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COMMENTARY

Ethical manoeuvring of grounded theory for public health: how grounded can we be?

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Abstract

The ethical imperative of public health as a discipline is being increasingly envisioned to advance the ideas of social justice, human rights, and equity. Research is a powerful tool to meet this end as it brings to the fore the socio-economic and political structures that produce and reproduce health inequity. One of the most widely used research designs to explain health inequity in public health is grounded theory. However, the prevailing understanding of this design demands that the researcher remains largely "uninformed" of the context to maintain its "inductive" nature. This persists despite an alternative approach proposed and practised by Charmaz and others. We argue that given the critical and constructivist nature of this alternative approach, which situates the phenomenon under enquiry in its socio-political context, with the researcher playing a significant part in the process, it is more aligned to the ethical orientation of public health as a discipline.

Keywords: *grounded theory, public health, constructivism, critical social research, inductive*

Ethics underlying the field of public health

Public health, as a discipline, goes beyond the biomedical model of health to integrate "the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health." [1]. According to DE Beauchamp, the leading political scientist of the 20th century, one of the most critical implications of public health is the responsibility of "organized collective action which is shared equally by all, except where unequal burdens result in increased protection of everyone's health and especially potential victims of death and disability" [2]. This is why public health primarily interrogates the existence of "unjust and unfair" differences in health determinants and outcomes according to intersecting social loci.

Consequently, a significant body of public health research over the past three decades has relied extensively on the justice and equity lens, which has revealed the powerful role of socio-economic and political structures in producing and reproducing health inequities [3]. While these studies may not have explicitly stated their underlying philosophical positions, the very idea of examining health inequity reflects their ontology as one that conceptualises health through the lens of privilege or oppression based on caste, race, sexuality, gender, class, ethnicity, and various other determinants. Such conceptualisation, in turn, demands an epistemological position that could go beyond establishing a grand theory, and reflect a view that knowledge develops through critique and is constrained by history and structure. It examines how social systems work, and how ideology or history conceals the processes that oppress and control people [4]. For instance, an in-depth enquiry into gender-based violence (GBV) reveals that while poor education, joblessness, financial constraints, alcoholism, and substance abuse could be considered as some of the immediate proximal determinants, the issue is deeply rooted in patriarchal structures.

The philosophical positions guiding any research — ontological, epistemological, and axiological assumptions — drive research questions, research design, and the methods one wants to employ. This further reflects the positionality, which locates the assumptions regarding a phenomenon under inquiry within the researcher's situatedness and establishes the relationship of the research process and the researcher, to the social, political, economic, and discursive context [5]. While some aspects of positionality, such as gender, race and caste are culturally ascribed and fixed, others, such as political ideology, personal histories and experiences are more fluid and subject to change [6].

For instance, depending on the philosophical positions one could explore GBV in several ways. We could use a critical realism lens and a post-positivist epistemological position to determine the factors associated with it, using a questionnaire-based cross-sectional study. Conversely, we could situate GBV in deep-seated patriarchal norms and subsequently explain it through critical social research such as a feminist epistemology, using qualitative research methods. Regardless of the lens, absolute fidelity of the methodology to the underlying philosophical positions of the research is an ethical imperative.

Grounded theory (GT) has been a widely employed qualitative research approach to explain how and why social structure and processes produce health inequities. In this approach, researchers develop theories to explain social phenomena, based on empirical data [7-10]. GT is largely employed in two forms — the classical, originally developed by Glaser and Strauss; and the constructivist, principally advocated by Kathy Charmaz. In this commentary, using the example of these two forms of GT, we examine how methodology can be manoeuvred as an instrument to

translate philosophical positions to uphold the integrity of public health research.

Grounded theory in public health research

A research study conducted in Lisbon aimed to assess primary maternal-child healthcare needs of women, embedded in the context of migration-driven diversity and socio-economic vulnerability. The findings demonstrated that the current context of crisis and challenges at the healthcare system level (unequal access to family doctors, excessive waiting lists, and increases in the direct costs of healthcare) primarily determined their needs [9]. Another study from Brazil highlighted the relevance of downward social comparison, territorial segregation, stigmatisation, and the erosion of social capital in the construction of social identities. These identities and resultant hierarchies in turn created shame, stress, pride, and empowerment, with critical implications for the health and health distribution of the population [10]. Both these studies clearly exemplify the usefulness of the grounded theory approach to delineating the pathways leading to health inequities.

Classical grounded theory, developed in 1967, aimed to develop a theory explaining the how and why of any phenomenon, through research that is entirely grounded in systematically gathered and analysed empirical data, without any preconceived assumptions about it [11]. Interestingly, this version of GT is deeply set in realism/objectivism. That is, it assumes an external reality that is independent of the observer, closely aligning with the strong positivist foundation of one of its original proponents, Glaser [12]. The other proponent, Strauss, brought the traditions of pragmatism and field work to GT, which inspires the study processes in natural settings [11]. Employing a "systematic" process of enquiry and analytic procedures, analogous to quantitative research, that allowed for verification and rigor, their version of GT had a clear positivist predisposition [12]. This was not surprising given the fact that during this period, social sciences prioritised quantitative research, which was considered rigorous, while qualitative research was deemed anecdotal and unfit for scientific exploration [12].

Charmaz argues that the objectivity rooted in classical grounded theory provided a template for many researchers to pursue qualitative research with a positivist epistemology [12]. In classical GT, the researcher is expected to be an unbiased, neutral observer of the social phenomenon under study, and is expected to suspend all assumptions and notions about it before entering the research arena. Additionally, they are also expected not to have a critical view of the phenomenon under enquiry, regarding justice or fairness. This clinical detachment is considered a basic prerequisite for a researcher employing classical GT [11]. In a sense, this design mandates the researcher to simultaneously hide herself as well as be desensitised and blind to the pre-existing socio-political knowledge that is "out there" shaping the context [11]. The narrow explanations emerging from such a restricted approach, wilfully neglect the structural conditions explaining social phenomena, and preclude a holistic explanation of the phenomena under enquiry. However, as described above, the underlying philosophical and ethical orientation of public health cannot justify a research design that is devoid of critical conceptualisation through the lens of power and oppression, and situates the researcher as an "outsider" to the process.

Critiquing the limitations of classical GT, Charmaz K proposed constructivist GT in 1995, which emphasises the connections between events and situations, meanings and actions, and individuals and social structures, that may otherwise remain invisible [11]. The constructivist grounded theory situates any phenomenon under enquiry in its socio-political context with the researcher playing a significant part in the process and co-constructing the theory with the respondents. In such an inquiry, researchers familiarise themselves with the context and broadly use "sensitising concepts" to conceptualise the research. Charmaz defines these "sensitizing concepts" as loosely defined abstract ideas without concrete indicators on which the scholars agree [11]. While the enquiry remains open, without a pre-existing rigid theoretical framework, the construction/explanation regarding the phenomenon under study starts with a set of sensitising concepts or a broad conceptual framework. However, with the simultaneous data collection and analysis which is a characteristic of grounded theory, loosely defined ideas get iteratively refined and those which do not fit into the emerging theory get dispensed with. In this process of constructing theory based on grounded data, the researcher's reflexivity guided by their positionality plays a profound role [11].

Authors' experiences with the grounded theory approach

Through informal conversations with fellow researchers, peer review comments, and interaction with qualitative research trainers, the authors of this commentary have found that a section of public health researchers continue to rely on classical grounded theory design to explain the phenomena under inquiry. Congruent to the underpinnings of classical GT, any theoretical/conceptual framework broadly governing the research enquiry could corrupt the inductive nature of the design. Subsequently, we have also come across research articles that have used classical GT to examine issues with clear equity implications.

For instance, we examine a study which aimed to generate a symbolic interactionist grounded theory (more aligned with classical GT), to understand how South Asian individuals (both recent migrants and long-term residents) in the United Kingdom, create and construct the meaning of Type 2 Diabetes Mellitus (T2D) prevention, and how this meaning influences their lived behaviours [13]. We argue that the absence of a priori conceptualisation regarding T2D prevention, has precluded the construction of a holistic

picture regarding a multidimensional and complex socio-cultural and political phenomenon like T2D among immigrants [13]. Another research study from Tehran aims to find the models and processes that account for procrastination in patients with T2D in the context of social interactions, including in the family, hospitals, and clinics. Although the authors have claimed to use a "multidimensional approach to this phenomenon to identify these models and the links between them", the lack of a conceptual framework has prevented us from understanding the sensitising concepts which guided the research [14]. Congruent with our fundamental argument that any inquiry into the how and why of health and disease production and distribution cannot be justified without the researcher being actively involved with the context, and critically reflecting upon its influence, we believe that a constructivist grounded theory approach could have been of greater utility in such research endeavours.

On the other hand, in a notable illustration of constructivist grounded theory, the researchers explain the ethical challenges identified, encountered, and subsequently navigated by public health providers while providing mental health services in Canada [7]. It was observed that the inherent values of the health system were in conflict with the underlying philosophy of public health, ie, health equity. The degree of critical consciousness of the providers regarding health equity decided how well they recognised these ethically challenging situations, foregrounding the role of positionality in public health research [7].

One of the authors, MM, was part of a large operational research study which attempted to understand the implementation process and challenges involved in the timely disbursal of cash transfer benefits to patients with tuberculosis in India through a government scheme, *Nikshay Poshan Yojana* (NPY), using GT as a research approach [15]. The research outcome thus generated — a theory explaining the challenges to implementation — was expected to contribute to the designing of specific strategies which could potentially address these challenges and improve the programme's implementation.

Initially, it was decided that the study would involve mapping the processes starting with registration of patients within the government electronic data portal to the disbursal of the last benefit instalment and identify the systemic gaps which led to the delay. However, the research team's understanding of the social and cultural context of the beneficiaries of the scheme led them to recognise the beneficiaries as the most important stakeholders in the inquiry. This also led to the identification of inequities in access to banking services as one of the most critical implementation barriers to the scheme. This was made possible due to the reflexive discussions that the research team had, which started well ahead of the qualitative phase of this multiphase study. The field research and supervision during the cross-sectional survey that preceded the qualitative phase was instrumental in understanding that individual bank accounts for every patient with tuberculosis, which was highlighted as a key strength, was also a barrier. For a plethora of reasons, including lack of necessary documents for proving identity, opening a bank account proved to be the most challenging task. We used this understanding of the contextual barriers including connectivity issues, difficult terrain, and digital infrastructure to conceptualise the qualitative study using GT.

In order to delineate the pathways explaining challenges with the banking system, it was crucial that the data sources covered a diverse range of respondents (registered beneficiaries of NPY) from various socio-economic and geographic locations, who experienced difficulties/delays in receiving the money. This enquiry also required the perspectives of systemic stakeholders who directly handled the cash disbursal at the district level. The programme beneficiaries perceived the research team as representatives of the state and were considerably hesitant to share their experiences regarding the programme, particularly related to the delays faced in cash disbursal. Similarly, the system-level stakeholders were concerned that the information that they shared about the systemic barriers would show the system in a bad light and lead to personal repercussions for them, including further enquiries. Hence, earning their trust was crucial for the credibility of the data collected. This also highlights loss of confidentiality as an important ethical issue in qualitative research, including grounded theory. Any qualitative research is reliant on the respondents' willingness to share their experiences and perspectives to build thick descriptions of the contexts and pathways of the research problem [16]. Hence, it is critical that the researchers be cognisant of this issue and take proactive measures beyond the routine ethical procedures to protect respondents.

Despite the predominantly biomedical orientation of the team, the researchers' situatedness in the public healthcare system of the country over a prolonged period of time, enabled them to understand how health inequities could be perpetrated during the implementation of such schemes, unless conscious efforts are made to account for the contextual barriers. Hence, the team could conceptualise the implementation of NPY as a social problem, rather than a mere techno managerial issue. In this case, remaining blind to the context and relying on classical grounded theory design would have been unethical.

Conclusion

Through its inductive nature, and clear codification of steps involved in data collection and analysis, classical GT has found great appeal among many social scientists who were inclined to qualitative research but lacked the skills to employ it [12]. Its positivist inclination could be one of the reasons prompting its alignment with "biomedically oriented" public health research, which is largely neutral,

value-free, apolitical and "objective". We agree that public health research using a grounded theory approach cannot commence with a rigid theoretical framework, as this essentially shreds the research of its inductive nature which is its hallmark. On the other hand, it is equally impossible to comprehend that the researcher can remain totally unfamiliar and detached from the context, as it violates the fundamental principles of public health as a discipline. Further, such a way of approaching research is not pragmatic, as research does not occur in a vacuum; rather, it is a process of inquiry that is deeply embedded in the socio-political and historical context of any society. It is this situatedness within the context that gives meaning and significance to the outcomes.

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