

# Cercetarea calitativă

C Baicus, 2019  
Școala doctorală

- Cercetarea **calitativă** se concentrează pe înțelegerea unei întrebări de cercetare ca o abordare umanistă sau idealistă.
- Cercetarea **cantitativă** este mai acurată pentru că se bazează pe numere și măsurători
- Cercetarea **calitativă** este folosită pentru a înțelege credințele, experiențele, atitudinile, comportamentul și interacțiunile indivizilor. Generează date non-numerice.

**TABLE 3.1 ● Characteristics of Qualitative Research**

<b>Characteristics</b>	<b>LeCompte and Schensul (1999)</b>	<b>Hatch (2002)</b>	<b>Marshall and Rossman (2015)</b>	<b>Ravitch and Mittenfelner Carl (2016)</b>
Is conducted in a natural setting (the field)	Yes	Yes	Yes	Yes
Relies on the researcher as key instrument in data collection		Yes		Yes
Involves using multiple methods	Yes		Yes	
Involves complex reasoning going between inductive and deductive	Yes	Yes	Yes	Yes
Focuses on participants' multiple perspectives and meanings	Yes	Yes		Yes
Is situated within the context or setting of participants or sites	Yes		Yes	Yes
Involves an emergent and evolving design		Yes	Yes	Yes
Is reflective and interpretive of researcher's background influences			Yes	Yes
Presents a holistic, complex picture		Yes	Yes	Yes

- Când am luat primul meu post de cercetare, un coleg de serviciu m-a sfatuit:
  - Găsește ceva de măsurat, și continuă să măsoari până ai adunat o grămadă de date. Atunci oprește-te, și începe să scrii.
  - Dar ce ar trebui să măsoar? am întrebat.
  - Asta, nu are nici o importanță.

Trisha Greenhalgh, How to read a paper [Cap. 11: Papers that go beyond numbers (qualitative research)]

- Limitările unei perspective exclusiv cantitative (numără și măsoară) în cercetare.
- O descoperire/rezultat este acceptat mai degrabă dacă este cuantificat (exprimat în numere)

- Cercetarea calitativă caută adevărul mai profund
- Încearcă să studieze lucrurile în mediul lor natural, încercând să găsească sensul, sau să interpreteze fenomenele naturale
- Perspectivă holistică ce păstrează complexitatea comportamentului uman
  
- Psihologie, filozofie, **sociologie**
- Se consideră din ce în ce mai mult că este nu numai ceva complementar, dar chiar o necesitate pentru cercetătorii “cantitativi”
- Nu sunt reciproc exclusive – *mixed methods research*

- Cecil Helman:

- Mami, cad frunzele din copaci!

- Spune-mi mai mult!

- Ei bine, au căzut cinci frunze în prima oră, și apoi 10 au căzut în a doua oră...

Acest copil va deveni un cercetător cantitativ.

- Cecil Helman:

- Mami, cad frunzele din copaci!

- Spune-mi mai mult!

- Ei bine, frunzele sunt mari și plate, și cele mai multe galbene sau roșii, și par să cadă din unii copaci, dar nu din alții. Și, mami, de ce nu au căzut frunze și luna trecută?

Acest copil va deveni un cercetător calitativ.

- Întrebări precum “câți părinți ar merge la medic când copilul face temperatură ușoară?”, sau ”Ce proporție de fumători au încercat să renunțe?” pot primi răspuns prin intermediul cercetării cantitative.
- Întrebări precum “De ce se îngrijorează părinții atât de mult când copii fac febră?”, sau ”Ce-i oprește pe oameni să se lase de fumat?” nu pot și nu trebuie să primească răspuns prin cufundarea în măsurarea primului aspect al problemei pe care noi (outsiderii) îl considerăm important.
- Mai degrabă ar trebui să ne oprim puțin, să ascultăm ce au oamenii de spus, și să explorăm ideile și îngrijorările cu care vin aceștia. După un timp, observăm că se conturează un model, care ne face pe noi să observăm într-un mod diferit.



# Metode (exemple)

Documente	Studierea documentelor care descriu evenimente (de ex întâlniri)
Observație pasivă	Urmărirea sistematică a comportamentelor și discuțiilor în mediul natural
Observație participativă	Observație în care cercetătorul are un rol, înafara observării
Interviu (în profunzime)	Conversații față în față, cu scopul de a explora probleme în detaliu. Nu are întrebări preformate, dar este condus prin intermediul unui set definit de teme.
Focus grup	Metodă de interviu în grup care include și folosește explicit interacțiunile din acel grup pentru a genera date



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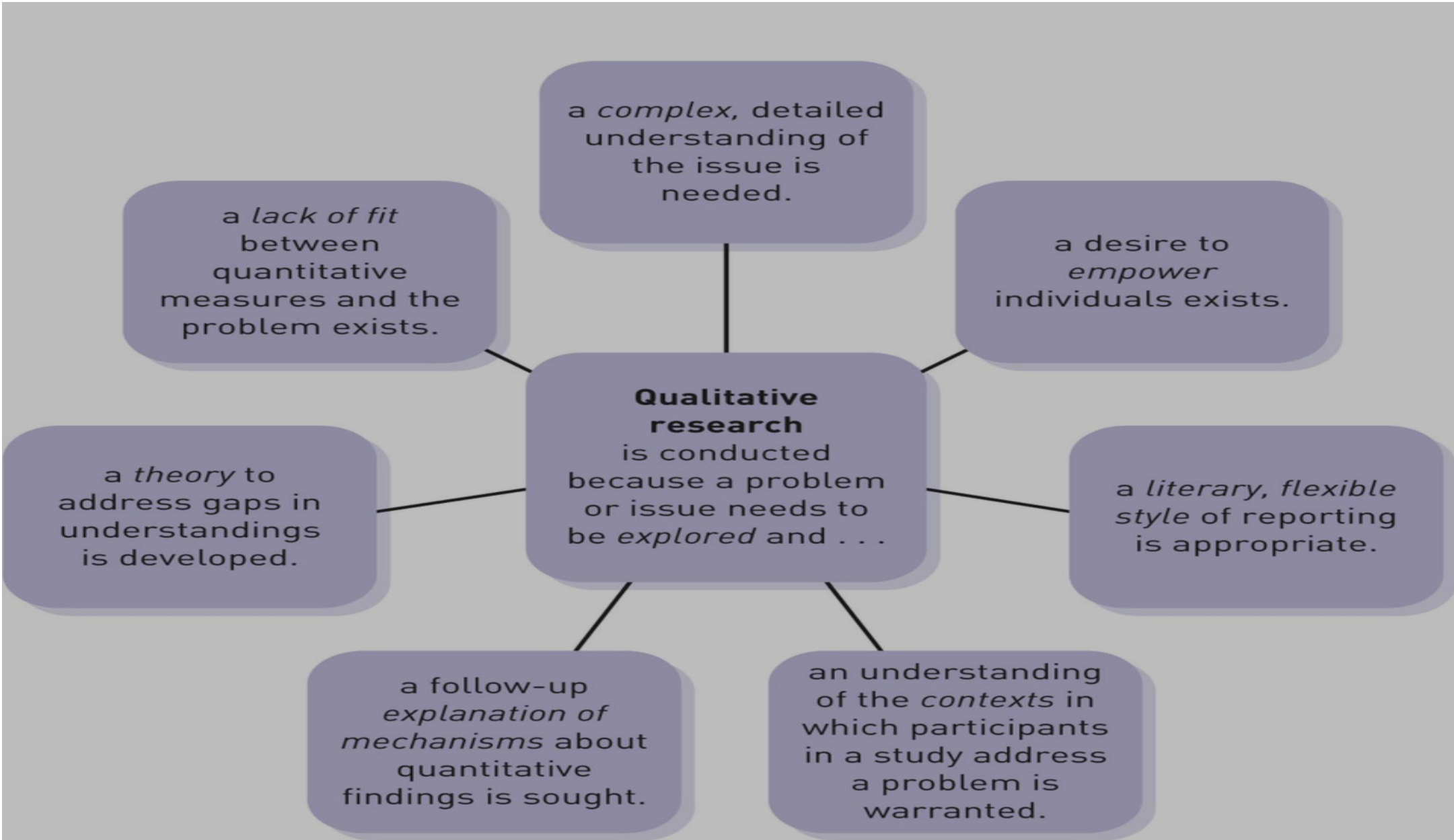
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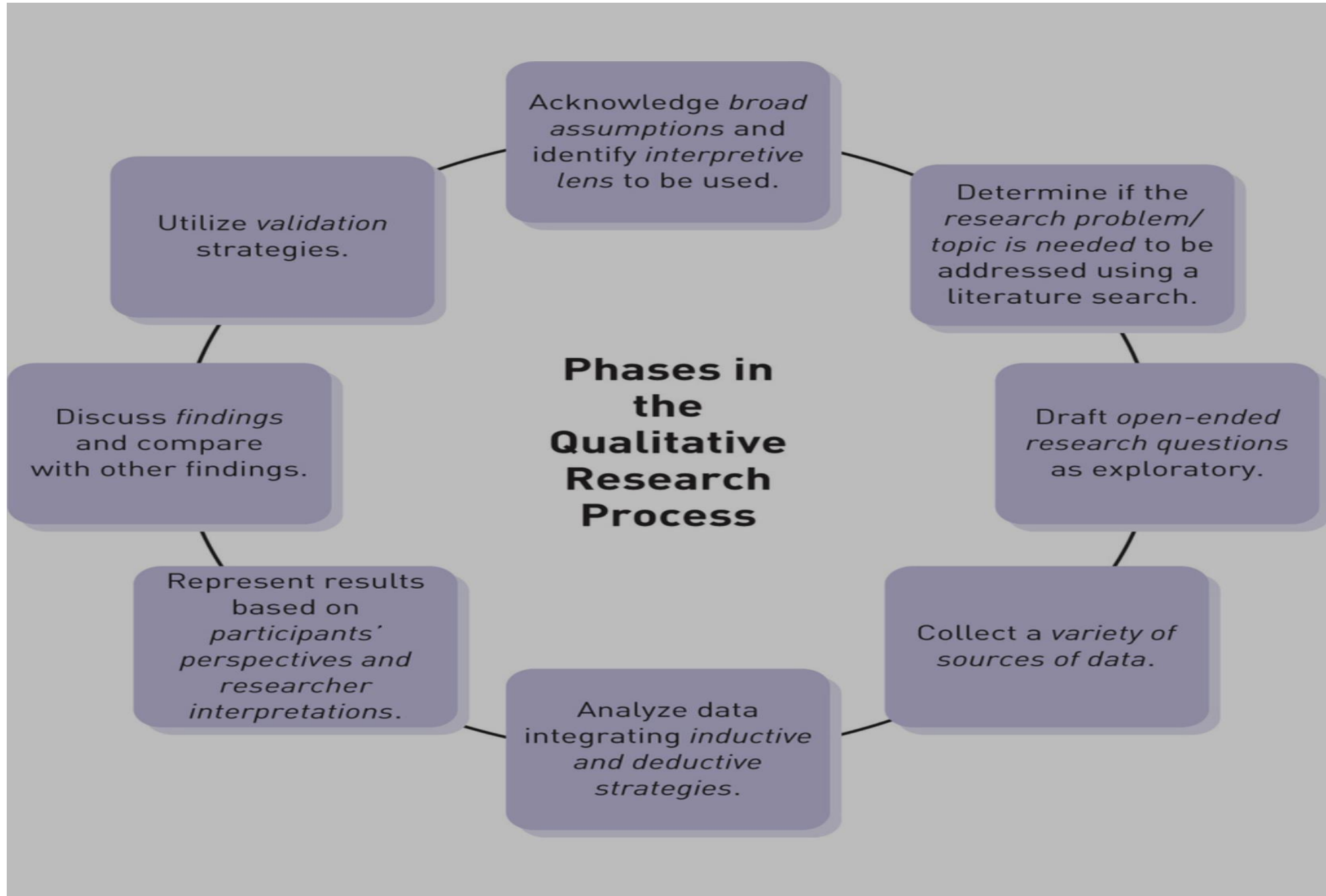
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# când folosim cercetarea calitativă



# Fazele procesului de cercetare calitativă



# 5 abordări calitative în funcție de necesitatea cercetării

Which qualitative approach best fits your research needs?

Explore the life of an individual.

Understand the essence of the experience.

Develop a theory grounded in data from the field.

Describe and interpret a culture-sharing group.

Develop an in-depth description and analysis of a case or multiple cases.

Tell *stories* of individual experiences.

Describe the essence of a *lived phenomenon*.

Ground a *theory* in the views of participants.

Describe and interpret the *shared patterns* of culture of a group.

Provide an in-depth *understanding* of a case or cases.

**Narrative Research**

**Phenomenological Research**

**Grounded Theory Research**

**Ethnographic Research**

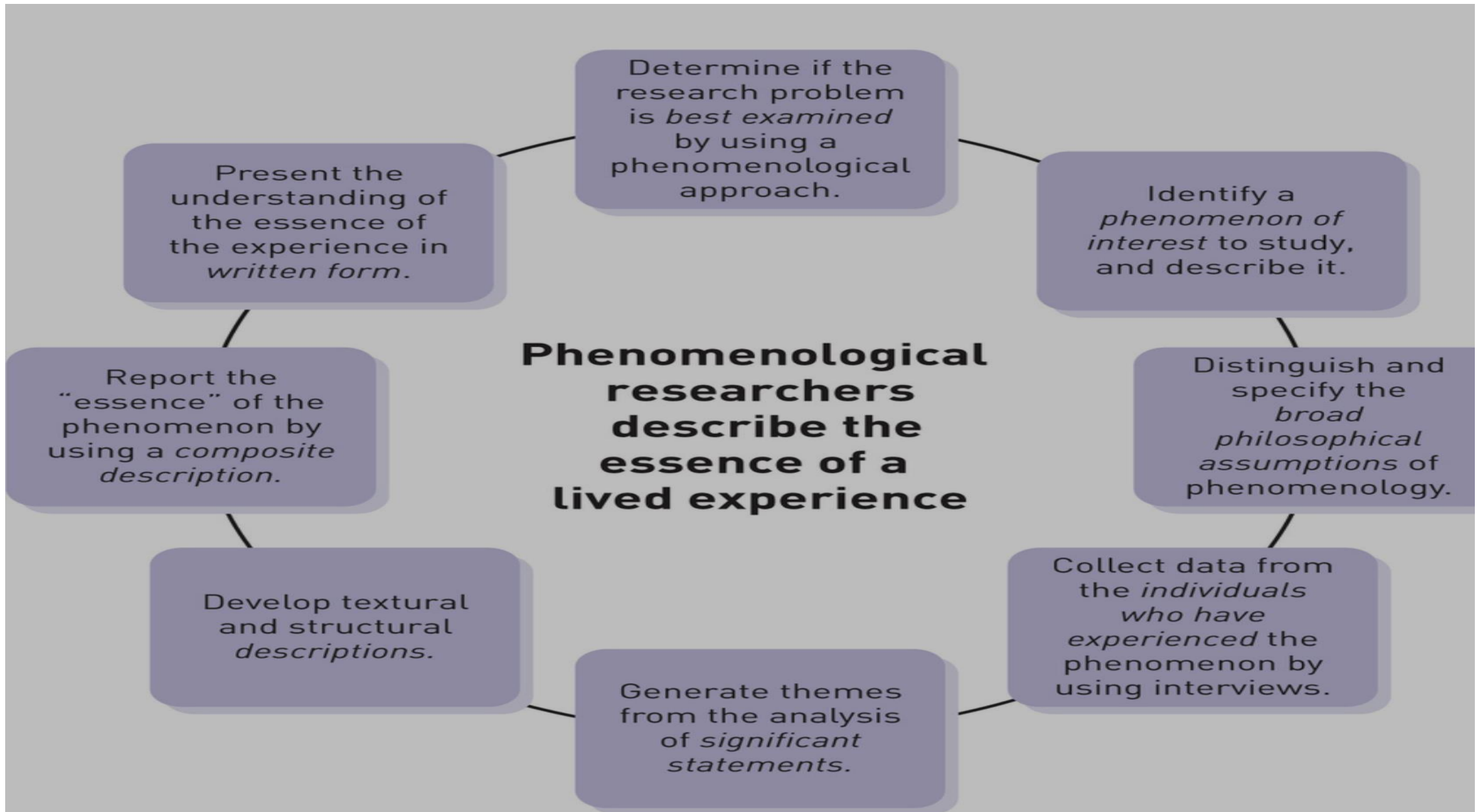
**Case Study Research**

Research Focus

Research Problem



# Cercetarea fenomenologică



# Criteria de validitate

- Studiul sa răspundă la o întrebare clinică importantă, examinată printr-o întrebare clar formulată,
  - Natura iterativă a cercetării calitative → întrebarea trebuie să fie clar formulată măcar atunci când articolul este scris!!

# Criteria de validitate

- Este potrivită abordarea calitativă?
  - Obiectiv: explorare, interpretare, înțelegere mai profundă a unei anumite probleme clinice



# Criteria de validitate

- Selecția locului și subiecților
  - Eșantionarea nu este statistică – nu ne interesează *media* populației
  - Căutăm indivizii/grupurile care răspund ideii noastre
  - Eșantion mai mic → *saturație*
  - Influența vederilor intervievatorului (cercetătorului)

# Criteria de validitate

- Care a fost perspectiva cercetătorului și dacă a fost luată în calcul?
  - Nimeni nu este total obiectiv
  - Cercetarea calitativă este subiectivă prin natura ei
  - Există tehnici de "obiectivizare" a cercetătorului
  - Descrie în detaliu cercetătorul (ce lucrează): perspectivă ideologică, culturală

# Criteria de validitate

- Metodele de colectare a datelor – descrise în detaliu
  - Sunt aceste metode cea mai bună cale de a examina întrebarea de cercetat?

# Criteria de validitate

- Analiza datelor, metode de control al calității
  - Transcrieri interviuri, discuții (focus grupuri)
  - Codificare
  - Metodă sistematică de analiză
  - Nu e suficientă prezentarea unor “citate interesante”
  - Analiza conținutului – stabilirea unor categorii codificate și împărțirea fragmentelor de transcripte în fiecare dintre aceste categorii
  - Controlul calității: datele (sau măcar un eșantion) verificate și de alt cercetător, pentru a vedea dacă le dă aceeași semnificație

# Criteria de validitate

- Rezultatele să fie credibile
  - Afirmațiile generale trebuie să se sprijine pe citate


# Criteria de validitate

- Concluziile să fie justificate de rezultate
  - Cantitativă: IMRAD
  - Calitativă: rezultatele sunt prin definiție interpretările datelor (nu prea există distincție între Rezultate și Discuții)
  - Concluziile să se bazeze pe date
    - Cât de bine explică analiza de ce indivizii se comportă astfel?
    - Ar fi de acord participanții cu aceste explicații?
    - Cât de mult concordă explicațiile cu ceea ce deja se știe?

# Criteria de validitate

- Rezultatele să fie transferabile și în alte locuri
  - Critica cea mai frecventă a cercetării calitative este că rezultatele se referă doar la o parte limitată din populație

# Being in a standstill-of-life: women's experience of being diagnosed with systemic lupus erythematosus: a hermeneutic-phenomenological study

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**Being in a standstill-of-life: women's experience of being diagnosed with systemic lupus erythematosus: a hermeneutic-phenomenological study**

Systemic lupus erythematosus (SLE) is a highly unpredictable and potentially lethal disease which ultimately challenges identity, future and the meaning of life. In a caring context, the experience of good health is perceived to be a balance between biomedical health and the existential experience of having a good life. This balance is jeopardised in the face of severe chronic illness and leads to extensive suffering if not handled carefully. Research suggests that patients suffering from severe chronic illness need support on an existential level, but also emphasises that, given its elusive nature, caring for the existential dimension is difficult to manage. This paper explores the experience of being diagnosed with SLE as an existential phenomenon. Through repeated phenomenological and

hermeneutic interviews with 15 women conducted from 2013 to 2015, data concerning the diagnostic phase of SLE were analysed using Van Manen's phenomenology of practice. The essence was found to be a standstill in life comprehended through three inter-related themes: standing in a swirl of events, standing on uneven ground and standing at a turning point with oneself and others. The paper elucidates how existential life phenomena are lived, during the course of being diagnosed. In conclusion, it provides an ethical awareness of how a standstill in life is lived and of the patients' existential transition during the diagnostic phase. A holistic approach is recommended in caring for patients with SLE.

**Keywords:** chronic illness, rheumatology, existence, long-term care, advanced nursing practice, lived experience.

*Submitted 30 April 2017, Accepted 3 May 2017*

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## **Method**

Data to this paper are drawn from a comprehensive study aiming to investigate women's existential experiences of living with SLE. The overall objective was to deepen evidence related to living with this chronic illness. In the initial analysis of data, the diagnosis phase emerged as an existentially critical point of life. Data concerning experiences around this phase were therefore extracted from the interviews and analysed separately.

### *Participants*

Interview participants were recruited from a university rheumatology department in Denmark. A unit manager provided the researchers with a list of persons with a confirmed SLE diagnosis.

Only women were included because the female incidence is considerably higher than the male incidence. Furthermore, clinical symptoms deviate compared to men in regard to disease severity and prognosis (26). Moreover, earlier research has indicated that women's experiencing of health and sickness is in some form differently perceived (27, 28). To capture diverse experiences, participants were purposefully recruited with regard to spread in age and disease duration (29). Eighteen women were contacted through an invitation letter stating study purpose and process. One woman declined by mail without reason. One woman wished to participate but expressed doubt due to emotional problems. After an informal conversation to clear out the matter, she decided not to participate. One woman did not show to the scheduled interview and did not respond to follow-up call and email. Thus, 15 women entered the study. Of these, one woman resigned after the first interview due to unresolved medical reasons, leaving 14 women for the following interviews (see Table 1 for socio-demographic data).

### *Data collection*

Data were collected with the purpose of getting rich and lived experiences. The women were interviewed three times from September 2013 to June 2015, making a total of 43 interviews (see Table 2). Interview location was at the discretion of the women. Most of them chose a familiar office in the hospital department. No family members participated in the interviews. Efforts were made to make the women feel comfortable by having an open approach.

The phenomenological approach, being open and giving time and space for the women to freely tell about their experiences, was valuable in exploring existential insights. Repeated interviews were chosen to provide the women with time to reflect on past and present experiences as well as future dreams while living with SLE (25).

Semi-structured interview guides were created for all three interviews to help the researcher stay focused on the study phenomenon. The guides were structured around the lived existentials and contained research and probing questions. The introductory question was: 'Please tell me how you feel living with SLE'. To ensure insight

and quality of data, probing questions such as 'Please tell me more' and 'Please elaborate how you felt (related to body, space, time and relational) in that situation' were used. The second interview took place 6 months later. The opening question was 'Tell about your experiences in relation to SLE since the last interview?' Following questions concerned new and changed insights related to living with SLE. The third interview was scheduled

## *Rigour*

To be rigorous, guidelines for evaluating phenomenological studies informed the process (25, 36). The researchers remained open towards the phenomenon of interest from the first salient thoughts all through collecting, analysing, disseminating the data and to the writing process. Staying open in a second person perspective was however challenging since our natural attitude (prejudgements) continuously evades the mind (36). We tried to incorporate an attitude in which 'seeing' the other's experience was gradually instilled into us in reading, discussing and writing processes. We were alternately dwelling in and distancing from data thus making the content subject to scrutiny through reflection and mutual discussion (37). The research team consisted of a Registered Nurse experienced in rheumatological care and a rheumatologist, both with extensive experience of SLE. Two other team members had years of experience in doing phenomenological studies. All authors kept these matters in mind throughout the study collection and analysis process, thus trying to hold their preunderstandings in abeyance.



### *Standing in a swirl of events*

Standing in a swirl of events refers to the women's experiences of uncharacteristic symptoms and numerous medical check-ups as well as rapid or insidious symptom progression. The swirl of events stretches from the pre-diagnostic phase of SLE and beyond the confirmed diagnosis to the initial and sometimes acute medical treatment. Standing in a swirl means to be placed in the middle of passing events and continuously trying to relate to and keep some distance from what is going on in order not to get swept away. In cases where the diagnostic phase is prolonged, the sense of standing alone is increased while new symptoms arise and others fade or recur. As the symptoms mysteriously become more serious and medical events increase in number, a feeling of uneasiness may develop, as formulated by one of the women:

Everything just happened around me. Every time I saw a new doctor I got a new diagnosis... I was admitted to God knows how many hospitals. Once I completely broke down . . . it was the feeling of fighting all the time to keep myself up. No matter how hard I fought, new things were just coming at me! I do understand the patients who can't get out of that turbulence. At some point the cup is bloody filled, and you can't handle it anymore. (Ashly. I1.p4, I2.p2)

## Sexuality in male partners of women with fibromyalgia syndrome: A qualitative study.

Romero-Alcalá P<sup>1</sup>, Hernández-Padilla JM<sup>2,3</sup>, Fernández-Sola C<sup>2,4</sup>, Coín-Pérez-Carrasco MDR<sup>5</sup>, Ramos-Rodríguez C<sup>6</sup>, Ruiz-Fernández MD<sup>2</sup>, Granero-Molina J<sup>2,4</sup>.

### Author information

### Abstract

The aim of our study was to understand how male partners of women diagnosed with fibromyalgia syndrome perceive sexuality. Gadamerian hermeneutic phenomenology and the Roy Adaptation Model provided the overall framework for this research study. Eighteen participants were recruited through convenience and purposive sampling. Data collection was conducted between February and July of 2017 and included a focus group and twelve in-depth interviews. Two main themes were extracted: "facing a new sex life" and "resisting the loss of the couple's sexuality". Fibromyalgia syndrome compromises the couple's sex life. Enhancing intimacy, skin-to-skin contact (during acute FMS outbreaks), finding new positions, non-coital sex and use of sex toys can increase female desire and help coping.

- [I am HIV-positive, but I am a human being: \*\*qualitative\*\* study on experiences of stigma in health care centres in the Islamic Republic of Iran.](#)

Abedinia N, Rasoolinajad M, Noorbala A, Badie BM.

East Mediterr Health J. 2019 Nov 4;25(10):669-676. doi: 10.26719/emhj.19.012.

PMID: 31774132

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98. Turriff A, Nolen R, D'Amanda C, Biesecker B, Cukras C, Sieving PA.

Am J Ophthalmol. 2019 Nov 22. pii: S0002-9394(19)30581-1. doi: 10.1016/j.ajo.2019.11.023. [Epub ahead of print]

PMID: 31765628

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## Barriers and Facilitators of Fruit and Vegetable Consumption in Renal Transplant Recipients, Family Members and Healthcare Professionals-A Focus Group Study.

Boslooper-Meulenbelt K<sup>1</sup>, Patijn O<sup>2</sup>, Battjes-Fries MCE<sup>3</sup>, Haisma H<sup>4</sup>, Pot GK<sup>5</sup>, Navis GJ<sup>6</sup>.

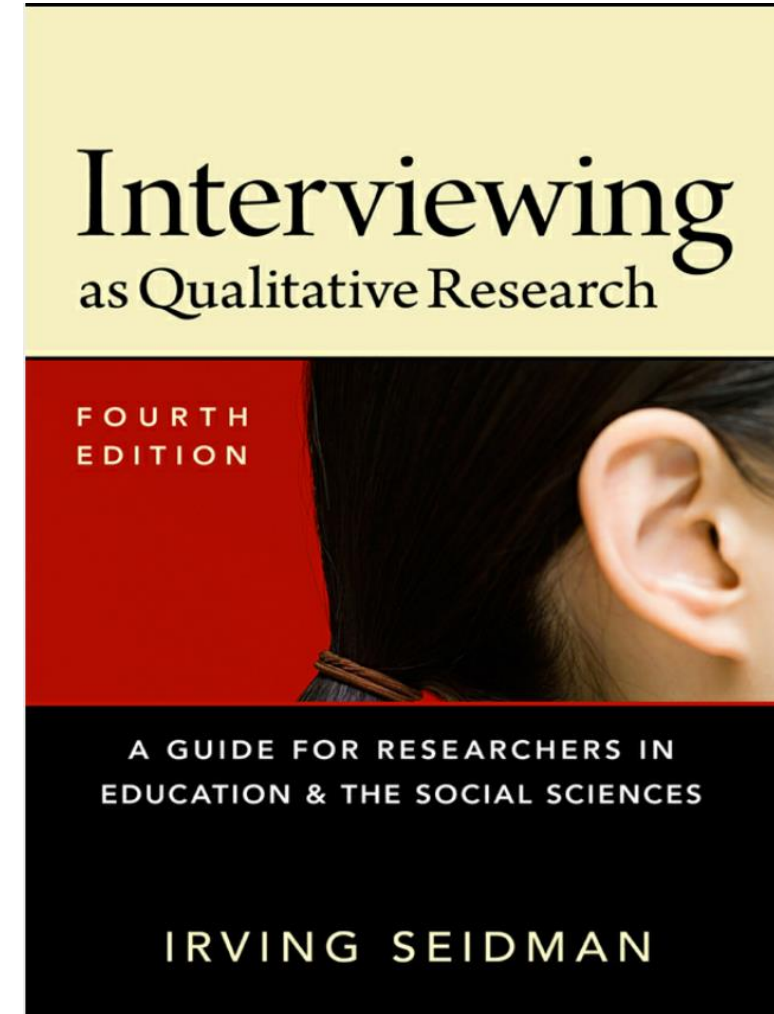
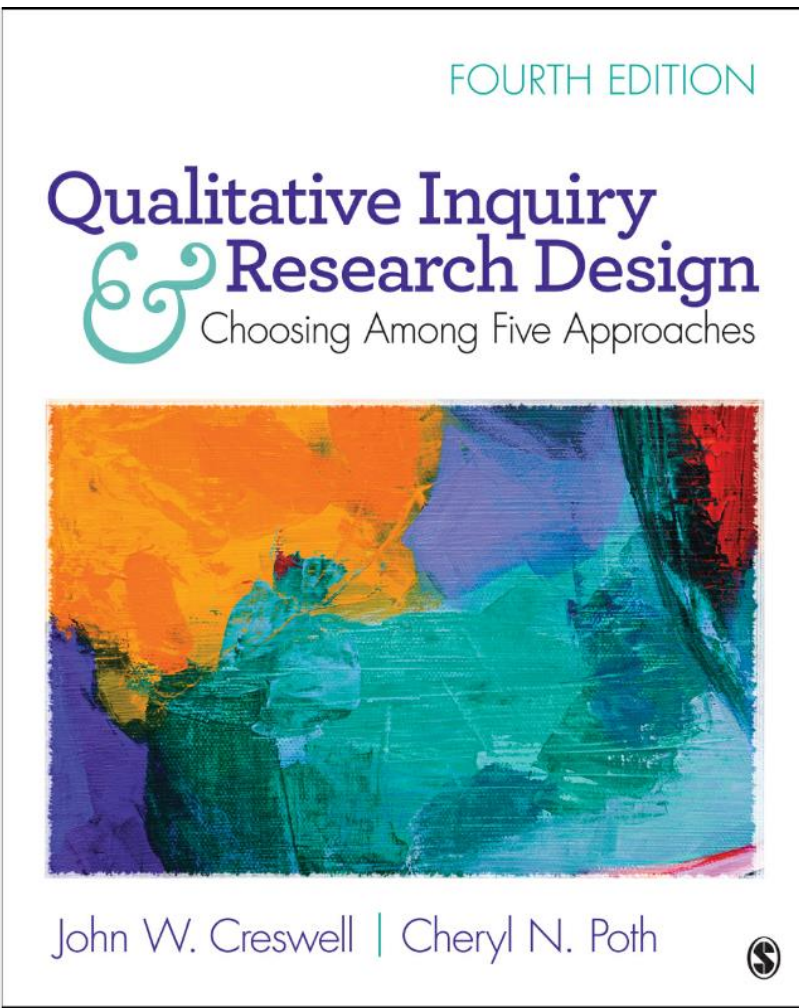
### + Author information

#### Abstract

Low fruit and vegetable consumption is associated with poor outcomes after renal transplantation. Insufficient fruit and vegetable consumption is reported in the majority of renal transplant recipients (RTR). The aim of this study was to identify barriers and facilitators of fruit and vegetable consumption after renal transplantation and explore if certain barriers and facilitators were transplant-related. After purposive sampling, RTR ( $n = 19$ ), their family members ( $n = 15$ ) and healthcare professionals ( $n = 5$ ) from a Dutch transplant center participated in seven focus group discussions (three each for RTR and family members, one with healthcare professionals). Transcripts were analyzed using social cognitive theory as conceptual framework and content analysis was used for identification of themes. Transplant-related barriers and facilitators were described separately. In categorizing barriers and facilitators, four transplant-related themes were identified: transition in diet (accompanied by, e.g., fear or difficulties with new routine), physical health (e.g., recovery of uremic symptoms), medication (e.g., cravings by prednisolone) and competing priorities after transplantation (e.g., social participation activities). Among the generic personal and environmental barriers and facilitators, food literacy and social support were most relevant. In conclusion, transplant-related and generic barriers and facilitators were identified for fruit and vegetable consumption in RTR. The barriers that accompany the dietary transition after renal transplantation may contribute to the generally poorer fruit and vegetable consumption of RTR. These findings can be used for the development of additional nutritional counseling strategies in renal transplant care.

**KEYWORDS:** barriers; focus groups; fruit consumption; nutrition; renal transplantation; vegetable consumption

**J Creswell, C Poth. Qualitative Inquiry and Research Design. Choosing Among Five Approaches. 4<sup>th</sup> Edition. SAGE publications 2018.**



**I Seidman. Interviewing as Qualitative Research. A Guide for Researchers in Education and the Social Sciences. 4<sup>th</sup> Edition. Teachers College Press 2013.**



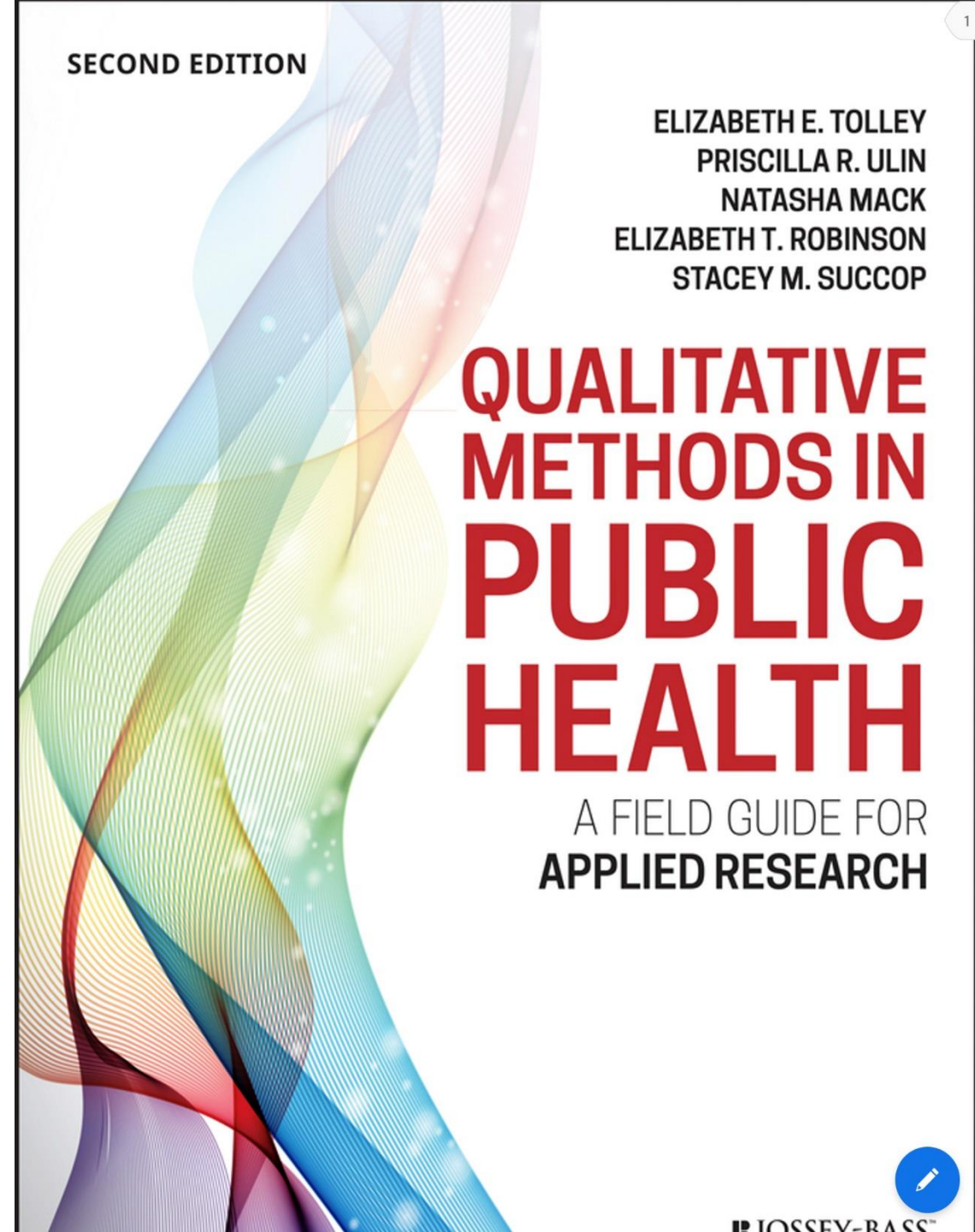


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# QUALITATIVE METHODS IN PUBLIC HEALTH

A FIELD GUIDE FOR  
 APPLIED RESEARCH



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To: Laura Elena Stoichituiu <[laura.elena.stoich@gmail.com](mailto:laura.elena.stoich@gmail.com)>

PONE-D-20-18668R1

COVID-19 pandemic preparedness period through healthcare workers' eyes: a qualitative study from a Romanian healthcare facility

PLOS ONE

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Thank you for submitting your manuscript to PLOS ONE. After careful consideration, we feel that it has merit but does not fully meet PLC

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Reviewer #2: This is a narrative or a commentary rather than a piece of scientific research. The authors have presented a series of responses to a standard set of interview questions in a journalistic format with no solid conclusion drawn. No information was provided about the number of eligible subjects and the response rate. Participants were voluntary and therefore selection bias is inevitable. With a sample size so tiny and such skewed demographics, it is impossible to draw any conclusions whatsoever.

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**Introduction** : Healthcare providers represent a limited resource, and their mental health is crucial for patient care and for ensuring containment of the pandemics. We aimed to explore how healthcare workers experienced the preparedness period of COVID-19 pandemic, in order to ascertain the perceived weaknesses and strengths.

**Methods** : Interviews were conducted with 17 participants encompassing senior physicians, residents, and nurses. They were audio-recorded, and the transcription was verbatim. We used thematic analysis.

**Results** : We identified four themes, with subsequent subthemes: shades of the unknown, human versus doctors, sense of helplessness, and a bridge to heaven, which explore how healthcare workers experienced the lack of knowledge, their feeling of losing control, and how they managed their internal fights. The disappointment provoked by the authorities and their colleagues was further evaluated. We identified factors involved in their well-being.

**Conclusions** : COVID-19 pandemic represented and will still pose a challenge for healthcare workers from all over the world. They felt unprepared for such a crisis. Further measures should be implemented in every hospital to maintain HCW awareness and to prevent physical imbalance. Appropriate standards of care should be further stated by the authorities so that the healthcare providers may find easier a balance between their safety and their patients' needs. Conducting qualitative research involving healthcare workers during pandemic times may help in informing more significant policy decisions.

Laura Elena Stoichitoiu, MD

Cristian Baicus



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## Hydroxychloroquine for prophylaxis of COVID-19 physicians survey: Despite lack of evidence, many would take or give to dear ones, and despite the perceived necessity of an RCT, few would participate

Cristian Baicus MD, PhD, Larisa Pinte MD, Laura E. Stoichituiu MD , Camelia Badea MD, PhD

First published: 21 September 2020 | <https://doi.org/10.1111/jep.13484>



## Methods

Between March 30 and April 02, 2020, a 16-item questionnaire was shared in a Romanian Facebook group of 2645 physicians dedicated to COVID-19 information, asking to be completed by physicians who could be directly involved in the care of these patients.

## Results

A total of 785 answers were collected. Nine physicians (1.1%) thought that there was clear evidence on prescribing hydroxychloroquine prophylaxis, 375 (48%) considered the evidence acceptable, 348 (44.3%) considered it weak, whereas 53 (6.8%) answered there was no evidence. 59 (7.5%) respondents were determined to take it (of which 31 = 4% already took), 192 (24.5%) were inclined to take, 271 (34.5%) were not decided yet. 175 (22.3%) of respondents declared they (would) give the treatment to their close ones, and this decision was associated with a higher age ( $P = 0.003$ ), and the opinion that there was evidence ( $P < 0.001$ ). When asked about the source of the treatment regimen, 286 (36.4%) indicated a scientific paper, while no scientific paper about the prophylaxis with hydroxychloroquine existed at that time.

718 (91.5%) considered a randomized clinical trial necessary (RCT), but only 333 (42.4%) answered they would enrol in such a trial. There was only a very weak correlation (Kendall's tau  $\tau_b = 0.255$ ,  $P < 0.001$ ) between the belief that an RCT is necessary and the willingness to enrol in such an RCT.



Of 785 respondents, 532 (67.8%) answered the open-ended question. We identified two major themes regarding the relation between physicians' need to promote medical research and their willingness to enrol actively in a trial considered useful: the balance between the "greater good" and personal risks, and the unavoidable harshness of dealing with the unknown. Their unwillingness to enrol in an RCT was justified by two different types of fears. For physicians who would take prophylaxis, the main driver was the fear of no treatment ("I would prefer to take prophylaxis if I would treat COVID patients; I can't afford the risk of taking placebo"). For people who would not take HCQ, the decisive factor was the fear of adverse reactions ("I think that for me, the adverse reactions of HCQ would be more serious than COVID-19"); besides, some considered that self-good is more important, advocating reasons like "out of commodity" and "I am not a lab rat". Physicians willing to enrol considered that evidence-based medicine and saving lives come first, stating "I am a physician. I am ready to contribute with whatever is needed in order to combat or to develop the prophylaxis against SARS-CoV-2". Physicians were torn apart between denial and hope, between their unwillingness to admit that HCQ has no proven positive effects and their forged hope, stating "I prefer to think that it has an effect, even a minimum one, than believing there is no treatment"; consequently, they decided not to enrol. Moreover, the perceived futility of breaking the unknown influenced their decision in a negative fashion, considering that if common sense indicates that a drug should not have a certain effect, it should not further be investigated "For the moment, because I do not understand the concept of prophylaxis with a drug which does not have an effect proven to be strictly antiviral".