

The Process of Conducting Qualitative Grounded Theory Research for a Doctoral Thesis: Experiences and Reflections

Sophie Soklaridis

University Health Network, Toronto, Ontario, Canada

In this article, the author offers her experiences as an example of the application of a grounded theory approach in qualitative research. She describes, in detail, her experiences of the process of collecting, analyzing, and storing data for her doctoral thesis. She focuses on the special challenges of employing a qualitative methodology to developing a conceptual framework. The substantive area in which the study took place was at a hospital-based occupational health clinic for professional artists. Various stakeholders involved in the clinic participated in in-depth individual interviews and focus groups to explore how the concept of integrative health care (IHC) is understood both in theory and in practice at the clinic. Key Words: Qualitative Research, Grounded Theory, Interviews, Focus Groups, and Research Process

Introduction

This article is based on my personal experiences of using a grounded theory (GT) approach as a qualitative research method for my doctoral thesis. My purpose is to present the reader with a detailed description of my experiences with data collection and analysis. This article outlines the thinking and working processes involved in generating theory from data collected from both individual interviews and focus groups. I believe that my own reflections of the process could produce an example of the importance of being flexible and adaptable when conducting qualitative research. My hope is that this example can help others who might be interested in conducting a qualitative GT study.

The sections below describe qualitative research and grounded theory, the process of interviewing and conducting focus groups, data analysis, data storage, and the development of a conceptual framework.

Qualitative Research and Grounded Theory

Many attempts have been made to define qualitative research, but as it has grown out of a wide range of intellectual traditions and disciplines, there is no consensus. However, basic tenets of qualitative research that are specific to this thesis can be identified as follows.

Qualitative research is grounded in a broadly interpretivist philosophical position, in the sense that it is concerned with how the social world is interpreted, understood, experienced, and produced. According to Creswell (1998), qualitative research is:

An inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The

researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting. (p. 99)

The emphasis is on deriving an understanding of how people perceive and construct their lives as meaningful processes, how people interact with one another and interpret those interactions in the context of the social world, and the importance of observation in “natural” settings (as opposed to the laboratory).

An inductive approach to conducting qualitative research was suitable for this exploratory and descriptive research thesis, as it seeks to establish an understanding between the research objectives and the summary findings derived from the interview and focus group data. Grounded theory (GT) is one of several interpretive approaches. According to Strauss and Corbin (1990) amassing and understanding of complex data is done in grounded theory studies:

. . . inductively, derived from the study of the phenomenon it represents. That is, discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore, data collection, analysis, and theory should stand in reciprocal relationship with each other. One does not begin with a theory, then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge. (p. 16)

This reciprocal relationship requires a suspension of knowledge and judgment, which is essential when conducting a GT study. I approached my doctoral thesis with an openness and interest in learning about the various perceptions of integrative health care (IHC) from the participants’ perspective. I was involved with a previous project that explored occupational stress and professional artists (article in press). When that project came to an end, and the possibility of conducting research for the clinic that could be used towards my PhD dissertation presented itself, I felt privileged and excited to begin. Research in artists’ health in general, and for this unique artists’ clinic, in particular, was important to me because it presented an opportunity to contribute to the arts through research. For this research project, I wanted to highlight the various factors involved in creating and sustaining an IHC clinic for professional artists in a publicly funded health care system.

The Setting

The study took place at an occupational health-care clinic for professional working artists located within a tertiary hospital in a large downtown hospital in Canada. A unique clinic, it offers both biomedical and complementary and alternative medicine (CAM) approaches of health care to patients/clients in a hospital setting. The enquiry began by exploring how biomedical and CAM practitioners, artists, hospital administrators, and the clinic’s board members interacted, communicated, and collaborated with one another for integrative patient/client care. Individual stakeholders’ knowledge and attitudes toward IHC were explored, to understand how these affected the

everyday interactions among stakeholders. The study also examined the organizational structures of the hospital and the Artists' Foundation. A GT approach was used to explore the experiences and interactions among the various respondents regarding the level of integration at the clinic. This type of approach provided a means to fully describe and explain the various interactions, perceived level of integration, and collaboration that occurred at the clinic from the respondents' perspectives.

Methods

Rationale for Qualitative Inquiry

To inductively gain an understanding of the phenomenon studied, it is necessary to use methods of data generation that are both flexible and sensitive to the social context in which data are produced (Berg, 1995). As such, the central methods of qualitative research include interviewing people, recording what they say, observing people in the course of their daily routines, and recording their behaviours. In this study, qualitative research methods were used, particularly in-depth interviews and semi-structured focus groups, to facilitate the gathering of information about IHC at the clinic. Through these methods, it was possible to gain an understanding of how the stakeholders at the clinic interact with each other, how they interpret those interactions, and how these meanings are informed by the wider socio-political context in which IHC takes place (e.g., the hospital setting, the Artists' Foundation).

In-Depth Qualitative Interview

According to Patton (2002), a qualitative interview should be open-ended, neutral, sensitive, and clear to the interviewee. In-depth qualitative interviews are generally flexible and exploratory in nature. For example, the researcher adjusts later questions depending on how the interviewee answers earlier questions, to clarify the responses, to follow promising new lines of enquiry, or to probe for more detail. The interview style is unstructured and conversational, and the questions asked are generally open-ended and designed to elicit detailed, concrete stories about the subject's experiences (Whyte, 1982). The purpose of such interviews is not to identify objective truth or to conclusively test hypotheses but to help the researcher understand the experiences of the respondents and the conclusions the respondents themselves have drawn from them. For my thesis, in-depth interviews were used to understand the social and physical setting of the clinic, including internalized notions of norms, traditions, roles, and values that are held by the respondents at this occupational health clinic.

The primary advantages of qualitative interviews are the flexibility they offer and the rich, detailed data they can provide. However, these advantages, as is true for all social science methods, are not gained without cost. There are two main disadvantages associated with qualitative interviewing (Fontana & Frey, 1994). First, due to the large amount of time and effort they involve, qualitative interviewers cannot usually study a very large sample of people and thus cannot be generalized to other similar populations. However, the interpretivist approach in qualitative research does not make any claims of

“truth” or generalizability. Making a claim that the findings of such a study can be generalized is not appropriate to – nor a desired outcome of – qualitative research. This study does not claim to be generalizable to other occupational health clinics that provide IHC. Second, since the interviewer in a qualitative interview takes a very active role in determining what data are collected, there is a higher probability that he or she may inadvertently bias the results of the study (Fontana & Frey). Following the interpretivist approach, the notion of the researcher being separate from the subject of research is neither desirable nor possible. As a qualitative researcher I understand that no matter how faithfully a researcher adheres to scientific methods (qualitative or quantitative), research outcomes are neither totally objective nor unquestionably certain.

Focus Groups

Focus groups, composed of relatively homogenous groups of people, are a form of in-depth group interview, which provides information on topics specified by researchers (Hughes & DuMont, 1993). The groups are fairly homogenous with respect to one or more characteristics of interest to the researcher. While focus groups were originally used mainly in marketing research as a preliminary step preceding quantitative research, their use has expanded into the social sciences. They may be used as a self-contained method, serving as the principle source of data, or (as in this case) as part of a multi-method approach, in combination with other qualitative methods such as the individual interview (Fontana & Frey, 1994).

Reliance is on interaction within the group (Morgan, 1997). The main advantage of a focus group is the opportunity to observe the group interact on a particular topic (Morse & Field, 1995). Similarities and differences in respondents’ opinions and experiences are provided directly through group discussion rather than inferred from statements by individual interviewees. Focus groups may also be useful when the researcher wants to give the group control over the direction of the session, as is the case with exploratory work.

In comparison to quantitative methods (such as surveys designed by the researcher), focus groups provide researchers with direct access to the language and concepts respondents use to structure their experiences and to think and talk about a designated topic (Kitzinger, 1995). Thus, focus groups move beyond the level of the individual and examine cultural knowledge that is shared among group members. I anticipated that the use of focus groups would allow a collective sense of community shared by group respondents to emerge from their discussions. For these reasons, focus groups were particularly well suited to study interaction, collaboration, and integration at the clinic.

Recruitment

The study involved two types of purposeful sampling methods; snowball and convenience sampling (Patton, 1987). The rationale for purposeful sampling was to select information-rich cases whose study would illuminate the research questions being examined (Morse & Field, 1995).

Recruitment for Individual Interviews

Between June and December, 2006, ten individual in-depth interviews were conducted with each of the health-care practitioners at the clinic. The average length of the interview was 60 minutes and each ranged from 45 minutes to 90 minutes in length. There was representation from the following eight health professions: chiropractic, massage therapy, medicine, naturopathy, nursing, osteopathy, physiotherapy, and psychotherapy. Health-care practitioners were contacted either by telephone, in person, or via e-mail to determine if they were interested in participating in an individual, in-depth interview as part of my thesis research. All of the health-care practitioners participated in the individual interviews, while only five practitioners participated in the focus group (see below). It was important to conduct both individual interviews and a focus group with this group, in particular, to further explore any issues that respondents may have been reluctant to share publicly in a focus group.

Recruitment for Focus Groups

Between June, 2006, and February, 2007, I conducted four semi-structured, qualitative focus groups with artists/clients of the clinic, hospital administrators, board members, and health-care practitioners working at the clinic. The average length of the focus group was two hours.

Respondents were selected based on one of two characteristics: (a) they were judged to be a key or critical representative of that category by my doctoral thesis committee members (JDC, MJK), and/or (b) if they were known to one of the team members, and recruited given their interest and their ability to provide valuable information (convenience sampling).

Artists (n=8)

Convenience sampling was used to recruit the artists. Artists who sought care at the clinic had an opportunity to see a recruitment brochure that was handed out by reception and also posted on the message board and in the waiting room at the clinic.

Hospital Administrators (n=5)

The hospital administrators and board members (see below) were recruited using the method of 'snowball sampling' (Grbich, 1999). Hospital administrators, those who were actively involved in assisting the operation of the clinic, were identified with the assistance of my thesis committee members and with the Foundation. A key informant list was identified with the clinic's supporting foundation and the health-care practitioners. These informants were contacted and when the purpose of the study was explained to them, they were asked to name individuals that would be important to include in the study. Participants from the snowball sampling method were invited to the focus group based on their availability and the frequency that their name was cited. Each hospital administrator was contacted over the telephone to explain the purpose of the

research, ask for their interest in being part of a focus group, and answer any of their questions.

Board Members from the Artists' Foundation (n=8)

A key informant list was generated in consultation with the Artists' Foundation, as well as the health-care practitioners at the clinic. I contacted these informants to explain the purpose of the research, recruit for the focus group, and answer any questions.

AHC Health-Care Practitioners (n=5)

Upon completion of the individual interviews, each of the health-care practitioners was contacted either by phone or secure e-mail to explain the purpose of conducting focus groups, recruit for the focus group, and/or answer any questions.

Data Collection

Preparing to Interview

Initially, it was planned that the focus group would be conducted before the in-depth interviews, as I believed that it would stimulate the respondents' thinking by hearing one another's opinions regarding the topic. Then there would be a follow-up with individual interviews to further explore any issues that respondents may have been reluctant to share publicly in a focus group. I had conducted research with this group a year before, for another project, and believed that their previous experience would serve as an enabler in recruiting for this project. However, during the recruitment phase, it was difficult to find a common time for the health-care practitioners to attend a focus group. After several months of failed attempts to recruit enough health-care practitioners for the focus group, I decided to begin individual in-depth interviews so as to complete data collection within a reasonable time.

Proceeding in this way had two key advantages. First, I was able to obtain information including minority or "silent majority" viewpoints regarding integration and collaboration among the health-care practitioners at the clinic – viewpoints that might not initially have been shared in a group format. Such issues were subsequently brought forward in the focus group for discussion. Second, by conducting the individual interviews first, rapport/trust with individual health-care practitioners was established, which facilitated their willingness to become further involved in my research by attending a focus group.

The Interview Process

Most interviewees are willing to provide the kind of information the researcher wants, but they need to be given clear guidance about the amount of detail required. The in-depth interviews were purposefully semi-structured, since the intent of the interviews was to explore issues of interaction, collaboration, and the level of integration at the clinic from each of the health-care practitioners' perspectives. A list of important

questions was prepared and referred to during the actual interview as they became relevant.

According to Patton (as cited in Whyte, 1982), it is usually best to start with questions that the interviewee can answer easily, and then proceed to more difficult or sensitive topics. The interview was organized into three stages. In the first stage, the purpose was to establish an understanding of the interviewees' background, asking questions about them, their health profession, and a brief history of how they came to be health-care practitioners at the clinic. In the second stage, the focus shifted to the details of their present experience at the clinic. For example, they were asked to "reconstruct a typical day" or "talk about their relationships with the people they work with." In the third stage, having reflected on their background and experience, respondents were asked to reflect on the meaning of their experience. Typical questions were: "What have you concluded from all this?" and "In your experience, is IHC happening at the clinic?"

While this was a basic outline for the interviews, it was not always possible to keep to this structure. For example, one of the health-care practitioners quickly started the interview with their thoughts on integrating CAM at the clinic. Following an iterative approach, the questions would be adjusted depending on what the interviewee discussed.

At the end of each interview each respondent was asked if there were any issues they deemed important that had not been discussed, or if there were anything that they would like to know more about (from the health administrators at the hospital and/or the board members).

Preparing for the Focus Group

Four different guides were constructed for each of the focus group sessions. Each guide included the background and context of the respondents, including specific, detailed information vis-à-vis their relationships and roles as client, health-care practitioner, administrator, and board member. Understanding that the various respondents may have very different perspectives and agendas, even amongst themselves, whenever possible, I posed questions that asked them to share their story or experience with the group as opposed to collecting opinions

There was a seven-week gap between the last health-care practitioner individual interview and the health-care practitioners' focus group, which may have allowed each practitioner time to reflect upon the interview. In fact, several of the practitioners contacted me after their interview to provide me with additional thoughts that emerged as a result of the interview. Logistically, the gap allowed time for transcription of the individual interviews, so that issues that had been raised in the interviews (along with any follow-up considerations sent to me) were addressed in the focus group. This process, referred to as "multiple depth conversations," describes the continuous clarification of emergent meanings (Seale, Gobo, Gubrium, & Silverman, 2004). The seven-week gap between interview and focus group was also a result of several failed attempts to coordinate the schedules of busy and mostly part-time health-care practitioners. In the end, five of the ten health-care practitioners attended the focus group.

The Focus Group Process

My role in each of the focus groups was to moderate or facilitate the discussion as an interested respondent. This study was exploratory and I was particularly interested in finding out what respondents believed to be important or interesting. I also wanted to observe how the health-care practitioners would interact when placed in a situation that required the construction of a collective identity. Hence, my involvement was minimal in the sense that I allowed information to emerge naturally.

I introduced myself and briefly explained my role in this process. I made clear that I was there to learn from them and their experiences, and assured them that the information they shared in the focus group would be anonymous. I asked everyone in the group to refrain from discussing any particular stories that had been shared during the focus group with others – “what is said in the focus group stays in the focus group.” In so doing, I hoped to create an environment where respondents felt comfortable enough to explore the similarities and differences of the various perspectives of integrative health care at the clinic as honestly and openly as possible. Speaking with various informants emphasizes the relativist tenet that no one experience is the norm; multiple voices are sought (Charmaz, 2000). Respondents were reminded that the session would be tape-recorded and transcribed verbatim. The consent form was reviewed prior to commencing with the group.

A list of important topical questions was prepared ahead of time and referred to during the focus group. Each focus group began with one of the topical questions and then we worked through each succeeding topic. Generally there was equal participation among the respondents in the groups.

As with the individual interviews, at the end of each focus group respondents were asked if there was anything that they wished to add.

Ethical Considerations

Prior to every interview and focus group, each respondent was asked to read and sign a consent form. Interviews and focus groups were tape-recorded and transcribed verbatim. I assigned each participant with a number in place of his or her name and removed any information that would identify individual respondents. Codenames for the focus groups and individual interviews were as follows:

Respondent Type	Method of Data Collection	Codename	Number of Participants
Complementary/Alternative Medical health-care Practitioner Biomedical health-care Practitioner	Focus Group	FG CAM HP # FG BIO HP #	5
Artists	Focus Group	Artists #	5
Artists Health Centre Foundation members	Focus Group	AHCF #	8
Hospital Administrators	Focus Group	HA #	5
Complementary/Alternative	Individual	CAM_HP #	10

health-care practitioner Biomedical health-care practitioner	Interview	BIO_HP #	
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All respondents were informed that they had the right to withdraw from the process at any time without penalty.

As a matter of course, each interview and focus group began by letting respondents know that they were not expected to self-disclose beyond their comfort level. The goal was to provide the respondents in the study a safe space within which to discuss their experiences of interaction, collaboration, and integration. The term safe space refers to my attempt to make the respondents in the study feel as comfortable with me (and with the process) as possible.

The University of Toronto granted ethics approval for this study on May 25, 2006, and the University Health Network granted ethics approval on July 25, 2006.

Data Analysis

To engage in qualitative research, one must be willing to spend much time in the field to generate data, followed by the ambitious task of categorizing the large amount of data into themes (Mason, 2002). The aim of a qualitative researcher is to explore a problem and/or describe a setting, a process, a social group, or a pattern of interaction (Marshall & Rossman, 1995). By producing a detailed, in-depth description of a setting, the research will reveal the complexity of the social interactions of everyday life. Even so, as a researcher who aims to produce this description and to share what I have learned, the question remains: why should anyone believe what I say or write? Or, how is validity assured?

According to Rubin and Rubin (1995), qualitative researchers judge the credibility of their research by how the research demonstrates transparency, consistency-coherence, and communicability. Additionally, researchers (Rubin & Rubin) often rely on the process of triangulation of the data to guard against the concern that a study's findings might simply be an artifact of a single method, single source, or single investigator's biases.

With respect to transparency, the reader of a credible qualitative research report is able to see the basic processes of generating data. Transparency allows the reader to assess the intellectual strengths and weaknesses of the interviewer. The interviewer must maintain careful records of what she or he did, saw, and felt to make their research transparent to others and to themselves (Heaton, 2004). Notes (including observations, conversations, maps, plans, reflections, and memos) are in many ways the data on which a substantial part of the analysis and interpretation of the study are based (Kirby & McKenna, 1989).

To ensure that the work in this thesis was transparent, three steps were taken:

1. *Literature review.* A detailed literature review was provided on the topic of integrative health care and specifically how that relates to an occupational health clinic in a hospital setting. This was meant

to assist interested individuals to judge the extent to which the study was applicable to other situations.

2. *Field notes.* During and after each interview and focus group, detailed field notes were taken of any non-verbal communication that had occurred.
3. *Memo writing.* All interpretations were recorded in content memos attached directly to the sections of the text that I was interpreting. That way the context was not lost during data analysis.

The individual interview and focus group transcripts, field notes and memo writing were all coded and constitute data for this research study.

With respect to consistency, a credible research report should show that the researcher investigated ideas and responses that appear to be inconsistent. In fact, one of the goals of qualitative research is not to eliminate inconsistencies, but to understand why they occur (Ritchie & Lewis, 2003). In demonstrating consistency, the researcher need not show that people’s beliefs are fully coherent or that the interviewees told some idealized version of the truth. The researcher must show that inconsistencies were examined and explored carefully. This is accomplished through the process of inductive coding. According to Strauss and Corbin (1990), coding “represents the operations by which data are broken down, conceptualized, and put back together in new ways. It is the central process by which theories are built from data” (p. 16). Once codes are developed, they are grouped at a higher, more abstract level termed categorization. Categories are generated through the same analytical process of making comparisons to highlight similarities and differences that is used for coding. Categories provide the means by which theory can be integrated (Strauss & Corbin).

Table 1

The Coding Process in Inductive Analysis

Initial read through text data	Identify specific segments of information	Label the segments of information to create categories	Reduce overlap and redundancy among the categories	Create a model incorporating most important categories
300 pages of text	Many segments of text	30 to 40 categories	15 to 20 categories	3 categories

Framework adapted from Creswell, 1998

The use of peer debriefing with my doctoral thesis supervisor and a committee member (RL and MJK) ensured that the data analysis in this thesis was consistent. A coding process was developed and followed with my supervisor and a committee member (RL and MJK). To begin coding, as transcripts became available they were read two or three times, with the following questions in mind: Are there similarities/differences between transcripts? Are there similar ideas that cut across each of the transcripts? When are the ideas similar/different? What were the initial impressions and how have they been substantiated and unsubstantiated? Is there a central idea (i.e., on integrated health care) with a series of subplots or is it more like a series of ideas and thoughts described by the respondents? Answers to these questions (which eventually led to more detailed questions) were highlighted in the margins of the transcripts.

A sub sample of transcripts (n=2) was read by RL and MJK. Each individually developed a preliminary coding frame for the sub-sample of transcripts and then came together to share interpretation of those transcripts. This strategy of ensuring trustworthiness of the data is also referred to as “investigator triangulation” (Schwandt, 1997), in which findings from different evaluators are compared and contrasted to eventually arrive at the same or similar conclusions regarding the coding of data. Similarities and differences of the data were discussed, thus producing a coding frame to be applied to all the data. This coding frame was used for the transcripts, and as new codes emerged, it was modified and the transcripts were re-read according to the new structure. Thus was a more nuanced picture of the material generated, as opposed to unwittingly imposing consensus on the data by stating “this is how it is or appears” in too simplistic or univocal terms. This process took approximately eight months of analysis and comparative work before I was able to conceptualize the findings as required by the rigour of grounded theory.

With respect to communicability, in credible research, the concrete detail of the context should resonate to the respondents and to the readers of the research report. To do so, in-depth interviews and focus groups were used, to allow for “prolonged engagement” (Lincoln & Guba, 2000) with respondents. By interviewing the same person more than once and/or interviewing respondents for an extended period of time, ideas, and themes of how they interpreted their context began to emerge more fully. To ensure communicability of this thesis, each focus group lasted from 90 to 120 minutes and the individual interviews lasted from 60 to 90 minutes. Health-care practitioners were repeatedly interviewed, first individually and then in a focus group format. Additionally, I conducted as many focus groups and individual interviews as I could, with the number of people willing and able to participate.

The final process of ensuring trustworthiness of the data was the triangulation of qualitative data sources (Schwandt, 1997). This meant comparing and cross-checking the consistency of information derived at different times and by different means within qualitative methods. It entailed one or more of the following: (a) comparing observational data with interview data, (b) comparing what people said in public with what they said in private, (c) checking for the consistency of what people said about the same thing over time, and (d) comparing the perspectives of people from different points of view. At the clinic, this meant triangulating health-care practitioner views, artist/client views, hospital administrator views, and views expressed by board members. The use of triangulation is

consistent with the grounded theory approach, which advocates the use of multiple data sources converging on the same phenomenon.

Triangulation of data sources within qualitative methods will seldom lead to a single, totally consistent picture (Pope, Ziebland, & Mays, 2000). According to Glaser and Strauss (1967), “no one kind of data on a category nor technique for data collection is necessarily appropriate. Different kinds of data give the analyst different views of vantage points from which to understand a category and to develop its properties” (p. 5). The point is to study and understand when and why there are differences. The fact that focus group data produce different results than those of the individual in-depth interview data does not mean that either or both kinds of data are untrue (although that may be the case). More likely, it means that different kinds of data have captured different things. In this thesis, every attempt was made to understand the reasons for the differences. At the same time, consistency in overall patterns of data from different sources, and reasonable explanations for differences in data from divergent sources, contribute significantly to the overall credibility of findings (LeCompte, 2000). As described throughout this article, various methods of triangulation were incorporated to ensure the trustworthiness of the data collected and analyzed.

Storing and Organizing Qualitative Data

A qualitative computer software package, NVivo (QSR International, 2002), was used to store and organize the various themes derived from the data. The software proved very useful, as each theme or topic was stored and then organized into larger categories as the research proceeded. (NVivo can also be used for searches and re-coding to help test various relationships in the data.) At a more specific level, using NVivo helped in the analysis and report writing in its capacity to store useful words, phrases, and dialogues that allow the researcher to visualize the data and move (or combine) information from one category to another category (as constructed by the researcher).

As the interviews progressed and more transcripts become available, I used NVivo as a tool in the interpretation and management of complex data, emerging ideas, patterns, and meanings. That said, the thinking judging, deciding, and interpreting were still performed by the researcher. As Tesch (1991) explains, “The computer does not make conceptual decisions, such as which words or themes are important to focus on, or which analytical step to take next. These analytical tasks are still left entirely to the researcher” (p. 77).

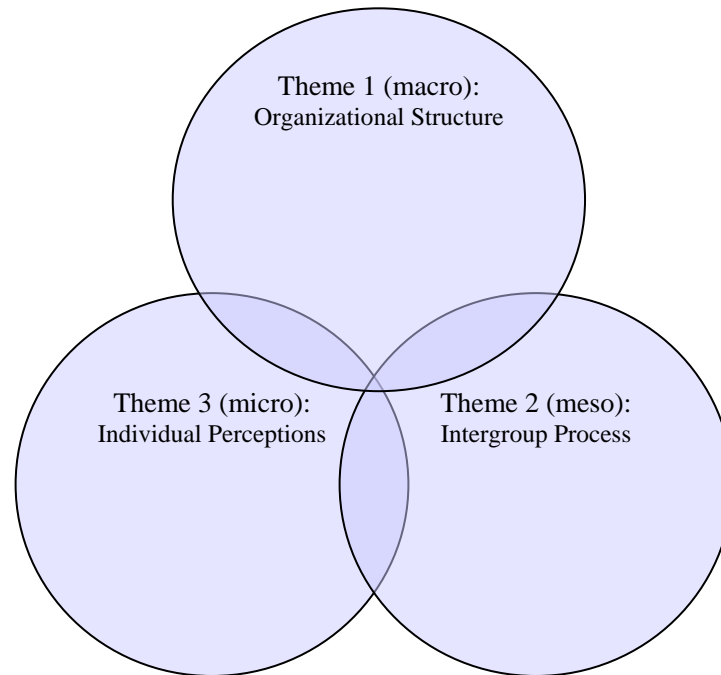
Results

Although the purpose of this article is to outline the research process and not to theorize the findings, I provide a brief discussion of the conceptual framework developed in this study as it related to the process of coding during data analysis.

The following describes the results of the focus groups with the artists, health care practitioners, hospital administrators, and board members; and also the individual interviews with each of the ten health-care practitioners at the clinic. Selective coding is the final phase in the grounded theory analytical process. During selective coding I developed the “story” and interpret the emerging theory. From the data, three themes

emerged: (a) the organizational structure and the effects of the hospital setting on the artists' clinic (macro level), (b) communication and day-to-day interactions between health-care practitioners, hospital administrators, board members and artists (meso level), and (c) personal/professional attitudes and knowledge of IHC (micro level). Figure 1 presents the conceptual framework that emerged from the data analysis process. It describes the interrelationship among the three different levels, macro-meso-micro.

Figure 1. Factors that affect integrative health care at the clinic



The framework is portrayed as a group of overlapping circles that operate at three levels. Theme 1 focuses on the effect of the organizational setting of the hospital and the Artists' Foundation; Theme 2 explores communication among the various stakeholders at the clinic; Theme 3 describes the knowledge of and attitudes towards IHC at the clinic. Together, the themes influence how the concept of IHC is practiced at the clinic. This framework is not offered as an unchanging depiction of reality, but rather as devices for organizing the central themes of this research. This framework organized the wide array of interrelated factors operating at the micro, meso, and macro levels that will be useful in advancing the theorization of this area of research.

Conclusion

This article provided an overview of how qualitative research, in general, and a GT approach, in particular, was used to inform this doctoral research. I have described the process and highlighted some of the challenges to collecting data using interviews and focus groups. To analyze qualitative data, several steps were taken to ensure the

trustworthiness of the data. The process of data analysis allowed for the concept of IHC, as understood by the respondents of this study, to emerge. By analyzing their perspectives, a clearer view develops of how IHC at the clinic is socially constructed and organized.

Conceptually and practically, as I reflect upon the process, I am most grateful for two things. Firstly, the research methods used for this study parallel the clinic's development. The artists' clinic began as a grassroots movement. In other words, it was driven by the artists in a community. These artists came together and gave their time, energy, and support to create and develop a vision of a health clinic for professional artists. Their vision was then presented to the hospital and through several years of negotiations, finally came to fruition. I feel that by taking a GT approach to this study, I was able to continue to use a "grassroots" perspective to support the clinic. A grounded theory approach requires developing a theory that is built from the data collected from the "ground up". The data itself was generated from respondents who were all important to the sustainability of the artists' clinic. This approach provided a method of hearing both the individual and the collective voices of the participants. From these voices I was able to create a storyline that describes and explains, from their unique perspectives, IHC at the clinic.

Secondly, following in the footsteps of the artists before me, this story was presented to the hospital, Artists' foundation board, and health-care practitioners. Although the majority of the decision-makers at both the hospital and board level read my thesis upon its completion, I also provided a summary document that detailed the issues and solutions to those issues as described by the study participants. The hospital was always supportive of the artists' clinic, but what this work has done is highlight the importance of sustaining the clinic. The hospital will be providing more financial and organizational support for the clinic and is taking the necessary steps to provide these resources.

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Author Note

Dr. Sophie Soklaridis is a sociologist specializing in qualitative research methods. She received her undergraduate degree and master's degree in Sociology, with a concentration in Women's Studies from the University of Ottawa. Her doctoral degree was earned in Public Health Science, with collaboration in Women's Studies from the University of Toronto. Her research interests focus on understanding the factors that

influence the process of returning to work and recovery for injured workers. She has a particular interest in artists' health and musculoskeletal occupational injuries.

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