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DOING QUALITATIVE RESEARCH

EDITED BY
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RICHARD B. ADDISON

Introduction

Hermeneutics is an awkward word with a long tradition. It simply stands for the business of interpretation. The word is thought to derive from Hermes, the Greek messenger god and trickster, who carried messages from the gods to the people. His role was to interpret these messages from the gods and to make them understandable to humans.

The central task of hermeneutic analysis is "the process of bringing a thing or situation from unintelligibility to understanding" (Palmer, 1969, p. 13). Trying to understand, take meaning from, or make intelligible that which is not yet understood is not only the central task of hermeneutics, it is an essential aspect of our being in the world (Gadamer, 1976; Heidegger, 1927/1962).

As an approach to understanding written texts, hermeneutics has long been applied to fields as diverse as biblical exegesis, legal interpretation, and linguistic and literary analysis. It was not until the end of the 19th century that a hermeneutic approach for studying the human sciences began to gain prominence (Bleicher, 1980; Palmer, 1969).

In this chapter I will provide a brief summary of a grounded hermeneutic approach to research, give examples of such research, list the central aspects of grounded hermeneutic research, describe the

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step-by-step research practices I employed in a grounded hermeneutic investigation of individuals becoming family physicians, outline the account I generated, and offer some helpful standards for evaluating qualitative research.

AN APPROACH TO RESEARCH

A grounded hermeneutic approach is not a method in the sense of a prescribed set of techniques that can be applied to any research project. A hermeneutic approach cuts below specific methods or techniques. For the research described in this chapter, I adapted a grounded theory method (Glaser, 1978; Glaser & Strauss, 1967; Strauss, 1987) and applied techniques developed in participant observation-related research (Agar, 1980; Erickson, 1977; Garfinkel, 1967; Geertz, 1973, 1983; Mehan & Wood, 1975; Schatzman & Strauss, 1973; Schwartz & Schwartz, 1955) on a hermeneutic framework (Bernstein, 1976, 1983; Bleicher, 1980, 1982; Caputo, 1987; Dreyfus, 1986, 1991; Habermas, 1968, 1977; Heidegger, 1927/1962; Lather, 1986a; McCarthy, 1978; Packer & Addison, 1989; Rabinow & Sullivan, 1979; Ricoeur, 1981).

I call the hermeneutic approach described in this chapter *grounded* for two reasons: first, it seeks to illuminate social, cultural, historical, economic, linguistic, and other background aspects that frame and make comprehensible human practices and events; second, it is grounded in the everyday practices of individuals in ongoing human affairs (see Kuzel, 1986, on naturalistic or constructivist research).

ASSUMPTIONS OF A GROUNDED HERMENEUTIC APPROACH

A grounded hermeneutic approach embodies certain assumptions or understandings about the world, the people in it, research activity, and the relationships among these. Briefly these assumptions and their implications for conducting research are as follows:

1. Participants of research are meaning-giving beings; that is, they give meaning to their actions, and these meanings are important in understanding human behavior.
2. Meaning is not only that which is verbalized; meaning is expressed in action and practices. To understand human behavior, it is important to look at everyday practices, not just beliefs about those practices.

3. The meaning-giving process is not entirely free; meanings are made possible by background conditions such as immediate context, social structures, personal histories, shared practices, and language. When something is noticed as missing, wrong, or problematic, illuminating these background conditions can allow change to occur.
4. The meaning and significance of human action is rarely fixed, clear, and unambiguous. Meanings are not limited to preestablished categories. Meaning is being negotiated constantly in ongoing interactions. Meaning changes over time, in different contexts and for different individuals.
5. Interpretation is necessary to understand human action. Truth is not determined by how closely beliefs correspond to some fixed reality. It is never possible to achieve an objective, value-free position from which to evaluate the truth of the matter. Facts are always value-laden, and researchers have values that are reflected in their research projects.

EXAMPLES OF HERMENEUTIC RESEARCH QUESTIONS

Certain classes of problems and concerns in primary care research are particularly well suited to a grounded hermeneutic approach. These include questions aimed at (a) understanding the meaning and significance of complex human interactions and events in the context of their everyday settings, and (b) understanding the relationship between behaviors, practices, or events and the sociocultural, historical, political, and economic background against which they take place. At this time, several promising investigations in process are employing hermeneutically informed approaches. These studies ask such questions as how physicians deal with medical mistakes (Newman, 1991), how the social and cultural context affects the doctor-patient relationship for patients with Type II diabetes (Bartz, in preparation), how patients think about their hip fractures (Borkan, Quirk, & Sullivan, in preparation), how women decide how to feed their infants (Marchand, 1991), what happens when elderly patients are discharged from the hospital to home (McWilliam, 1991), how to understand barriers to providing primary care to HIV patients (Epstein, in preparation), and how family practice resident-physicians deal with dying patients and their families (Dozor & Addison, in preparation). Other primary care research studies have used aspects of an interpretive or hermeneutic approach (e.g., Benner, 1984, 1985; Brody, 1990b; Crabtree & Miller, 1991; Frankel & Beckman, 1982; Kleinman, 1988; Mishler, 1984; Mizrahi, 1986; Stein & Apprey, 1985; Willms et al., 1990).

CENTRAL PRACTICES OF GROUNDED HERMENEUTIC RESEARCH

Even though a grounded hermeneutic approach is not a method in the sense of a set of techniques, it is possible to list the following seven practices that are central to grounded hermeneutic researchers:

1. Immersing oneself in the participants' world in order to understand and interpret the participants' everyday practices
2. Looking beyond individual actions, events, and behaviors to a larger background context and its relationship to the individual events
3. Entering into an active dialogue with the research participants, research colleagues, research critics, the account itself, and his or her own values, assumptions, interpretations, and understandings
4. Maintaining a constantly questioning attitude in looking for misunderstandings, incomplete understandings, deeper understandings, alternative explanations, and changes with time and context
5. Analyzing in a circular progression between parts and whole, foreground and background, understanding and interpretation, and researcher and narrative account
6. Offering a narrative account of the participants' everyday practices that opens up new possibilities for self-reflection and changed practices
7. Addressing the practical concerns of the researcher and the research participants against a larger social, cultural, historical, political, and economic background

Accordingly, grounded hermeneutic researchers approach a particular problem from a concerned, involved standpoint; immerse themselves in the participants' world; analyze human actions as situated within a cultural and historical context; offer a narrative account of how a problem developed and is maintained; and offer directions for positive change. These practices will be illustrated in the following step-by-step discussion of my research practices.

Becoming a Family Physician

For many years I had been interested in the long and arduous education and training involved in becoming a physician. I saw this

intense, stressful process as a problem for the trainees, their families, and their patients. I wanted to better understand what becoming a physician was like for the individuals involved, how the practices of resident-physicians became problematic, and whether positive alternatives were possible.

CHOOSING AN APPROACH TO THE PROBLEM

The method of inquiry must fit the problem and goals of the research question. To address the questions detailed immediately above, I knew that questionnaires or self-report surveys would be inadequate for capturing the complexity and richness of the everyday practices of individuals as they became physicians. I wanted to understand what they actually did as they began their residency, not just what they thought they were doing, believed they were doing, intended to do, or said they did. This is the kind of question that can be addressed effectively by a grounded hermeneutic investigation.

NARROWING THE FOCUS

After talking to many people in the field of medical education, I informally visited different training programs. I observed different primary care specialties (pediatrics, family practice, internal medicine, as well as some observations in emergency medicine residencies), in different settings (county, private, HMO), in different locations (urban, semiurban), and with different affiliations (university based, university affiliated, community). After 9 months I chose one university-affiliated family practice residency program in a semiurban county setting.

CLARIFYING INITIAL UNDERSTANDINGS

I tried to clarify my initial understandings about the problematic aspects of family medicine and residency training. These understandings centered around two issues. First, increasing technological expertise was demanded of physicians who had chosen family medicine; this would create a contradiction for them in their training if they envisioned themselves as healers rather than technicians. Second, stress and impairment in physicians, as evidenced by poor patient care,

burnout, dropout, marital problems, substance abuse, depression, and suicide, seemed to be far more problematic than ever before.

I decided to focus on the first year of residency, long recognized as most stressful in terms of its encompassing demands and most significant in terms of inculcating attitudes, beliefs, values, and practices (Bloom, 1963; Mumford, 1970). Habits and patterns of behaving and interacting that are forged at this time often extend beyond internship and residency into personal and professional lives.

IMMERSING MYSELF

The program I chose to look at had accepted nine new residents. I narrowed my focus to observing these nine residents in one residency setting at the beginning of their residency training in order to gain as thick and comprehensive an understanding of their everyday existence as possible.

I presented myself as a psychologist and researcher who was studying how individuals become physicians. I followed the nine first-year residents solidly for a year and intermittently for the next two, observing them in almost every aspect of their lives. I followed some more closely than others, as I found some residents more welcoming of my presence, some more verbal, and some more critically reflective. I openly recorded observations about what I saw, what I felt, how I was doing research, what I understood and did not understand, and what I thought was important. I interviewed the residents, their spouses, and others associated with their education and training, asking questions about what I observed. I read the enormous volume of memos, schedules, and documentation that was churned out by the hospital, the residency, and the residents themselves.

Immersing myself in the everyday activities and practices of the residents was important for me to develop an understanding of what these activities meant to them. For example, when I accompanied them to their first surgery conference, the surgery coordinator made them stand up and recite differential diagnoses. He called on one of the first-year residents who was very uncomfortable talking in front of groups. She sounded unsure of herself, hesitated, and the coordinator quickly moved on to someone else. I felt her embarrassment; it reminded me of how my seventh-grade teacher ridiculed me in front of the class because I spoke my answer too softly. When I later interviewed the resident, I told her that I knew how she had

felt at the moment. She went on to talk about a wealth of similar experiences in medical training when she had felt embarrassed, chagrined, abused, and demeaned. As a resident she sometimes did not attend conferences held by certain physicians. I saw these dynamics repeated with other residents in other interactions. Out of this I came to an interpretation about the importance of such interactions in constituting residents' practices.

This type of analysis is essentially and necessarily a hermeneutically circular process: I moved from immersing myself in the residents' everyday existence wherein I developed an experiential understanding of their practices. I then made this understanding explicit in the form of an interpretation of the meaning of their practices. I then incorporated this fuller interpretation into my further observations and immersion to understand more or different aspects of their existence.

CONCURRENTLY COLLECTING, FIXING, AND ANALYZING

Hermeneutic analysis is a necessarily circular procedure. Even now as I attempt to describe this process by writing words, sentences, and paragraphs that follow one another in linear fashion, I am aware of the difficulty of communicating the circular feel of my research procedure. While I was still immersed in observing resident practices, taking notes, and recording interviews, I began analyzing the notes and interviews. I moved back and forth between collecting, analyzing, reflecting, and writing in a way that cannot be laid out or predicted in advance.

All of the collecting, coding, and analyzing was done in light of my practical research question: the problematic aspects of becoming a family physician. Although I analyzed far more data than I eventually used, my selection of data was determined by this question.

I had my notes and interviews transcribed onto only the left half of the page, saving the right half for text analysis. I treated the social action I observed as a type of text (Ricoeur, 1979). I "fixed" events, behaviors, interactions, dialogues, and practices in the form of a text so that I could interpret and analyze them. Although texts are usually thought of as written material, audiotaped and videotaped material (see Chapter 8) also have been used as hermeneutic texts, usually along with a transcript of the tapes. Thus the typed transcripts of my

audiotaped interviews, my handwritten notes, and my reflections on both of these became the text for analysis.

I used two different types of analysis for developing my account. The first type, often referred to as "in vivo" coding (Strauss, 1987), consisted of selecting from transcripts residents' words or phrases that stood out to me as potentially significant for understanding how the residents were becoming family physicians. For example, I coded such words as *punting, pimping, dumping,* and *surviving*. These were terms residents used that later became categories in the developed account. I used as much in vivo coding as possible.

I also used a second and more global type of analysis. This type of analysis was like the reflective process notes I take after seeing psychotherapy clients. In this latter type, I recorded comments and notes on what the residents' words or practices reminded me of, on what I felt to be significant, on what I thought their practices meant and were connected to, on what I did not understand, on how I thought my presence influenced their practices, and on the implications of their practices for their professional socialization. For example, one of these notes read:

> I went up to see (a 21-year old patient who was dying): the guilt of not spending enough time with him, and the discrepancy I noticed between the people around him who know he's going to die, and his not talking about death, or not having anyone to talk to about dying .... I feel guilty at not spending enough time with him, and I'm sure the residents do too.

This note developed into an analysis of residents' difficulties in dealing with dying patients.

Again, collecting, coding, and analyzing data occurred concurrently. Interpretation and analysis began as soon as I started observing residents and collecting data. For example, one of my early notes read: "I sit at the nurses' station . . . trying to hide out and write my notes. I am feeling absolutely overwhelmed with the amount of input." Another note read: "I feel tired, not at my best, even though I got five hours sleep, considered a good night on call (white cloud). The residents must get used to this." These notes and others around this issue helped me understand how "totalizing" their lives as residents were.

I started to put all of these codes and notes on index cards. I cut up relevant sections of my transcribed notes and interviews that

were too long to fit on index cards. I began to sort the hundreds of cards and longer selections into piles that seemed to have a common thread. I looked for patterns and relationships between cards and piles of cards. I looked for themes that organized piles of cards. Every horizontal surface above floor level was filled with cards and cut-up transcripts. I began to see progressions and flows. I started making lists of groups of practices, people, reactions, and events, and connecting these lists on big sheets of white paper. Since no horizontal surfaces were left, I removed pictures and prints and tacked these lists and categories onto walls.

Suddenly, 3 or 4 months after beginning, out of this wealth of seeming chaos, I had a flash of clarity: The central organizing theme for the residents as they began the residency was "surviving." It seemed to both describe and unify their practices in a way that made sense. On finding such a unifying theme, I set out to learn how they survived and how they did not survive that first year of residency.

DEVELOPING THE ACCOUNT

I therefore began to reanalyze my transcripts, interviews, notes, and index cards with reference to surviving. I began seeing a different, more cohesive organization that seemed to incorporate previously scattered experiences and practices. I constructed a diagram that encompassed most of the lists and categories from my wall charts. This beginning diagram or attempted pictorial whole of what happened to these individuals as they began their residency looked something like a child's drawing of an extraterrestrial's digestive system. It was the first of many such attempts to make diagrammatic sense out of their existence.

SPIRALING AROUND THE HERMENEUTIC CIRCLE

The above progression illustrates the circular movement of hermeneutic research from understanding to interpretation to deeper understanding to more comprehensive interpretation. After immersing myself in the residents' lives (understanding), I began to analyze my notes and interviews (interpretation) to make sense out of them. My flash of (deeper understanding of) how surviving played such a central role for them led me to reanalyze my transcripts, diagrams, and models in light of the centrality of surviving (more comprehensive interpretation). Following this, I returned to observe and interview the residents (aiming for greater understanding and even further development of the interpretive account). Thus, as I moved around the hermeneutic circle, my understanding continued to deepen and my account became more coherent, cohesive, and comprehensive.

QUESTIONING THE ACCOUNT

I tried always to keep my critical voice active, questioning my notes, looking for contradictions, inconsistencies, gaps, omissions, and ambiguities in the developing account. For example, I knew that two strategies the residents employed for surviving—"helping" and "isolating"—were only part of a larger story. It was not until I questioned the conditions under which residents survived by isolating themselves and the conditions under which they survived by helping that I was able to push the account further. It was then that I came up with the more comprehensively explanatory modes of "Covering-Over" and "Over-Reflecting."

This is only one example of how questioning an account serves as a key element of hermeneutic research. It is essential for developing and refining any account of human practices.

ENTERING INTO A CRITICAL DIALOGUE WITH OTHER RESEARCHERS

Since I worked alone and was not part of a research team, I joined a weekly analytic seminar of other health care student researchers led by a sociologist and health care researcher (see Strauss, 1987, pp. 167-168). At various stages, I also presented the developing account to other colleagues and teachers. One mentor (an educational sociologist) cautioned me about identifying too strongly with the residents' plight and encouraged me to expand my interpretations. Bonding or identifying too closely with the research participants is a frequent occurrence in participant-observation research. Although my bonding with them helped me understand their everyday practices, I also needed to stand back, reflect on, and question my understanding. Another mentor (a psychologist and behavioral scientist) filled in valuable pieces of local history. Another primary care physician and researcher pointed out logical inconsistencies in my account.

SHOWING THE ACCOUNT TO RESEARCH PARTICIPANTS

When I felt ready, I tried to explain the working diagram to the residents. I received many helpful comments and questions about various aspects of the diagram. I was also greatly surprised at the initial reaction I received: No first-year resident could sit through my brief presentation of the account without either crying or becoming extremely anxious. One first-year resident told me of his reaction:

> I had an incredible amount of anger about everything that was on that sheet. I mean, everything that was bothering me was on there in some way . . . and all the arrows went exactly the way the arrows in my brain were going . . . but I was unaware of a lot of them at the time. . . . And I looked at them all and . . . within fifteen seconds my eyes were just welling up with tears. . . . It just made me feel so uncomfortable. (Addison, 1989, p. 49)

I took this reaction to the diagram as a sign that the account was a powerful one; it had some significance for the residents. I also interpreted this type of reaction to mean that they had no broader understanding of what was happening to them as they carried out their everyday tasks and responsibilities. This understanding of their limited range of reflective vision became a central element of the developed account. Additionally their reaction told me that I needed to be sensitive and careful about whom I presented the account to, when I presented it, and how I presented it. I needed to think through the implications of showing the account to individuals already experiencing a great deal of stress.

REFLECTING ON INITIAL UNDERSTANDINGS

One of the essential elements of hermeneutic research is the inclusion of the researcher in the hermeneutic circle. Since no privileged position exists from which to observe human behavior, researchers' beginning understandings inevitably influence how researchers carry out their observations, what questions get asked, what data get selected, how data get interpreted, and what findings get reported.

An example of how these early, sometimes taken-for-granted understandings can affect the course of inquiry (and how understandings can change during the course of inquiry) involved the residents'

choice of specialty. As noted above, when I began my study, I was very interested in the split between why I thought individuals chose family medicine: because they wanted to be healers; and what they would be doing as they learned family medicine: learning the technology of medicine. I thought this split would be the central contradiction in their everyday existence. I came to understand that although this contradiction was important to the residents, it was not nearly as central as I thought. I learned that individuals chose family medicine for a variety of reasons: because they thought it would be challenging, because they would meet interesting people, because they thought it would allow them to perform a great variety of procedures and give them enormous breadth of knowledge, because they thought they would not be accepted in other specialties, and because they saw themselves as altruistic healers. I only came to this fuller interpretation after I reflected on my professional choices: I became a psychologist instead of a family physician and a psychotherapist who eschews technical or cookbook approaches to psychotherapy. Once I saw how my professional choices affected my developing understanding of the residents, I began to see some of the other reasons why the residents had chosen family medicine. At the same time, the split I had identified as central (technician-healer) became far less central. By moving in a circular fashion between reflecting on my evolving account and my developing understandings, these understandings changed as my interpretation of their everyday practices evolved.

CONTINUED OBSERVATIONS

At the same time, I continued observing and interviewing to flesh out underdeveloped portions of the account and to correct aspects that were not yet coherent or cohesive. For example, the residents were troubled by their outpatient clinics, the kind of setting in which they would be spending most of their time after residency. One of their complaints about their clinics was that they had too many patients to see; they always felt rushed and harried. When I questioned the faculty as to the rationale for the number of patients residents were required to see, they replied that residents needed to learn how to see patients quickly and efficiently now in order for them to earn a decent living after residency. After continued questioning of other medical educators, I identified another and perhaps more important

reason for the number of patients in the residents' clinics: The outpatient facility needed the income from these visits.

In addition to showing the value of continued questioning, the above example illustrates how it is impossible to interpret sufficiently the significance of a singular event without reference to the larger context within or upon which the event took place. I moved back and forth between foreground (the residents' dissatisfaction) and background (the economics of the clinic and hospital). Again this circular, back and forth movement is central to a hermeneutic approach to analyzing research data.

REVISITING THE PROBLEM

From my immersion and analysis, I constantly returned to the problem at hand: how individuals became family physicians. I wanted to make sure the account addressed this question directly and did not wander off on interesting and important points that were not quite relevant to my specific question.

REFINING THE ACCOUNT BY WRITING IT UP

As I began to fill in the gaps, inconsistencies, and mistaken understandings of the developing account, my diagrams changed, looking less indigestive and otherworldly, more digested and cohesive. I grew more confident of the account and began to write it up as a narrative whole. Even at this stage, I saw other aspects of the account that did not quite hang together. I had to go back and reinterview and reobserve to fill in missing connections or sections that were unworkable.

THE ACCOUNT ITSELF: SURVIVING THE RESIDENCY

Since the focus of this chapter is the process of analysis, I will provide only a brief summary of the account. A more detailed narrative can be found elsewhere (Addison, 1984, 1989).

In summary, I found "surviving" to be the unifying theme of the residents' everyday practices. As they began the residency, they were confronted by certain immediate issues (work and information overload, time pressures, sleep deprivation, inexperience, responsibility, control, and dying patients). They encountered different groups of people (other residents, nurses, receptionists, faculty, attending physicians, and significant others) whom the residents sometimes found helpful, and sometimes found to be sources of abuse. In response, residents adopted certain strategies for dealing with these stressful issues and interactions. Strategies ranged on a continuum from helping to isolating and included learning the ropes, forming teams, covering, punting, dumping, and pimping. These encounters took place against a background of conflicts and contradictions in the fabric of the residency.

These contradictions occurred in two arenas. I called the first arena *spheres of existence*. It consisted of three spheres: work, education, and life outside of residency. As residency progressed, the purpose and balance of the spheres changed radically. Work became all-encompassing, education became defined as doing procedures, and life outside became negligible.

I labeled the other arena of conflict and contradiction *models of medicine*. Although residents entered the residency hoping to learn family medicine, they soon found themselves torn among the medicine practiced and taught by specialists and subspecialists, the medicine practiced and taught by general practitioners, and the medicine taught by behavioral scientists. Their ideals and their everyday practices were in conflict. They found no family medicine role models, especially in the hospital where they spent most of their time.

At times they found themselves "Covering-Over" these conflicts and contradictions; at times they found themselves "Over-Reflecting." When they became buried in the Covering-Over mode, they barreled through their work, forgot their ideals, and lost sight of their own place in the process of becoming a family physician. When they became paralyzed in the Over-Reflecting mode, they became overwhelmed, had difficulty becoming involved in learning family medicine, and thought of quitting. Residents bounced back and forth between these two extremes in a jarring fashion without seeing what was happening to them. They defined the whole of their existence by the mode they found themselves in. What was missing was the opportunity to perceive the larger picture of this movement, to reflect on the disparity and contradiction between their ideals and their everyday practices, to learn to move more flexibly between Covering-Over and Over-Reflecting, and eventually to begin to

integrate these two disparate modes into one workable mode of being a family physician.

THE HERMENEUTIC AND NARRATIVE CHARACTER OF THE ACCOUNT

The product of my inquiry was a comprehensive hermeneutic and narrative account grounded in the everyday practices of the residents. I do not believe that the account corresponds with, represents, or reconstructs "reality." Rather, I generated an interpretive account that looks at a crucial period in the process of becoming a physician; provides an interpretation of how distress developed and was maintained; describes the conditions, context, and problematic atmosphere of the process; discusses the costs and significance of the process for residents, their families, and health care; and suggests directions for improving physician training. The account can be modified as time, social conditions, and individuals change.

Conclusion

Grounded hermeneutic research is an extremely well-developed and powerful approach to meaningful, difficult, and complex human research questions. It addresses practical concerns of the researcher and research participants. It aims to describe and uncover significant background conditions, understandings, and practices that contribute to the problem at hand. It takes into account the values, attitudes, beliefs, and practices of the researcher. It can produce a cohesive, interpretive account of research participants' everyday practices. Such an account can open up new possibilities of self-reflection and action for the participants. It is my hope that this chapter will encourage researchers to recognize its value for addressing primary care research questions.