alone cannot express the feelings and experiences of those parents. Narrative analysis, however, brings us closer to perceiving the range of ways that parents engage with, survive, and find meaning amidst ongoing tragedy and inevitable loss. The authors close with practical advice for how healthcare practitioners could most sensitively and effectively communicate with caregivers of life-limited children.³

While Lafrenaye et al. discusses the benefit of mutual narrative construction between caregivers and practitioners, Linda Behar-Horenstein et al. approach narrative co-construction in a very different context.⁴ Behar-Horenstein et al., construct a research success story through analysis of interview data collected over two years. Specifically, they report on a research center partnership featuring specialists from multiple fields of study, but all sharing the same goals pertaining to reducing cancer disparities and promoting cancer disparity research. Behar-Horenstein report remarkable success measured by an enormous number of publications and grant awards generated by the research center. As the authors point out, qualitative research is uniquely positioned to understand why the center functioned so well, albeit after some initial settling while providing a model for similar ventures elsewhere:

The findings offer discernment into [participants’] feelings, beliefs, and actions relative to interdisciplinary, multi-university collaborative efforts. Building a contextualized, real-time understanding for how and why team scientists perceive collaboration effectiveness and subsequent responses may augment the rate and pace of future Center productivity as we use these findings to reify and normalize team development processes. After all, we cannot improve that which we cannot assess or understand.⁴

“Narrative” takes a more ominous tone in Nynne Barchager’s article about discursive patterns between patients and healthcare providers are institutionally conditioned amidst Danish cardiac care.⁵ Combining textual analysis with ethnographic observation, Barchager illustrates how official texts “*happen* and are active in the interactions” between patient and provider:

In [official] documents, *the patient* as an institutional category is characterized by a lack of knowledge.

The notion of educating the patient can be seen as a ruling relation as it originates beyond the local context of the rehabilitation program, but structures the actual interactions between healthcare professionals and patients. It organizes consciousness and actions as it orients healthcare professional...⁵

The “general narrative of progress” supported by medical research provides a dominant framework within which patients who are unable to follow medical advice—due to lack of money, for example—are rhetorically held accountable for what can only seem to be (from the medical perspective) poor choices.⁵

In their analysis of women’s perceptions of risk associated with familial breast-ovarian cancer, Mariya Lorke et al. specifically focus on risk narratives, demonstrating that narrative construction and presentation is part of an ongoing process in which risk assessment is entangled with sometimes conflicting perceptions of identity, fate, and family.⁶ For the women interviewed in the research, genetic testing is more than an event that happens to a woman. Rather, it is a

process that brings...attitudes, values, and ideas to the surface. This is the reason to suggest that patients’ explanatory models of risk, their general attitude towards health and disease, their lived experience and biographical background should be taken into consideration...⁶

Health literacy plays a crucial role in negotiating stress associated with genetic testing, Lorke et al. explain; being health literate, women are more able to balance perceptions of the health system as a means of healing and as a source of anxiety.⁶

Each of the articles in this issue develop qualities book-ended by Mariaelena Bartesaghi’s premier and closing editorials. In their different, yet overlapping ways, articles collected in this issue each embody (I use that word deliberately) the self-reflexive, messy mindfulness that we expect from solid qualitative research. I am proud to share them with you as we carry Dr. Baresaghi’s work forward.

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