OBESITY EXPERTISE

A first-principles curriculum in 196 books

BOOK 3 4th of 196 in the series

Qualitative and mixed methods · Rung 1

Asking people, listening, and treating what they say as data

INTERVIEWS, FOCUS GROUPS, TOPIC GUIDES, AND THE QUOTATION AS EVIDENCE

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NOT ADVICE

This book is for learning. It is not medical, legal or financial advice, and it does not replace a qualified professional who knows your situation.

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Harsh Maheshwari completed his MBBS at King George's Medical University (KGMU), Lucknow, and is a resident in MD Community Medicine at the All India Institute of Medical Sciences (AIIMS), Raipur. His MD thesis, on chrononutrition and obesity, was selected by the Indian Council of Medical Research (ICMR) for funding in 2026.

He learns best from first principles: rebuilding an idea from what came before it until the formula feels like the only reasonable answer. This series grew out of that habit.

His long-term aims are to reduce obesity in India and to help make India healthy.

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Introduction

Why this book exists

Numbers tell you how many people eat after dark, and how much weight a programme took off. They do not tell you why a family keeps the late dinner, or why a clinic's patients stop coming. Those are questions about meaning and reasons, and they are answered by asking people and listening well. This book teaches the first half of that craft: what questions it answers, the interview and the focus group as instruments, the topic guide, and how to run an interview without steering it. It ends with five pilot interviews you conduct, transcribe and read yourself.

How to read it

Read Book 0's sections on evidence first, or at least the ones this book names as it goes. Then read this one in order. The exercises here are things to do with people, not sums: write the questions, run the practice interview, read your own transcript back. Do them as you go; the skill is in the doing.

Every section has the same shape. **Definition** states the idea exactly. **In plain terms** says it again in everyday words. **Illustration** works through one real case, usually with a source you can open yourself. **Where this picture breaks** says where the illustration stops being true. **Must-know points** are what should change what you do. Then come **exercises** and, in most sections, a graded **practice set**.

Do the exercises before you look anything up. The worked answers are in the appendix at the back, under the same numbers. The references for each Part follow that Part. The glossary lists every term of art in the plain words it was first given. The last pages list all 196 books in the series and show where this one sits.

If you are new to this

On a first reading, read each section's definition, plain-terms explanation, illustration and must-know points, and do the exercises. Worked derivations can be skimmed and revisited once the idea feels familiar. Keep a calculator beside you: every worked answer can be followed with pen, paper and a calculator. Anything beyond the stated prerequisites is explained where it first appears, or marked as beyond this book. The **Symbols used in this book** page lists every sign and Greek letter with how to read it and where it is first used.

How to send feedback

If something is wrong, unclear, or could be better, please write to **contact@drharshmaheshwari.com**. Put the book number, the version and the section in the subject line (for example: *Book 3, v1.1, section C5*). Say what the text says, what you think it should say, and, if you can, the source.

Corrections are made in new versions. The version number and the date of the last update are on the copyright page of every book, and the newest version of every book is at **drharshmaheshwari.com**.

> **WHERE THIS BOOK SITS**
> Book 3 of the series' 196 books (Book 0 and 195 rung books). Before it: Book 2, Mathematics for modelling and inference · Rung 1. After it: Book 4, Food systems, value chains and Indian food policy · Rung 1. The full list is at the back.

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Before you start

This book uses the following Book 0 sections. Each is summarised where it is first needed; work through Book 0 itself if a summary is not enough.

- Book 0, A1 · Counting, place value, and what a calculator is actually doing
- Book 0, A3 · Decimals, rounding, and significant figures
- Book 0, A4 · Percentages, and the percentage of a percentage
- Book 0, A5 · Ratios, rates and proportions
- Book 0, D5 · Average and spread, and why the average is not the person
- Book 0, D6 · Sampling: how a part can tell you about a whole
- Book 0, D7 · Random error and systematic error as different things
- Book 0, F3 · Checking a reference
- Book 0, F4 · Argument: premise, inference, conclusion
- Book 0, F5 · How government works, in the shape you need to read a regulation

Rung 1 — Introductory

1 · Two kinds of question: how many, and why and how

DEFINITION. A research question of the first kind asks how many or how much: how common something is, how large a quantity is, or how large a difference a treatment makes. Research of this kind is called quantitative research.

A question of the second kind asks what something is, what it means to the people involved, how it comes about and why. It is answered by qualitative research: research that gathers people's own words and actions, by interview, group discussion or watching, and analyses them without turning them into counts.

The two kinds answer different questions, and neither is a weaker version of the other. [1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15]

IN PLAIN TERMS. Some questions ask how many or how much. How many adults with obesity seen at a clinic last year came back for a second visit? By how much does a reminder message raise that number?

Other questions ask what, how and why. Why do patients stop coming? You answer these by asking people and listening to what they say, in their own words. That is qualitative research.

One way to test a treatment is a trial: chance decides who gets it, then the groups are compared. This is a randomised controlled trial. A trial cannot tell you why patients stop coming. An interview cannot tell you how many do.

Green and Britten argue that good evidence goes further than the pooled results of randomised controlled trials. Different questions need different kinds of research.

The two kinds also feed each other.

ILLUSTRATION. Here is the setting this book uses from start to finish. It is made up. A district hospital in Chhattisgarh runs a non-communicable disease (NCD) clinic. Many of its adult patients with obesity come once or twice and then stop coming. You want to know why.

Start with an attempt that fails. Suppose the clinic adds a question to its follow-up phone call: "Why did you not come back? Distance, cost, felt better, or other."

Ask where the four choices came from. The clinic staff wrote them, before anyone had asked a patient. The count is exact. It is an exact count of the staff's guesses.

Now sort four questions about the same clinic yourself, before you read the table. For each one, say whether it asks how many or how much, or what, how and why. Then say what would answer it.

Question	Kind	What answers it
How many adults with obesity seen last year came back for a second visit?	how many	Count the clinic register
Does a reminder text message the day before raise the share who come back?	how much	A trial: chance decides who gets the message, then the groups are compared
Why do adults with obesity stop coming back?	why	Find people who stopped, ask them, and listen
What is a clinic day like for someone who works for a daily wage?	what and how	Ask such people, and listen

Look hard at the third row. No count answers it, because you do not yet know what to count.

Suppose you go and ask. In a made-up example, one woman says the clinic is on the first floor. Her knees hurt on the stairs, and she waits standing because the benches are full. Nobody on the staff had put "stairs" on the tick-list. Now it can go on one.

So the two kinds pass the work back and forth. Asking finds what matters and in what words. Counting says how common it is. A trial says whether a fix works.

WHERE THIS PICTURE BREAKS. The line between the two kinds is not always this clean. "Which patients stop coming, and why?" asks for a count and a reason at once. Split a question like that into its two halves before you choose a method, and give each half its own method.

MUST KNOW POINTS FOR YOU.

- The error is to treat an interview study as a trial that could not afford enough people. It is not a small trial. It answers a question a trial cannot, such as why patients stop coming.
- Before you choose a method, write the research question as one sentence and look at its first words. "How many" and "how much" send you to counting and measuring. "What", "how" and "why" send you to asking people.
- Someone in a meeting will call interview findings "anecdotal". Answer that an anecdote is a story told without analysis. A rigorous interview study chooses people on a stated plan and analyses what they said step by step. And it answers a question a trial cannot: why patients leave.
- A drop-out number tells a programme how big its problem is. It does not say what to change.
- Asking people tells you which reasons exist and how they work. It cannot tell you how common each reason is, or whether a fix works.

EXERCISE 1 (design). Here are five questions about the clinic in this section. For each, say whether it asks how many or how much, or what, how and why, and say what kind of study would answer it.

1. What share of adults with obesity attending the clinic have also been told they have diabetes?
2. How do patients decide whether a follow-up date is worth keeping?
3. Does moving the clinic to the ground floor raise the share of patients who come back?
4. What do patients understand the word “follow-up” to mean?
5. Which patients stop coming, and why?

EXERCISE 2 (critique). A district programme officer writes: “Interviews are the weakest kind of evidence. We will wait for a trial before we look at why patients leave the clinic.”

Lay the argument out as premises and a conclusion. Then say where it fails.

EXERCISE 3 (teaching). A journalist has three minutes and asks you: “Isn’t qualitative research just people’s opinions?” Answer without jargon, and give one sentence they could quote.

2 · Who you talk to, and what the answers can claim

DEFINITION. In a qualitative study the people who answer, called respondents, are chosen on purpose, for what they can tell the researcher about the question. The choice and its reasons are written down.

A deliberate choice is not a convenience sample. A convenience sample takes whoever is available.

Because the people were chosen and not drawn, the findings describe the range of experiences, reasons and meanings among them, and how these connect. They do not estimate how common any of these is in a population. What carries beyond the study is an idea, a reason and how it works, that a reader can test in another setting. This is conceptual, not statistical, generalisation.

Such a study is judged by its own tests. It gives a clear account of how people were chosen and how the data were gathered and analysed. It searches for cases that contradict the emerging explanation, and reports them. The number of people interviewed is not the test, and there is no power calculation, the sum a survey or trial does to decide how many people it needs. [16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30]

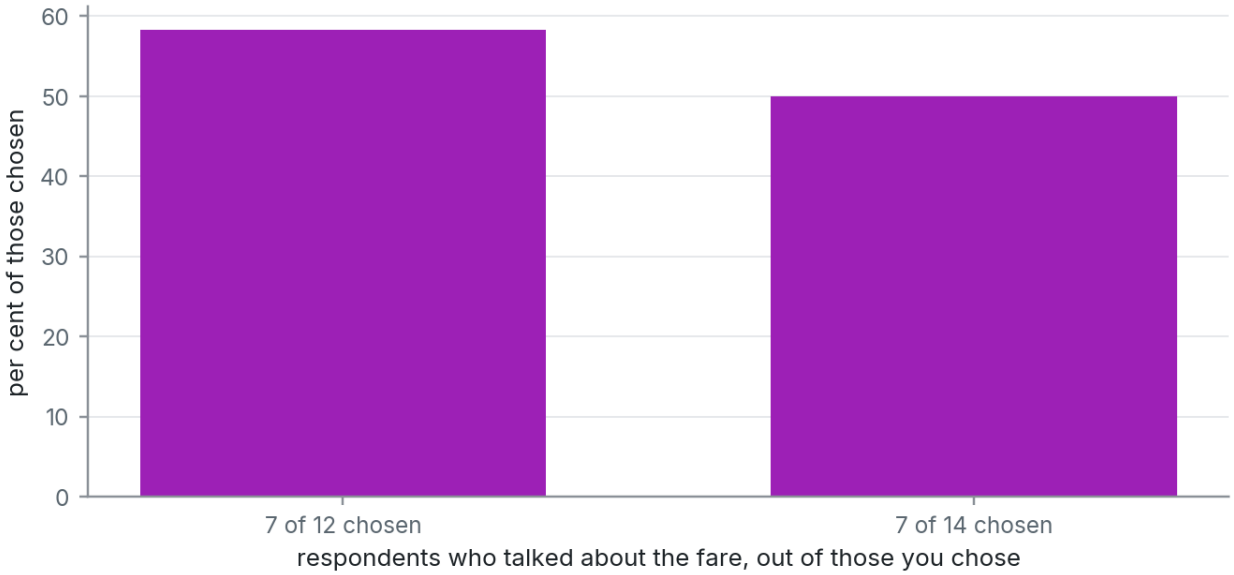
IN PLAIN TERMS. Book 0 taught you two ways to get a sample. A random sample lets chance pick who is in it. A convenience sample takes whoever is easy to reach. A qualitative study uses a third way. You choose people on purpose, for what they can tell you.

Suppose you want to know why patients stop coming to a clinic. The people who can tell you are the ones who stopped, so you go and find them. You choose some who live far away and some who live near, men and women, younger and older. You are after the widest spread of reasons, not an average.

That choice has a price. Say seven of your twelve respondents, the people who answer, mention the bus fare. That does not mean 58 per cent of patients stop because of the fare. You might have picked more people from far villages. Pick differently, and the seven changes.

What the study can claim is different, and it is still worth having. It can say what the reasons are, how each one works, and how they connect. A reader in another district can take that idea and test it against their own clinic.

So a qualitative study is not judged by how many people it asked. Ask three things instead. Did the authors say how they chose people, and why? Did they say how they gathered and read what was said? Did they look for people whose story did not fit, and report them?



The same 7 respondents talked about the bus fare both times. Among the 12 you chose, that is 58 per cent; choose two more from within walking distance who do not mention it, and among 14 it is 50 per cent. The clinic did not change; your choice did, so the share describes your choice, not the clinic.

Illustration 1. Here is a plan that fails, in the made-up clinic from the last section. You have one Tuesday free. You decide to interview whoever is in the waiting room that morning. It is easy, and the patients are right there.

Now ask who is in that room. Every one of them came back. The people you want to hear from, the ones who stopped, are exactly the people who are not there. This convenience sample has left out the whole question.

So build the group on purpose. Open the clinic register. Mark the adults with obesity who came once or twice and then missed their next date. From those, choose people who differ in the ways you suspect might matter. Write your reason beside each choice.

Choose some who…	Because…
live more than an hour away	travel may be one reason
live within walking distance	if they stopped too, travel is not the whole story
look after small children or older relatives	a clinic day may cost them more than the fare
work for a daily wage	a clinic day may be a day’s pay lost
came only once	the first visit itself may have put them off
came several times, then stopped	something may have changed later

Look at the second row. You chose those people because their story might break your first guess. Mays and Pope wrote a 2000 paper on judging qualitative research. They count this as one of the tests of a good study: looking for the case that contradicts the explanation, and discussing it.

Keep the table. That written record of whom you chose, and why, is part of the study. A reader judging it will ask for it first.

WHERE THIS PICTURE BREAKS. The register helps only if the clinic keeps one and it is complete. Patients who never gave a working phone number or address cannot be found this way, and they may have the most to tell you. Say so in your account of how you chose people, so a reader knows who could not be reached.

Illustration 2. Now suppose you have interviewed twelve people chosen this way. The numbers here are made up. Seven of the twelve talked about the bus fare. A first draft of your report says: "58 per cent of patients stop coming because of the fare." Check the arithmetic first.

```
7 divided by 12 = 0.5833333333
0.5833333333 times 100 = 58.33333333
```

The arithmetic is right. The claim is still wrong. Lay it out the way Book 0's section on argument taught.

- *Premise:* seven of these twelve respondents talked about the fare.
- *Conclusion:* 58 per cent of the clinic's patients stop because of the fare.

The inference needs a premise nobody wrote down: that the twelve stand for the clinic's patients in known proportions. They do not. You chose them, and you chose several from far villages on purpose. Suppose you had also chosen two more people from within walking distance, and neither mentioned the fare.

```
7 divided by 14 = 0.5
```

The clinic has not changed. The share has, because your choice changed. So the share describes your choice, not the clinic. Pope, Ziebland and Mays, in a 2000 paper on analysing qualitative data, give the same warning: results written as relative frequencies may mislead when the sample was never meant to be representative.

Here is what the twelve can support. The fare came up often, and you can say how it works. In the made-up interviews, one woman explains she pays it twice, for herself and for the grandchild she cannot leave at home. And one respondent, R11, lives ten minutes' walk away and stopped too. She says she was weighed in the corridor, where other people could see. That case does not fit "the fare". You keep it and report it. It shows distance is not the whole story, and it names a reason no count of the first answers would have found.

If a decision needs to know how common the fare is as a reason, say to budget for bus passes, that is a how-many question again. It needs a count from a random sample, or from the whole register.

WHERE THIS PICTURE BREAKS. Counts are not forbidden in a qualitative report. Authors sometimes give a simple count as a summary of what they heard. Read such a count as a description of the group they chose, never as a rate for the population.

MUST KNOW POINTS FOR YOU.

- A count of respondents is not a rate. "Seven of twelve mentioned the fare" describes the twelve you chose.

- When you read a qualitative study, find the account of how people were chosen before you read the findings.
- A reviewer trained on trials will ask for your sample-size or power calculation. There is none to give, because the study does not estimate a rate.
- A small number is not, by itself, a weakness in this kind of study. DeJonckheere and Vaughn note that an interview project with as few as 8 to 12 people can be highly meaningful.
- The easiest people to reach can be the ones your question is not about.
- A qualitative study tells you which reasons exist and how they work among the people you chose. It cannot tell you how common any reason is. If a budget or a target depends on "how many", ask for a count from a random sample or a complete register.
- When a trainee writes percentages into the results of an interview study, have them replace each one with what was said and how it works. Then have them add the case that did not fit.

EXERCISE 1 (critique). Here is a made-up newspaper line. "A study interviewed 15 women with obesity in Raipur. It found that 60 per cent avoid clinic visits because of long waiting times."

Say what is wrong with the sentence, and rewrite it so that it claims only what an interview study can support.

EXERCISE 2 (design). You want to know why men with obesity in your district stop coming to follow-up at a non-communicable disease (NCD) clinic. Write the list of the kinds of men you would choose to interview, at least five, with one line on why you chose each. Then say which row is there because it might break your first guess.

EXERCISE 3 (teaching). A health secretary has asked for one page. A made-up qualitative study of 20 patients found that bus fares keep some of them from the clinic. An officer wants to use "14 of 20 said fares" to size a bus-pass budget for the whole district. Write the page in this order: the answer in one sentence; why; what the study does give you; what to do.

3 · The interview: structured, semi-structured, in-depth

DEFINITION. A research interview is a conversation in which a researcher asks a respondent about a topic in order to gather the respondent's account of it. Interviews are sorted into three kinds by how much is fixed before the interview begins.

A structured interview administers a questionnaire. A questionnaire read aloud is a structured interview, and its answers are counted.

A semi-structured interview follows a short guide of open-ended questions that define the area to be explored.

An in-depth interview fixes less still. No interview is wholly without structure, so "unstructured interview" is a misleading name.

A research interview is not a clinical consultation. The interviewer therefore does not diagnose, advise or correct. [31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51]

IN PLAIN TERMS. Interviews come in three kinds. What separates them is how much is decided before you sit down.

In a structured interview, everything is decided. You read out a questionnaire. Most answers are picked from a list.

In a semi-structured interview, the topics are decided and the path is not. You carry a short guide of open questions: questions the person answers in their own words, not by picking from a list. You change the order and the wording to suit the person. When they say something you did not expect, you follow it, then come back to the guide.

In an in-depth interview, almost nothing is decided. You open with one broad question about one or two issues. Everything after that comes from what the person has said: "What happened then?" "What do you mean by that?"

The semi-structured kind is the most common, usually with one person, face to face, and recorded with their agreement.

A research interview is not taking a history. In a history, you steer the patient's story toward a diagnosis and a plan. You do not diagnose, you do not advise, and you do not correct.

Illustration 1. Take the question from the last two sections: why do adults with obesity stop coming back to the clinic? Here is the same topic set up three ways. Every question here is made up for this book.

Structured. You read from a printed form and tick boxes.

Question	Answers allowed
In the last three months, how many clinic dates did you miss?	none; one or two; three or more
What was the main reason?	distance; cost; felt better; other

Semi-structured. You carry a guide of a few open questions, and use it as a map, not a script.

- "Tell me about the first time you came to this clinic."
- "What has made it easier or harder to come back?"
- "Tell me about the last date you did not come for."

In-depth. You open once, then follow.

- "I am trying to understand what coming to this clinic is like for people. Can you tell me about it, from the beginning?"

Now decide what each one can give you, before you read on.

The structured form gives a tick in a box. You can count the ticks across a hundred people, and a count is what it is for. It cannot give a reason nobody put on the form. That is the tick-list from the first section again.

The semi-structured guide makes sure the same few areas come up with everyone. It still leaves room for the answer you did not expect.

The in-depth opening goes deepest into one person's story. It covers only what that person chooses to bring up.

For a why question, the structured form is the wrong tool. Choose between the other two by how much you already know about what matters. Knowing the areas but not the answers points to the semi-structured guide.

WHERE THIS PICTURE BREAKS. The three kinds are points on a line, not boxes with walls. A structured form may end with one open question, and a semi-structured interview can turn into an in-depth one halfway through.

Papers also use the names loosely. DeJonckheere and Vaughn call the interviews they describe both semi-structured and in-depth. When you read a study, look at what the interviewer fixed in advance, not at the name it uses.

Illustration 2. Now a made-up exchange, translated from Chhattisgarhi. You are the interviewer, I. The respondent, R1, is a woman in her fifties who stopped coming to the clinic. Each made-up interview in this book is separate, and the labels R1, R2 and so on start again in each one. You are also a doctor, and the habit of taking a history is strong. Here is what the habit does.

Speaker	Words
I	Why did you stop coming?
R1	After the second time, my knees were very bad.
I	Which knee? Is the pain worse in the morning?
R1	Both. Mornings, yes.
I	Are you taking the tablet the doctor gave you? You should take it every day.
R1	Yes, yes, I take it.

Look at what happened. She mentioned her knees, and you turned them into a diagnosis. You asked closed questions to fit them into a medical category. Then you gave advice. She gave the answer that ends the topic. You now know about her knees. You still do not know why she stopped coming.

Now run the same opening as a research interview.

Speaker	Words
I	Tell me about the last time you came to the clinic.
R1	After the second time, my knees were very bad.
I	Your knees. Tell me more about that.
R1	The clinic is upstairs, and there is no lift. I climb, then I wait standing, because the benches are full. By the time my name is called, I cannot think.
I	And after that visit?
R1	My son said, why go and suffer. So I stopped.

This time the knees led somewhere. The stairs, the full benches and a son's advice are reasons a clinic can act on. You got them by asking her to say more, and then by waiting. You did not diagnose, advise or correct.

Her knees still matter. If she asks for help with them, Britten's way out is to say you will come back to it at the end of the interview, and then do.

WHERE THIS PICTURE BREAKS. This exchange is built to make the contrast plain. Real respondents do not always open up when asked to say more. Some keep to short answers whatever you do.

A respondent who knows you are a doctor may also answer as a patient does, with what she thinks a doctor wants to hear. Britten warns of exactly this. The second exchange removes the history-taking, not the white coat.

MUST KNOW POINTS FOR YOU.

- A research interview is not a history with a recorder running. In a research interview, steering the account into your own categories is the error, because it swaps the respondent's account for yours.
- Choose the kind of interview from the question. A how-many question with known answer options takes a structured form whose answers you count. A why or how question takes a semi-structured guide. One story told in full, such as one family's experience of a diagnosis, can take an in-depth interview.
- When a respondent mentions a symptom, you will feel pulled back into doctor mode. Do not ask the diagnostic question and do not advise. Ask her to say more, and offer to come back to her health question when the interview ends.
- A questionnaire read aloud is still a questionnaire.

- The labels are used loosely in papers, so the name of the interview tells you little. Look in the methods for what the interviewer fixed in advance and what they followed.
- When you teach a resident to interview, have them play back their own recording. They mark every place they diagnosed, advised or corrected.

EXERCISE 1 (interpretation). Three made-up descriptions of how interviews were run. Name the kind of interview in each, and say what in the description told you.

1. "Field workers read 24 questions from a printed form. Each answer was marked on a four-point scale."
2. "The interviewer opened with: 'Tell me about your life since the diagnosis.' She then asked only about what the respondent raised."
3. "Interviews followed a guide of six open questions on meals at home. Interviewers were free to change the order and to follow up on what respondents said."

EXERCISE 2 (critique). Here is a made-up exchange from a practice interview on why patients stop coming to the clinic, translated from Hindi. R2 is a woman in her forties.

Speaker	Words
I	So you stopped coming after March?
R2	Yes. My sugar was fine by then.
I	Fine? What was your last reading? You know, sugar can be high without any symptoms.
R2	I don't remember the reading.

Say where the interviewer left the research interview. Then rewrite the interviewer's second line so the interview stays one.

EXERCISE 3 (teaching). A first-year resident asks: "I take histories every day. Why would a research interview need any new skill?" You have ten minutes and a whiteboard.

4 · The focus group, and choosing between it and the interview

DEFINITION. A focus group is a form of group interview that uses the talk between participants to produce its data. A group interview can be run simply as a quick way to hear several people at once, each answering the researcher in turn. A focus group is different in method: participants are asked to talk to one another.

The person who runs the group is the moderator. Kitzinger calls this person the facilitator, and says the facilitator should explain that the aim is for people to talk to each other rather than to the researcher.

The talk between participants gives what a one-to-one interview cannot.

The same group process has costs. A shared norm, once voiced, may silence someone who disagrees.

The choice between the two follows from the question. A questionnaire suits counting how many people hold an opinion. [52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71]

IN PLAIN TERMS. A focus group puts several people in a room with one moderator.

Here is the trap. A room of six people answering one at a time is not a focus group. It is six short interviews with an audience. In a focus group the moderator asks people to talk to each other. That talk between them is the data.

Kitzinger, who wrote a guide to the method for health researchers, puts the ideal size at four to eight people. Her sessions last one to two hours, sometimes longer. Other guides give other numbers. Blackstone's textbook prefers three to five for a heated topic, and reports recommendations from three to twelve. There is no fixed rule.

What a group does well:

- It shows what a group takes for granted — the things everyone nods at.
- It shows the words people use among themselves, which are often not the clinic's words.
- It can bring in people who would not sit through an interview alone, and people who cannot read or write.

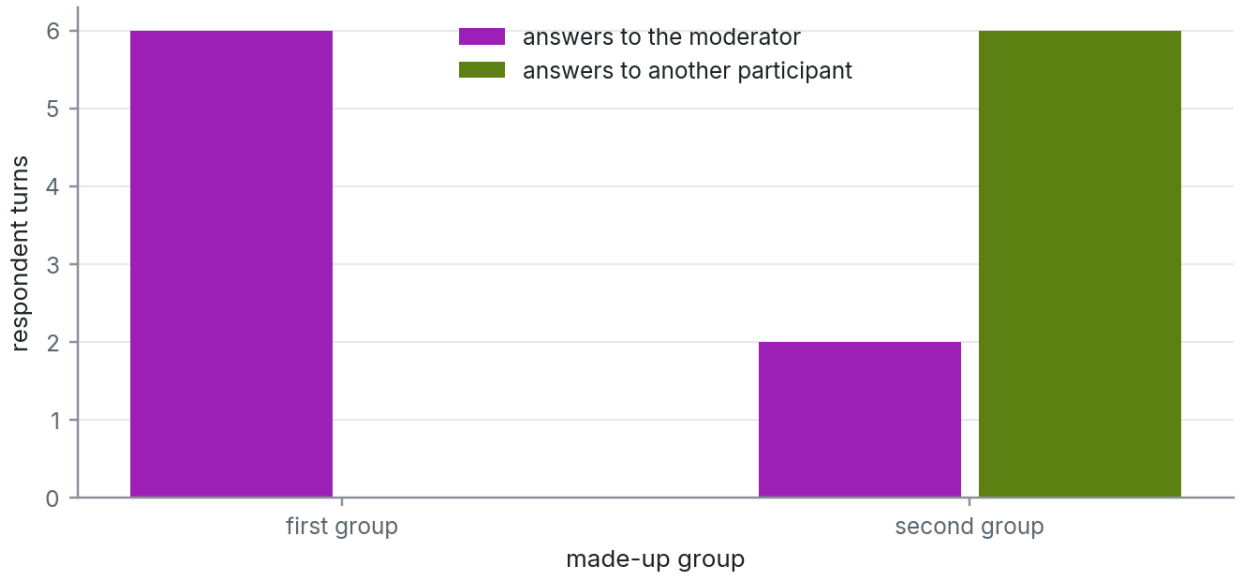
What a group does badly:

- One loud voice can set the line, and the rest may go along with it.
- Everyone hears everything. You cannot promise a person that what they say stays private.
- A person of higher standing in the room, such as a staff member among patients, can hold others back.

So choose from the question you are asking.

If you want to know	Use	Because
how patients at a clinic talk about coming back, and the reasons they share	a focus group	the shared words and reasons come out when they talk to each other
one woman's own story of the months after she stopped coming	an interview	it is one person's story, and she tells it without an audience
how many patients missed their last visit	neither: the clinic's register or a survey	that is a count

This book teaches you to recognise a focus group and choose it. Running one is left to the next level.



In the two made-up groups below, who each respondent's turn answered. In the first group all 6 turns answer the moderator and none answers another participant: a group interview. In the second, 2 answer the moderator and 6 answer another participant: a focus group.

Illustration 1. Suppose you want to know why adult patients with obesity at a district hospital NCD clinic in Chhattisgarh stop coming back for follow-up. NCD stands for non-communicable disease. You invite six patients to talk as a group. What follows is a made-up exchange, written to show the method. The patients spoke Chhattisgarhi, and their words are given here in English. M is the moderator; R1 to R6 are the patients.

Speaker	Words
M	Why do people stop coming back to this clinic? R1, you start.
R1	The doctors here are good. People are careless, that is all.
M	R2?
R2	He is right. We are careless.
M	R3?

Speaker	Words
R3	Yes. Careless.
M	R4?
R4	Same as them.
M	R5?
R5	Yes.
M	R6?
R6	We should come. It is our own fault.

Go through the respondents' turns with a pencil. Beside each one, write M if the person is answering the moderator, and P if they are answering another participant. All six turns are M. Nobody spoke to anybody but the moderator.

That is a group interview, not a focus group. The moderator asked each person in turn, so the one thing a group can give you never happened. The first answer set the line, and five people followed it.

Now look at what you cannot write in your report. You cannot write "all six patients said people stop coming because they are careless". Kitzinger warns against giving percentages from focus groups. She says to tell apart one person's view from what the group actually agreed. Here you do not know what R2 to R6 think. You know only that they did not contradict R1 in front of each other.

WHERE THIS PICTURE BREAKS. The exchange is made up, and so short that every turn can be marked. In a real two-hour group, many turns answer the moderator and the group at once. A turn can also change the subject without answering anyone. The M and P marks are then a rough reading aid, not a measurement.

A group that agrees quickly has not always been silenced. Sometimes people simply agree. The transcript alone cannot tell the two apart. What tells them apart is whether anyone, given a real chance, says something different.

Illustration 2. Here is a second made-up group of six patients from the same clinic. This time the moderator reads out a sentence written on a card and asks the group to talk about it with each other. Kitzinger describes group exercises built on statements written on cards; this uses one card in a simpler way.

Speaker	Words
M	I will read out a sentence. Talk about it with each other, not with me. "People stop coming because the visit takes the whole day."
R3	That is true. The bus from our village leaves at six. By the time the doctor sees you it is past two.
R1	But you get a month of tablets. Is one day a month so much?
R3	For you, maybe. My husband loses a day's wages when he brings me.
R5	Same for us. And after the whole day they weigh you and say the same thing.

R2	What do they say to you?
R5	Eat less, walk more. Every time.
R4	R5 is right about the words. For me it is the scale. It stands in the corridor, and the whole queue watches.
M	R4, say more about that.
R4	I would rather not, here.

Mark the respondents' turns again. The first R3 turn answers the moderator's card, so it is M. The next six turns each answer another participant, so they are P. R4's last turn answers the moderator, so it is M.

group	answers to the moderator	answers to another participant
first group	6	0
second group	2	6

Now look at what the talk between them produced. You could not have got it by asking six people in turn.

- A shared phrase, "the whole day", which the group uses for the cost of a visit.
- A disagreement. R1 thinks one day a month is small. R3 answers that it is not her day that is lost but her husband's wages. So the cost depends on who pays it.
- A question you might not have thought to ask. R2 asks what the staff actually say.
- Set beside the first group, a move away from blaming themselves, towards the bus, the wages and the scale in the corridor. Kitzinger describes group talk allowing exactly this shift, from personal, self-blaming explanations towards structural ones.

R4's last turn shows the limit. Being weighed in front of the queue is something R4 will mention in the group but will not describe there. That is a private, possibly painful experience. It is the kind of thing one person's story in an interview is for. So you might offer R4, and anyone else, a one-to-one conversation later, away from the group.

Figures quoted in this illustration are from [72, 73].

WHERE THIS PICTURE BREAKS. Both groups are made up, and each was written to show one thing clearly. A real group mixes the two: some stretches of real talk between participants, some stretches of each person answering the moderator.

Kitzinger's account of what groups do well and badly comes from a guide to the method, built on her own studies and others'. It is not a trial comparing the two methods on the same people. It gives no effect size. A study that ran groups and interviews on the same topic and the same kind of people, and found the groups added nothing the interviews missed, would count against it. Until then, treat its claims as practical guidance from experience.

MUST KNOW POINTS FOR YOU.

- A focus group is not a quick way to interview six people. Read your transcript and check whether anyone ever answers anyone other than you.

- Refuse the sentence “the group agreed”, and any count like “five of six said”. First check who spoke first, and whether anyone was given a real chance to differ.
- Choose the method from the question. If your question is “how many”, a group is the wrong tool however well it is run.
- When many of the people you need to hear from cannot read or write, a written questionnaire shuts them out. A group or an interview does not; choose between those two by the question.
- Where the topic is a private or stigmatised experience a person may not want neighbours to hear, the group stops being trustworthy for it. Offer that person an interview instead, and keep staff out of patient groups.
- If someone tells you focus groups give “more honest” or “truer” data than interviews, or the reverse, do not accept it. Kitzinger holds that group data are neither more nor less authentic than other data.

EXERCISE 1 (interpretation). Here is a made-up excerpt from a session at the same clinic. The respondents’ words are translated from Hindi.

Speaker	Words
M	What do you all think of the diet sheet the clinic gives?
R2	I cannot read it. My daughter reads it to me.
R6	You are lucky. Nobody at home reads it to me.
R2	Then how do you know what is on it?
R6	I ask the woman in the next bed at the ward.
R3	The sheet says no rice. How can we eat no rice?
R1	Nobody eats no rice. They just write that.

Is this a focus group or a group interview? Say what it shows that an interview with R2 alone could not. Then say one thing you could not write in your report on the strength of it.

EXERCISE 2 (design). For each of these three questions about the clinic, choose a focus group, an interview, or neither. Give one reason for each choice.

1. What do patients at this clinic call the follow-up visit among themselves, and what do they say about it to each other?
2. What happened in the life of one man in the months after he stopped coming?
3. How many patients registered in 2025 came back at least once?

5 · Open, closed and leading questions

DEFINITION. A closed question fixes the possible answers before the respondent speaks. The answer is yes or no, a number, or one of a set of options the question supplies.

An open question leaves the form of the answer to the respondent.

Open and closed describe the form of the answer. Whether a question is leading is a separate property. A leading question shows the answer the asker expects, or takes for granted part of what it is asking about. “Don’t you find the diet hard?” is closed and leading. “How hard is the diet for you?” is open in form and leading, because it takes for granted that the diet is hard.

A double question asks two things in one sentence.

The standard for the questions of a semi-structured interview, in DeJonckheere and Vaughn’s words: “All questions should be open ended, neutral, clear and avoid leading language.” This book applies it to the questions that carry the study. A plain fact, such as age, may be asked closed. [74, 75, 76, 77, 78, 79, 80, 81, 82, 83]

IN PLAIN TERMS. Every question you write can be put through three checks.

Check 1: the form of the answer. Could the person answer with yes, no, a number, or one of the options you gave them? Then it is a closed question. If they have to answer in their own words, it is an open question. “How many”, “how often” and “how long” want a number, so they are closed. “How much” and “how hard” are open in form, but ask only for an amount.

Check 2: what the question takes for granted. In Book 0, F4, a premise is a statement an argument rests on. Some questions carry a premise the respondent never offered. “How hard is the diet for you?” rests on “the diet is hard”.

Other questions show which answer you would like: “Don’t you think the tablets help?” Both kinds are leading questions. A leading question can be open or closed.

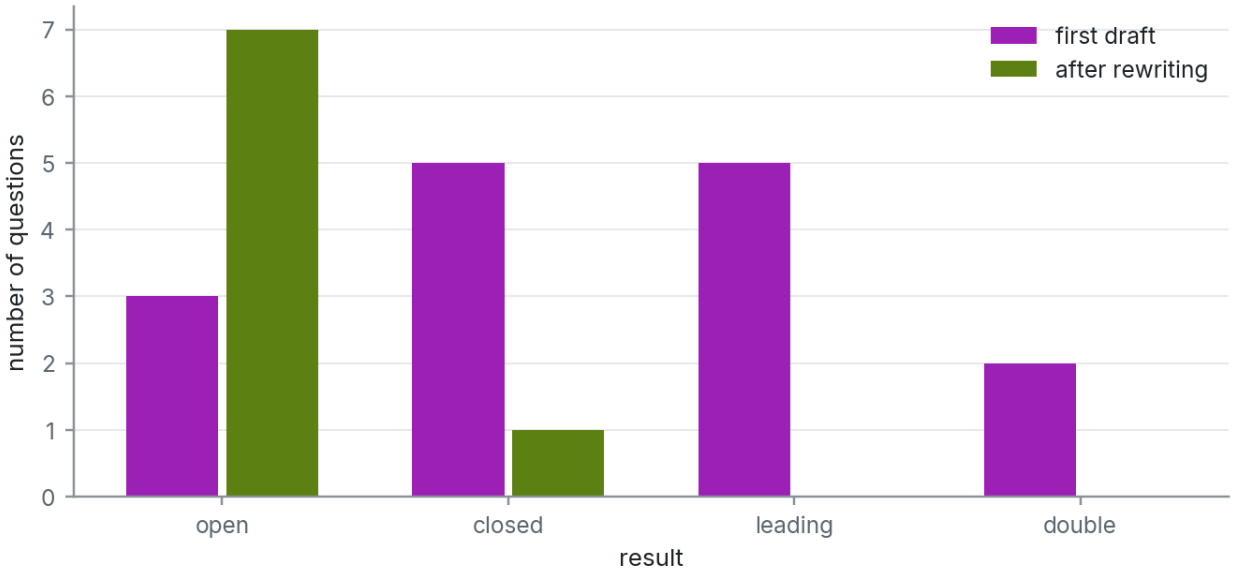
Check 3: how many questions are in it. “Did the doctor explain the diet, and did you follow it?” is two questions. That is a double question. Split it.

One more trap, about the word “why”. “Why did you stop coming?” is open. It also asks the person to give reasons for what they did, as if they owed you an explanation.

It carries the premise that they decided to stop. Ask what happened instead: “Tell me about the last time you came here.”

Closed questions are not wrong. “How old are you?” should be closed.

Last, a clash of words to know about. DeJonckheere and Vaughn’s guide to interviewing lists probes: short follow-ups that ask for more. One of them is called “leading”. There it means asking someone to explain their reasoning, as in “Tell me how you came to that decision”. It is not a leading question.



The eight questions of the made-up first draft and of the rewrite in the second illustration below, counted by result. Open questions go from 3 to 7 and closed from 5 to 1; leading questions go from 5 to 0 and double questions from 2 to 0. Open and closed always add to eight, because every question is one or the other.

Illustration 1. You are studying why adult patients with obesity at a district hospital non-communicable disease (NCD) clinic in Chhattisgarh stop coming back for follow-up. Here is the first question you wrote, tried on a made-up respondent. The exchange is invented to show the method, and translated from Hindi.

Speaker	Words
I	Don't you find it hard to come back every month?
R1	Yes, it is hard.
I	Why?
R1	It is just hard.

Put the first question through the three checks. It can be answered yes or no, so it is closed. "Don't you" shows the answer you expect, and "hard" is your word, so it is leading. It asks one thing. You learned that R1 agreed with you. You did not learn what coming back is like for her.

Your "Why?" then asked her to defend a feeling you had handed her. She had nothing to add.

Try the first rewrite most people reach for: "How hard is it to come back every month?" It is open in form. But it still rests on "it is hard". R1 can now only tell you how much.

Now ask about an event instead of a judgement.

Speaker	Words
I	Tell me about the last time you came to the clinic.
R1	My son brought me on his motorcycle. He works at the rice mill, so it has to be his day off. We waited from nine. The sister weighed me and wrote on the paper. The doctor said the sugar is high. Then we went home.

I	You said the sister wrote on the paper.
R1	Yes. I did not understand what she wrote. I did not want to ask in front of everyone.

The question is open, takes nothing about her experience for granted, and asks one thing. R1 now tells you things you had no word for in your draft. Her visit depends on her son's day off. She waited. She did not understand the paper, and did not ask in front of others. Whether any of this is why she stopped coming is still open. But it is her account, not yours.

WHERE THIS PICTURE BREAKS. The exchange is made up and tidy. A real respondent may answer a leading question with a long account anyway, or answer an open one with "fine". One exchange shows what a question allows. It does not show what a question will always produce.

"Takes nothing for granted" is never literally true. "The last time you came to the clinic" takes for granted that she came at least once, which the clinic's register already shows. The check is for premises about what you are trying to find out: her experience, her reasons, her feelings.

Illustration 2. Now run the three checks on a whole first draft. Here are eight made-up questions for the same study, with each one's result.

No.	Question	Open or closed	Leading	Double
1	How old are you?	closed	no	no
2	Don't you find it hard to come back every month?	closed	yes	no
3	Did you stop coming because of the distance or the cost?	closed	yes	no
4	Why did you stop taking the tablets?	open	yes	no
5	Was the doctor rude to you, and did the nurse explain things?	closed	yes	yes
6	Do you eat rice at night?	closed	no	no
7	What do you think about the diet the nurse gave you?	open	no	no
8	How does your family help with the diet and the walking?	open	yes	yes

Question 3 offers two reasons and no others, so the respondent's own reason has no room. Question 4 takes for granted that she stopped the tablets. Question 5 puts "rude" in her mouth and asks two things. Question 8 takes for granted that the family helps, and asks about two things.

Here is the draft after rewriting.

No.	Question	Open or closed	Leading	Double
1	How old are you?	closed	no	no
2	Tell me about the last time you came to the clinic.	open	no	no
3	What happened after that visit?	open	no	no
4	Tell me about any medicines you have been given here.	open	no	no
5	What was it like talking to the doctor?	open	no	no
6	What does a usual evening meal at home look like?	open	no	no
7	What do you think about the diet the nurse gave you?	open	no	no

No.	Question	Open or closed	Leading	Double
8	Who at home, if anyone, knows about the diet?	open	no	no

Question 1 stays closed, because age is a plain fact. The nurse half of question 5 and the walking half of question 8 are not lost. They wait as follow-ups, to ask if the respondent raises them.

Count each result in the two drafts. Each draft has eight questions.

result	first draft	after rewriting
open	3	7
closed	5	1
leading	5	0
double	2	0

Check the counts. Every question is either open or closed, so those two rows must add to eight.

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3 plus 5 = 8
7 plus 1 = 8
```

WHERE THIS PICTURE BREAKS. A table of results is a check on your own draft, not a score for it. A guide with no leading questions can still be a poor guide. Its questions may be in the clinic's words rather than the respondent's, or may miss what matters. And the results are judgements: two careful readers can disagree about a borderline question, such as whether "if anyone" fully removes the premise in question 8.

MUST KNOW POINTS FOR YOU.

- An open question can still lead. Run the premise check on every question, including the ones that start with "how" or "what".
- Refuse the quick fix of deleting "don't you". A rewrite that removes the signal words and keeps the premise is still leading.
- Ask "what happened" before "why". "Why did you stop coming?" asks a patient to defend a decision you have assumed she made.
- A yes to a leading question tells you the respondent did not contradict you. If the question carried the premise, the answer cannot be evidence for it.
- The three checks tell you whether a question gives the respondent room. They do not tell you whether it asks about the right thing, or in words the respondent uses.
- When a trainee's list of questions is all closed, do not tell them "use open questions". Take one of their questions, ask them what answer they expect, and show them that the question already contains it.

EXERCISE 1 (critique). A colleague's made-up draft for the clinic study opens with these three questions.

1. Did you know that coming every month keeps your sugar under control?
2. Why haven't you been coming?
3. Is it the cost, the distance or your family?

Say what is wrong with each. Then write one opening question that fixes all three problems.

PRACTICE. Ten problems on this technique, easiest first. Work them on paper before turning to the answers, which are in the appendix at the back under this section's name.

1. Put this question through the three checks: open or closed, leading or not, double or not.

Do you travel to the clinic by bus?

2. Put each question through the three checks.

1. Tell me about your last visit to the clinic.
2. How many kilometres is it from your home to the clinic?
3. Don't you think the tablets help?
4. How hard is the walking the doctor asked for?

3. Put this question through the three checks. Then split it into separate open questions.

Did the doctor explain the diet, and did you follow it?

4. This line is from a made-up first list of interview questions for the clinic study.

Did you stop coming because the clinic is too far?

Put it through the three checks. Then write a neutral open question to replace it.

5. Here are two lines from a made-up interview transcript at the clinic, translated from Chhattisgarhi.

Speaker	Words
R2	I have the tablets at home. A whole strip is still there.
I	Why did you stop taking the tablets?

Put the interviewer's question through the three checks. Say how R2 might hear it. Then write a better next line for the interviewer.

6. A colleague's made-up draft guide on family meals has six questions.

1. How old are you?
2. What does a usual evening meal at home look like?
3. Is rice served every night?
4. Don't you think a late dinner is bad for your weight?
5. How does your family support your diet and your walking?

6. Why do you eat after the others have finished?

Put each through the three checks. Count how many are open, closed, leading and double. Say which questions to rewrite first.

7. Here is a worked answer. Find the step that broke.

```
question: “Tell me, do you eat rice at night?”
check 1: it begins “Tell me”, so it invites the respondent’s own account: open
check 2: it takes nothing about her experience for granted: not leading
check 3: it asks one thing: not double
```

8. Here is a worked answer. Find the step that broke.

```
original: “Don’t you find the diet hard?”
check 1: yes or no, so closed
check 2: “don’t you” shows the answer wanted, so leading
rewrite: “How hard do you find the diet?”
the rewrite needs the respondent’s own words, so it is open
“don’t you” is gone, so the rewrite is not leading
```

9. A made-up draft protocol for the clinic study says:

“We will ask patients whether they find the diet hard.”

Turn this into a question to ask. Then say what the answers to it still cannot show.

10. A colleague says: “None of my questions lead. They are all open. Every one starts with ‘how’.”

Here are the four interviewer lines from one of their made-up transcripts.

Speaker	Words
I	How much does your weight worry you?
I	How did the nurse’s advice help you?
I	How often do you miss the evening walk?
I	How do you get to the clinic?

Test the claim. Then say what your answer does not establish.

6 · The topic guide

DEFINITION. A topic guide is the written list of areas and questions an interviewer takes into a semi-structured interview.

It is a guide, not a script. The interviewer changes the order and the wording of the questions to fit the respondent and the moment.

The questions run from easy to hard. The questions come from the study's research question, which DeJonckheere and Vaughn call the driving force of the whole design.

A guide is tried out before the study, in a pilot interview. [84, 85, 86, 78, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99]

IN PLAIN TERMS. A topic guide is the sheet you take into the interview, with all your questions on it in the order you expect to use them.

It is not a script. You do not read it out top to bottom.

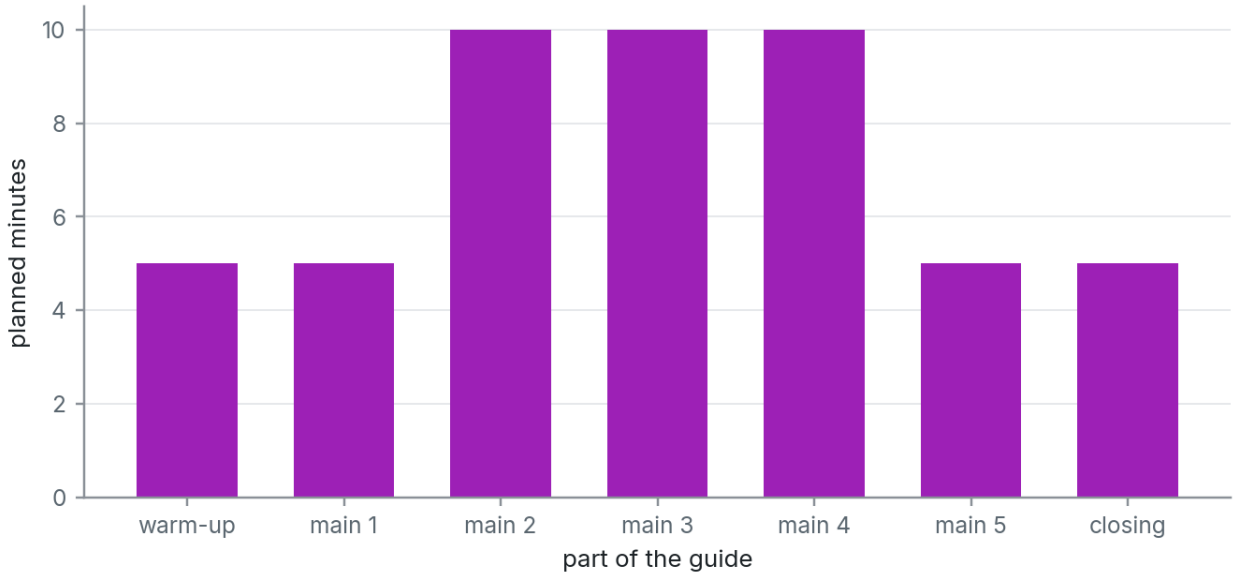
A guide has four parts.

- **A warm-up question.** Something easy the person knows all about, to get them talking. "Tell me about a usual day for you."
- **Main questions.** These are the questions your study turns on.
- **Prompts under each main question.** Short notes of the things you hope the answer covers. You use a prompt only if the respondent does not get there on their own. A prompt names a topic, never an answer: "the journey", not "Was it the bus?"
- **A closing question.** "Is there anything I have not asked about that I should have?"

Three rules for the order and the words:

- Easy and factual first, personal later.
- Every main question comes from your study question.
- Use the respondent's words, not the clinic's.

Last, a guide is never finished on paper. Try it in a pilot interview, see which questions fall flat, and change it. A question falls flat when it gets a one-line answer, is heard as a different question, or never draws the person's own words.



The made-up time plan for the clinic guide in the second illustration, in minutes: 5 for the warm-up, 5, 10, 10, 10 and 5 for main questions 1 to 5, and 5 for the closing question, 50 minutes in all. Most of the time goes to main questions 2, 3 and 4: the events and the most personal part, where the reasons are most likely to come out.

Illustration 1. Start with a guide that goes wrong. Here are the first five lines of a made-up first draft for the clinic study, from a guide that runs to nineteen questions.

No.	Question
1	How do you feel about your weight?
2	Why did you stop coming for follow-up?
3	How many times did you come last year?
4	Are you compliant with the diet chart?
5	What is your BMI?

Read it the way a respondent would hear it.

- It opens on the most personal question in the whole study, before the person has said a word about anything easier.
- Question 2 is the “why” trap from the last section. It takes for granted that the person decided to stop, and asks them to defend it.
- “Follow-up”, “compliant”, “diet chart” and “BMI” (body mass index) are the clinic’s words. A patient may not use them, and may not know the last one.
- Every line is a full question to read out. There are no prompts, so every answer the person gives has to be followed by the next line on the sheet.
- Nineteen questions is a questionnaire, not a guide. There is no time left to follow what the respondent says.

WHERE THIS PICTURE BREAKS. The draft is made up, and every fault is put in on purpose. A real first draft usually has one or two of these faults, not all five, and they are harder to see in your own writing than in someone else's.

Illustration 2. Now build the guide properly. Suppose your study question is: why do adult patients with obesity at a district hospital non-communicable disease (NCD) clinic in Chhattisgarh stop coming back for follow-up? The study question can use the clinic's word. The questions you ask patients cannot.

Break the study question into the parts of a patient's experience it covers. Getting to the clinic. What happens at a visit. What happens after it. What being talked to about weight is like. What the person would change. Each part becomes one main question. The guide below is made up for this book. Respondents would be asked in Hindi or Chhattisgarhi.

Part	Question	Prompts, only if not covered
warm-up	Tell me about a usual day for you.	work; who lives at home
main 1	How did you first come to this clinic?	who suggested it; how you travel here
main 2	Tell me about the last time you came here.	the journey; the wait; what happened inside; what you were told
main 3	What happened after that visit?	the tablets; meals at home; the next date on the card
main 4	What is it like to talk about your weight at the clinic?	who brings it up; how it is said; what you do afterwards
main 5	If you could change something about coming here, what would it be?	the day; the place; the people
closing	Is there anything I have not asked about that I should have?	anything you want to ask me

Check the order. The warm-up and main 1 are easy and factual. Main 2 and main 3 are about events. Main 4 is the most personal, and it comes after the person has been talking for a while. Main 5 lets them end on what they would do, not on what was hard.

Check each question against the last section's three checks. Six of the seven are open. The closing question is closed in form, which is fine: a yes is followed by "Tell me". None takes the person's experience for granted. None asks two things. The prompts are not questions to read out. They are notes for you, so that if the person talks about the wait but not the journey, you remember to ask.

Now plan the time. A guide that runs out of time before main 4 has lost the question the study most needs. Here is a plan, which is your own choice, not a rule.

part	planned minutes
warm-up	5
main 1	5
main 2	10

part	planned minutes
main 3	10
main 4	10
main 5	5
closing	5

Add it up.

```
5 plus 5 plus 10 plus 10 plus 10 plus 5 plus 5 = 50
```

The plan comes to 50 minutes. Most of it goes to main 2, main 3 and main 4: the events and the most personal part, where the reasons are most likely to come out. Main 1 is easy and main 5 closes.

Then you try it. Suppose that in your first pilot interview, main 1 gets a one-line answer and main 2 takes twenty minutes. That is not a failure. It tells you to cut main 1's time and give main 2 more. If a question falls flat in two pilots running, replace it. Write the new version of the guide with its date on it.

WHERE THIS PICTURE BREAKS. The guide fits one study question about one clinic. A different study question gives different main questions, even with the same patients. The minutes are a plan, not a finding. A real interview runs to whatever length the respondent needs, and the plan only tells you where you are when you look at the clock.

Main 4 assumes weight is talked about at an obesity clinic, which is the reason the patients are there. At another kind of clinic the same question would carry a premise.

MUST KNOW POINTS FOR YOU.

- A topic guide read out word for word, in order, is a structured interview with extra steps. Change the order to follow what the respondent says, and use their words in your follow-ups.
- Put the easy, factual questions first and the most personal one late, after the person has been talking for a while.
- Write each main question from a part of your study question, and cut any main question you cannot tie to one.
- DeJonckheere and Vaughn suggest five to 10 core questions, their name for main questions. Treat ten as a ceiling for a pilot guide.
- Refuse the clinic's words in your questions: "follow-up", "compliance", "BMI". Use the words patients use, and once a respondent gives you their own word, switch to it.
- A guide on paper cannot tell you whether its questions work. Only a pilot interview can. Keep every version dated, because respondents who heard different versions answered different questions, and your analysis has to know which was which.

EXERCISE 1 (design). Write a topic guide for the five pilot interviews you will run at the end of this book. Choose a study question you can ask of people you can reach who are not your patients. For example: how do families in which one adult has obesity decide what is cooked for the evening meal?

Your guide should have a warm-up question and five to 10 main questions, with prompts under each. End it with a closing question. Add a time plan that adds up. Then put every question through the three checks from the last section.

EXERCISE 2 (critique). A trainee shows you this made-up guide for the clinic study and says it is ready.

1. Warm-up: What is your name, age, address, occupation and monthly income?
2. Do you think obesity is a disease?
3. Tell me about the last time you came to the clinic.
4. Why don't you follow the diet?
5. Closing: Thank you.

Say what to change, in order of how much it matters.

7 · Consent, recording and privacy before you switch on the recorder

Checked against the sources as they stood on 2026-09-25.

DEFINITION. In India the rules a researcher follows with people who take part in health research are set out in the National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. The Indian Council of Medical Research (ICMR) published them in October 2017.

Informed consent, in the guidelines' words, is a process with "three components – providing relevant information to potential participants, ensuring the information is comprehended by them and assuring voluntariness of participation" (section 2.2). The researcher "must obtain voluntary written informed consent from the prospective participant" (section 5.0). Spoken consent, without a signature or thumb impression, is allowed only in exceptional cases, with the approval of an ethics committee, or EC (section 5.3.8).

The information given must say that this is research, its purpose and methods in simple words, how long taking part lasts, any foreseeable risks, and who the research team is, with contact details (Box 5.1). It must include the person's "Freedom of the individual to participate and/or withdraw from research at any time without penalty or loss of benefits" (Box 5.1). It must include how far confidentiality can be kept, and its limits (section 2.3.2). With the ethics committee's permission, what a person said may be disclosed on a court's order, when someone's life is threatened, or for a public-health risk (section 2.3.6).

A person who cannot read gives consent in front of an impartial literate witness (section 5.4.3). A person who cannot sign gives a thumb impression (section 5.4.4).

Privacy is the person's right to control what is collected about them and who sees it. Confidentiality is the researcher's duty to protect what was entrusted, including "from unauthorized access, use, disclosure, modification, loss or theft" (section 2.3). Raw data, audio-visual material included, should be shared only after processing "to mask identifiers" (section 9.2.12).

Every proposal goes to an ethics committee. The committee, not the researcher, decides the kind of review: exemption, a quick review by a few members, or review by the full committee (section 4.8.3, Table 4.2). [100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160]

IN PLAIN TERMS. Before you ask anyone a research question, three things have to be settled. Does the person agree, knowing what they are agreeing to? Do they agree to be recorded? And what will happen to their words afterwards?

In India the rulebook for this is the ICMR's National Ethical Guidelines of 2017. No legislature passed it, so it is not a statute. A statute on personal data also covers recordings, but most of it is not yet in force.

An ethics committee is a group of people at a hospital, college or research body. It reads a researcher's plan before any research starts, and it can say yes, no, or change this first.

Consent, in the guidelines' own words, has three parts. You give the person the information. You make sure they understood it. And you make sure they are free to say no.

Ask about the recorder on its own, and take no for an answer.

Privacy is the person's right to decide who hears about them. Confidentiality is your duty to keep safe what they told you. An interview recording carries a voice, a name, a village, a family story.

Last, the question every learner asks: does my practice interview need an ethics committee? You send the committee its forms, and the committee decides.

Illustration 1. Suppose you are about to interview a woman who comes to the district hospital's NCD clinic in Chhattisgarh — the clinic for non-communicable diseases such as diabetes. She has obesity, and she stopped coming back for follow-up. You want to know why. Here is a made-up exchange, translated from Chhattisgarhi, showing how the first minute can go wrong. You are wearing the clinic's white coat. The recorder is already running on the table.

Speaker	Words
I	Namaste. This is for a study. Just sign here, it is nothing.
R1	What study? Will the doctor see this?
I	Don't worry. So, Sunita-ji, tell me why you stopped coming.
R1	Theek hai. The tablets are good.

Now read it the way the ICMR guidelines would have you read it. Count what went wrong.

The recorder was on before she agreed to anything. She was never asked about it separately.

"It is nothing" is not information. She was not told what the study is, how long it takes, or that she can stop at any time. Box 5.1 of the guidelines lists those among the things she must be told.

She asked the most important question herself: will the doctor see this? It went unanswered. Section 5.3.10 says you must tell her that saying no will not affect "the patient–clinician relationship". In a white coat, in her own clinic, she has every reason to think it will.

You said her name aloud on the tape. Now her name and her reasons for leaving the clinic sit in one file.

And her answer is two words, then praise for the tablets. The guidelines warn that in India people often cannot say no out loud. They name "silence, monosyllabic replies, or restlessness" as signs of refusal (Box 9.4). "Theek hai" here may mean "let me go".

Now do it again, in order. Recorder off. Say who you are and who you are not: "I work on this study. I am not your doctor, and I will not tell the doctor who said what." Explain the study in Chhattisgarhi, in words she uses. Say what stays private, and its limits. Say she can stop at any time, and her treatment stays the same whether she takes part or not. Ask whether she has questions, and wait. If she agrees, take her signature, or her thumb impression if she cannot sign. If she cannot read the form, an impartial literate witness hears it read to her. Then ask, as a separate question: "May I record our talk? Only the study team will hear it, except in the rare cases I told you about." Switch on only after she says yes. Open the recording by speaking her speaker label, R1, and never her name.

WHERE THIS PICTURE BREAKS. The steps here follow ICMR 2017 as issued. They do not tell you what your own institution adds on top. An ethics committee can ask for more, such as a particular form, a translated sheet checked back into English, or a named place to store the files. Its instructions come first.

Illustration 2. Now the question that stops most learners. You plan five practice interviews. Do they need an ethics committee? Do not answer from memory, yours or anyone's. Look it up.

Open the National Ethical Guidelines for Biomedical and Health Research Involving Human Participants on the ICMR website. Search inside the document for "routine questioning". It sits in Table 2.1, on minimal risk. Minimal risk means harm no greater than "that ordinarily encountered in routine daily life activities". That looks like good news for an interview.

Now search for "linked identifiers". It sits in Table 4.2. Exemption from review is for proposals "with less than minimal risk where there are no linked identifiers". Your recording has a voice on it, and her consent form has a name. Is that a linked identifier? You may think not. The guidelines do not let you think it for the committee.

Search for "cannot decide". Section 4.8.3 reads: "A researcher cannot decide that her/his proposal falls in the exempted, expedited or full review category. All research proposals must be submitted to the EC."

Last, search for "Preliminary activity". Section 9.2.12 says notes from observing, made before the research itself begins, "need not be submitted for EC's review". Is a practice interview that kind of note-making? The same passage goes on: any ethical issue in that early phase "should be included in the research proposal for review by the EC". So even this passage sends you back to the committee.

The answer to your question is therefore not yes and not no. It is: fill in the committee's forms (Box 4.4). They include a protocol, the consent sheet in English and the local language, and the questionnaire, here your topic guide. Send them to your institution's ethics committee, and ask it which kind of review applies. You may ask it, with reasons, to consider exemption (section 4.8.3). If you have no institution, this book's suggestion is to ask the ethics committee of the hospital or college where you would do the interviews.

WHERE THIS PICTURE BREAKS. This reading covers the sections of the guidelines named here. Other sections, and later ICMR notices, can change the answer. The guidelines themselves urge

you to check the latest government rules. Whatever you find, the committee's written reply to your plan is what you act on, not your own reading.

MUST KNOW POINTS FOR YOU.

- None of the review categories in the guidelines (Tables 2.1 and 4.2, section 4.8.3) makes an exception for a practice interview. Send your plan to an ethics committee and let it decide, before you record anyone.
- An interview can feel harmless and still carry risk. The guidelines warn that risks in social and behavioural research can be "misconstrued as no/minimum risk research" (Box 9.1). One of the main risks is information getting out. So before you ask for consent, decide where the recordings live: one locked device or folder that only the study team can open. The guidelines ask that access to stored records "should be limited" (section 2.3.5). Do not delete them the day you finish either. Records, data and notes "should be retained for the required period" (section 1.1.10). Your ethics committee tells you how long.
- Ask about the recorder as its own question, after consent to the interview. Someone may agree to talk and refuse to be recorded. Then take written notes instead, or do not go ahead, but never record anyway.
- In a clinic, tell the person in plain words that saying no will not change their treatment.
- In India a person may not say no out loud. The guidelines tell researchers to read silence, very short replies or restlessness as possible refusal, and not to carry on (Box 9.4).
- Keep names out of everything but the consent form. Give each person a speaker label such as R1 and use it on the recording, the file name and the transcript. Keep the signed forms, and the list that joins labels to names, apart from the recordings.
- Tell people the limits of confidentiality, not a promise of perfect secrecy. The guidelines require you to say that it "may not be possible" to protect privacy in every circumstance (section 2.3.2). Name the limits: a court's order, a threat to someone's life, a public-health risk (section 2.3.6).
- The law on recordings is the Digital Personal Data Protection Act, 2023 (Act No. 22 of 2023). It is a statute, passed by Parliament (Book 0, F5). ICMR's guidelines are not. The Act's definitions and its Data Protection Board are in force from 13 November 2025. Personal data is "any data about an individual who is identifiable by or in relation to such data" (section 2(t)). By that definition, a recording or transcript that can identify someone is personal data. That person is the Data Principal. The Data Fiduciary is whoever "determines the purpose and means of processing" (section 2(i)). Recording and storage are processing (section 2(x)). The rest of the Act starts later: notice, consent, withdrawal, the duties and the exemptions. They start "eighteen months from the date of publication" of notice G.S.R. 843(E). 13 November 2025 + 18 months = 13 May 2027. Until then they are law on paper, not yet in force. From then, section 17(2)(b) exempts processing "necessary for research". The data must not be used to decide something about the person. And the work must meet the standards in the 2025 Rules (Second Schedule). It must be lawful and for that purpose only. It uses only the data needed,

> kept accurate, kept safe, and kept only while needed. One person is accountable. The Act does not define "research". It does not say whether a practice interview counts. It does not mention ethics committees. So your ethics committee and institution still decide. Plan as if the duties applied, because ICMR 2017 already asks for most of them. A legal question goes to a lawyer.

EXERCISE 1 (design). A patient of the NCD clinic stopped coming for follow-up, and you are about to interview her. Write what you will say before the first question, in the order you will say it. Write it as spoken sentences, not headings. Then write one line saying when the recorder goes on.

EXERCISE 2 (critique). A colleague writes: "It's only a practice interview with a clinic patient, so it's minimal risk under ICMR. That means no ethics committee. I'll record in the waiting area so she is comfortable." Find each claim that the guidelines do not support.

EXERCISE 3 (teaching). A first-year resident wants to "just chat" with five patients from the NCD clinic about why they stop coming. They plan to record on a phone and use the recordings in a presentation. You have ten minutes and a whiteboard. Teach them what has to happen first.

8 · Running the interview without leading it

DEFINITION. A semi-structured interview runs through the same parts in the same order: opening, questions, close. Within them it follows the respondent.

It opens with who you are, why you are talking to this person, the consent steps and the recorder. The first question after that is an open one the respondent can answer easily.

From then on the interviewer's main work is listening. The interviewer follows the respondent's words with probes. In this book a probe is a short follow-up that asks for more of what the respondent just said without suggesting what that should be. DeJonckheere and Vaughn list, among others, a pause, after a question or when the person trails off ("wait time"), repeating or summarising the respondent's words ("echo"), short affirming words such as "yes... okay..." ("verbal agreement"), asking them to say more ("expansion") and asking what they meant by a word ("explanation"). Their table also has a probe they call "leading": asking the person to explain their reasoning, in their own words. That is not leading in this book's sense. Britten warns against summarising too early, so echo their words rather than your summary.

Either person may leave the topic guide to follow an idea. Britten stresses that the interviewer keeps control, knowing what they want to find out. So come back to the guide when a thread has stopped giving new material, or time for the remaining questions is running out. Come back through their words: "You said earlier that ... Can I ask about ...?" On Whyte's scale, which Britten prints, probing an idea from earlier is less directive than introducing a new topic.

The interviewer does not judge, teach, advise or correct. Questions the respondent asks can be answered at the end.

The interview closes in order: any answer you promised, the guide's closing question, thanks, then the recorder off. [161, 161, 162, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 173, 173, 175, 176, 176, 176, 177, 177, 177, 178, 179, 180, 181, 182, 183]

IN PLAIN TERMS. Listening sounds passive. It is not. You are deciding, all the time, which of the person's words to follow.

You stay quiet and wait. You repeat the person's own words back. You say "tell me more", or "can you give me an example?", or "what do you mean by that?". None of these adds an idea of yours.

Some things feel helpful and damage the interview. Giving advice is one. So is correcting a wrong belief, or finishing the person's sentence. Agreeing with what they said, as opposed to showing that you heard it, is another. Each one tells the person what you think.

Then write field notes (DeJonckheere and Vaughn call them memos) — what happened, where, how it felt, what surprised you. This book's rule is to write them the same day.

Illustration 1. Here is a made-up exchange, translated from Hindi, from the running example: the district hospital non-communicable disease (NCD) clinic in Chhattisgarh, and patients with obesity who stop coming back. The respondent, R2, is a man who works for a daily wage. Read it and count the moments where the interviewer, I, takes the interview away from him.

Speaker	Words
I	Tell me about the last time you came to the clinic.
R2	That was before the rains. After that, the bus fare, and the queue...
I	...takes the whole day, yes. But the doctor does need to check your sugar every month.
R2	Yes, madam.
I	So you will try to come next month?
R2	Yes, I will come.

There are three. First, I finished his sentence, so the words about the queue are the interviewer's, not his. Second, I gave clinic advice. Now he is a patient being told what to do, and his next answer is the one a patient gives. Third, I asked a closed question with the answer built in. "Yes, I will come" is the least useful line in the transcript. It is what anyone would say to that question, so it tells you almost nothing about him.

Now the same moment, run the other way. This version is made up too.

Speaker	Words
I	Tell me about the last time you came to the clinic.
R2	That was before the rains. After that, the bus fare, and the queue...
I	(waits)
R2	The queue is the whole day. If I come here, I do not work that day. No work, no money.
I	No work that day.
R2	And my son says, why go? They only tell you to lose weight.
I	Tell me more about what your son says.

Name what the interviewer did. A pause, until he finished his own sentence. An echo, "no work that day", in his words. Then an expansion, "tell me more", on the thread he opened.

Now look at your guide. Its next question was about the tablets. Leave it for now. The son's view of the clinic is a reason for not coming back that your guide did not have. Follow it to its end, and come back to the tablets after.

WHERE THIS PICTURE BREAKS. A pause works when the person is gathering words. It fails when they have finished and are waiting for you, or are uneasy. A silence that runs on can feel like pressure, and in the consent section's terms a very short reply or restlessness may be a sign they want to stop. Then ask, in plain words, whether they want to go on.

Illustration 2. Here is a made-up moment from later in the same interview. R2 turns to you.

Speaker	Words

R2	Madam, if my sugar is fine now, can I stop the tablet?

You may know the answer. If you are a clinician, the pull to answer is strong. Answer it now, and you undo the last half-hour. You become the clinic again, and he goes back to saying what a patient says. Refuse flatly, and he may stop answering you.

Britten (1995) offers a middle way: say that such questions can be answered at the end. She notes this is not always satisfying. So say it with care, and keep the thread open:

Speaker	Words
I	That is an important question. I am not the right person to answer it, but before I go I will tell you who at the clinic can. What makes you think about stopping it?

At the end, keep your word. Give him the name of the clinic's doctor or nurse to ask. Ask your topic guide's closing question. Then thank him for helping you understand his experience, and switch off the recorder.

The same day, before you listen again, write your field notes: the setting, the person, your own slips. Three made-up lines: "Sat on the bench outside the clinic; queue noise throughout." "He went quiet after asking about the tablet." "Surprised: the son's view." These notes are what you will need when you read the transcript later.

WHERE THIS PICTURE BREAKS. Waiting until the end works for questions that can wait. It stops working when what the person says suggests danger to their life or someone else's. The Indian Council of Medical Research (ICMR) guidelines give researchers a responsibility to disclose such information to save life. If such findings are likely, the guidelines want the plan in the protocol. Know that plan before the interview, not during it.

MUST KNOW POINTS FOR YOU.

- Running an interview well does not mean never steering. Britten's point is that the amount of steering should be right for the moment, not zero.
- Showing you heard is not agreeing with what was said. "Yes... okay..." keeps a person talking. "You are right, the diet is impossible" tells them which answer you like, and the next answers will lean towards it.
- Before you say a probe, check it for words the respondent has not used. A probe made of their words, a pause, or "tell me more" adds nothing of yours. A probe that brings in a new word, such as "was it the cost?", has already suggested the answer.
- When a respondent says something medically wrong, do not correct it. What they believe is the data.
- If a respondent asks you a medical question, say you will come back to it at the end. Then do come back to it: give them a name at the clinic to ask. Answering in the middle turns the interview into a consultation.
- Write field notes after every interview; DeJonckheere and Vaughn call them memos. This book's rule is to write them the same day, before you listen again. The recording

keeps the words. It does not keep the room, who else was near, or the moment the person went quiet.

- What someone says after the recorder is off goes in your field notes, marked as said off the recording. Ask before you use it, because they chose not to say it on the record. This is the book's advice; no source covers it.
- If what a person says suggests danger to their life or another's, the ICMR guidelines give you a responsibility to disclose it to save life. Know your protocol's plan for this before the interview starts, and say the limits from the consent section's script (section 7).

EXERCISE 1 (critique). Here is a made-up exchange from an interview at the NCD clinic, translated from Chhattisgarhi. R4 is a woman who stopped coming for follow-up. Find each line where the interviewer takes the interview away from her, say what the line does, and rewrite it.

Speaker	Words
I	What was it like, coming here for your check-ups?
R4	The sister (the nurse) weighs me in front of everyone. Then the doctor...
I	I know, the doctors can be very strict about weight.
R4	Hmm.
I	You should still come, though. Obesity leads to diabetes.
R4	Yes.
I	Was it the weighing that stopped you, or the travel?

EXERCISE 2 (design). Here is a made-up answer from a respondent. "After my knee got bad, I stopped walking to the bus stand. And my daughter-in-law does not like to bring me." Write three probes, each of a different kind, that use no word the respondent did not use. Name the kind of each.

EXERCISE 3 (teaching). A first-year resident has just run a practice interview. Every time the patient spoke, the resident said "Right, exactly". They think this built rapport. You have ten minutes and a whiteboard. Teach them what it did.

9 · The interviewer is part of the data

Checked against the sources as they stood on 2026-09-24.

DEFINITION. What a respondent says in an interview depends in part on who is asking, and where.

Britten (1995) states the general case. Researchers "need to consider how they are perceived by interviewees and the effects of characteristics such as class, race, sex, and social distance on the interview". The problem is sharper when the interviewer is a doctor. A respondent who is, or may become, a patient "may wish to please the doctor by giving the responses he or she thinks the doctor wants". The place matters too: "The setting of an interview affects the content".

Mays and Pope (2000) make the effect something a study must report. Reflexivity, in their words, "means sensitivity to the ways in which the researcher and the research process have shaped the collected data".

None of these sources measures how large the effect is. Where the interviewer is a doctor or clinic staff, Britten names the direction: towards what the respondent thinks the doctor wants. Whatever the direction, it is the same in every interview one person runs in one setting. By Book 0's reasoning on systematic error, that makes it bias, and more such interviews do not shrink it. [176, 176, 176, 176, 184, 185, 186, 186, 163, 187, 187, 188, 189, 126, 190]

IN PLAIN TERMS. People answer the person in front of them. Many patients will say what they think the doctor would like to hear. The same patient, talking at home to someone with no link to the clinic, may say something quite different.

Age, sex, class and the job you do all tell the person something about you. So does the place. A consultation room and a kitchen draw out different stories.

Because the pull is the same in every interview one person runs, it is bias: an error that points one way and does not shrink when you collect more. Twenty interviews by the clinic's own doctor do not cancel it. They repeat it twenty times.

What you can do is make the pull weaker, and make it visible. Say who you are and who you are not. Promise, truthfully, that the clinic will not know who said what, and say the limits you gave at consent (section 7). Interview where the person is at ease. Then write down who you were to them, so that anyone reading your transcripts can judge.

Illustration 1. Here are two made-up answers from the running example, translated from Chhattisgarhi. They show the direction of the pull. They are not a measurement of it. Suppose two different interviewers each talk to R3, a woman with obesity who stopped coming to the district hospital's non-communicable disease (NCD) clinic.

In the first, the clinic's own medical officer asks, in her white coat, in the consultation room, during clinic hours.

Speaker	Words
I	Tell me about coming to this clinic.
R3	The clinic is very good, doctor. Everyone is kind. We get busy at home, that is all.

In the second, a researcher with no job at the hospital asks the same question in R3's kitchen. Earlier, the researcher said: "I do not work at the clinic, and the clinic will not know who said what."

Speaker	Words
I	Tell me about coming to this clinic.
R3	The last time, the doctor said if I do not lose weight there is no point coming. In front of the others. After that I did not want to go.

Read the first answer with Britten's sentence in mind: a patient "may wish to please the doctor". Praise, and a reason that asks nothing of the clinic, is what that pull would produce. It may also be true. You cannot tell from the answer alone. That is exactly the difficulty.

Now suppose the medical officer interviews twenty patients the same way. Each of the twenty meets the same person, the same coat and the same room. The pull is in every interview. So the twenty answers do not scatter around the truth and average out. They lean the same way together. That is Book 0's systematic error, which more readings on the same instrument do not remove.

WHERE THIS PICTURE BREAKS. The two answers are invented to show a direction, and the second is not "the truth" just because it is critical. An interviewer from outside the clinic brings their own pull. A respondent may, for example, tell a stranger a harsher story than the one they live with. Moving the interview changes the push. It does not remove it.

Illustration 2. Now suppose you are the one with the white coat. You are a doctor at this hospital, and your five pilot interviews will be with people who know the clinic. Here is what you can do about the pull at this stage.

Do not interview your own patients if you can avoid it. Britten says so directly. If you cannot avoid it, tell them in plain words that they may say what they really think. Then do not correct them when they say something you believe is wrong.

Take off the coat. Say who you are and who you are not before the first question: "I am a doctor here, but today I am not your doctor. Nothing you tell me will change your care, and the clinic will not know who said what." DeJonckheere and Vaughn advise telling people that their answers will not influence their care.

Choose the place with them. Britten notes that the setting changes what is said, and that home is usually better. At home, notice who else can hear.

If you need an interpreter, choose with the same care. The Indian Council of Medical Research (ICMR) guidelines advise against using a person from the respondent's own village, "keeping in mind the hierarchies existing in the context".

Then write field notes about yourself, the same day. A made-up example:

Field note	Why a reader needs it
I am a doctor at the district hospital, though not in the NCD clinic. R3 knew this.	Her answers may lean towards what a doctor wants to hear.
We sat in her kitchen. Her husband came in for the last ten minutes.	She may have said less once he could hear.
I said "that must be hard" twice about the bus fare.	That line is agreement, not a neutral probe.

This is what Mays and Pope call reflexivity: showing how you and your methods may have shaped the data, so a reader can judge it.

WHERE THIS PICTURE BREAKS. These steps weaken the pull and record it. They cannot tell you how much of any one answer it shaped. Some pulls, such as the power differences the ICMR guidelines note between researchers and participants in India, run deeper than a removed coat. They are taught in the next level of this subject.

MUST KNOW POINTS FOR YOU.

- Doing more interviews does not average out the interviewer. To change it, change the interviewer or the setting. Adding interviews will not.
- A run of praise from patients interviewed by their own clinic's staff is not evidence that the clinic is liked. Before you accept such a finding, ask who did the interviews and where.
- Do not interview your own patients for research if you can avoid it.
- Before the first question, say who you are and who you are not. Say that nothing the person says will change their care, and repeat the limits you gave at consent.
- Write field notes about yourself, not only about the respondent. Record who you are to them, where you sat, who else could hear, and any moment you steered. You cannot report what you did not write down.
- In India, power differences make it hard for people to refuse a researcher outright, as the ICMR guidelines note. Expect more agreement than people feel.
- None of the sources this section rests on puts a size on the interviewer's effect. When a finding depends on it, one check this book suggests is to compare what different interviewers heard. It is taught in the next level of this subject.

EXERCISE 1 (interpretation). A made-up report on the NCD clinic says: "All 12 patients interviewed by the clinic's diabetes educator said they were satisfied with the service. Missed follow-

up is therefore not due to dissatisfaction." Say what this finding shows, what it does not show, and what you would ask first.

EXERCISE 2 (design). Plan the part of your five pilot interviews that deals with who you are. Write the two or three sentences you will say about yourself before the first question. Then write the headings of the field notes you will fill in about yourself after each interview.

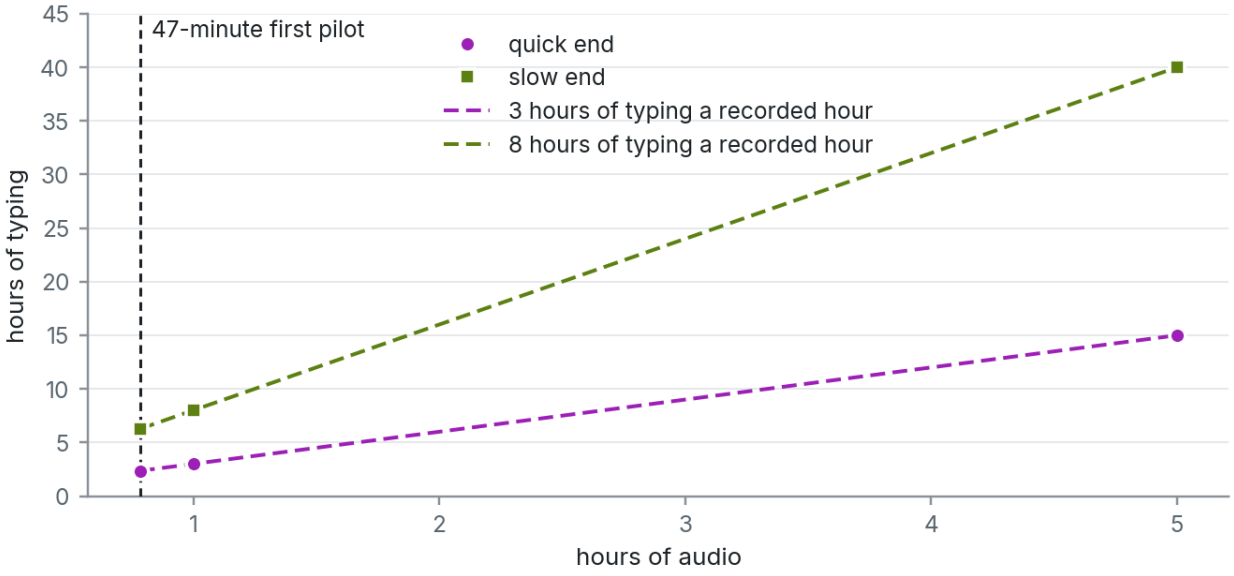
EXERCISE 3 (teaching). A journalist has three minutes. A hospital has told them: "Our interviews show patients love the NCD clinic." Help them decide what to ask the hospital, with no jargon.

10 · Recording and transcribing

DEFINITION. An audio recording of an interview is the record of what was said. A transcript is a written version of that recording, made by a person or a program, and it is the text that analysis works on. [191, 192, 193, 193, 193, 194, 195, 196, 197, 197, 198, 198, 199, 200, 201, 202]

IN PLAIN TERMS. The recording is what was said in the room. The transcript is what you will read, mark and quote from for the rest of the study. They are not the same thing.

Full verbatim keeps everything: every filler, every repeated word, every broken-off sentence. Cleaned transcription (papers often call it intelligent verbatim) tidies speech into readable sentences and drops the fillers and repeats. Choose before you start, write the choice down, and use it for every interview.



Typing time rises in step with the length of the recording: 3 hours of work for each hour of audio at the quick end of McMullin's range, 8 at the slow end. The 47-minute first pilot, 0.7833 of an hour, needs 2.35 to 6.27 hours. Five pilots of about an hour need 15 to 40 hours, and 40 is not a ceiling.

ILLUSTRATION. Suppose you are interviewing a woman at the district hospital non-communicable disease clinic in Chhattisgarh. She has stopped coming for follow-up, and you want to know why. What follows is a made-up stretch of that interview, about twenty seconds of it, written in English.

Here is the trap. Two people can type those twenty seconds and produce two different transcripts, and both can say they wrote down "what she said".

First, the full verbatim version. `I` is you, the interviewer. `R1` is the respondent.

Speaker	Words
I	And after that, what happened?
R1	After that... um... I, I did not- I thought I will come next month. [pause, 4 seconds] But my husband, he said, what is the use, you are going there and the weight is not going.
I	Mm-hm.
R1	[laughs] So. My son [son's name] also cannot take leave. [inaudible, 00:12:41] and the bus also.

Now the cleaned version of the same twenty seconds.

Speaker	Words
I	And after that, what happened?
R1	After that I thought I will come next month. But my husband said, what is the use, you are going there and the weight is not going. So my son also cannot take leave, and the bus also.

Read the two side by side. Here are five of the things the cleaned one dropped.

- The broken-off "I did not-".
- The four-second pause before her husband comes in.
- The laugh before "So".
- Your own "Mm-hm", a whole turn of yours, gone.
- The place where something could not be heard.

Now ask whether any of that matters for your question. A reader of the cleaned version sees a smooth list of reasons. A reader of the full version sees her hesitate at one of them.

There is no single standard set, so here is one simple set to use in your pilot.

Mark	What it means
I, R1, R2	who is speaking: you, then each respondent by number
[pause, 4 seconds]	a silence long enough to notice, with its length
[laughs]	a sound that is not a word
did not-	a word or sentence broken off
[inaudible, 00:12:41]	could not be heard, and the minute and second on the recording where it falls
[son's name]	a name taken out, replaced by who the person is

The time on the inaudible mark is what lets you, or anyone checking you, go straight to that second of the recording.

McMullin puts transcription at between three hours and over eight hours of work for one hour of audio, depending on typing speed. You plan five pilot interviews. Suppose each one runs about an hour. A shorter one is a fraction of an hour: 30 minutes is 30 divided by 60 = 0.5 hours. Work out the typing time at each end of her range.

```
5 times 3 = 15 hours at the quick end
5 times 8 = 40 hours at the slow end
```

Forty is not a ceiling. Plan the hours before you book the interviews, not after.

Figures quoted in this illustration are from [203].

WHERE THIS PICTURE BREAKS. The exchange is made up, and it is written in English. A real recording would be in Chhattisgarhi. Putting it into English adds a second set of choices. This example does not show those.

The hours are for one person typing from a recording. They do not tell you how long it takes to check a draft made by speech-to-text software.

MUST KNOW POINTS FOR YOU.

- A transcript is not the recording. Keep the recording until your analysis is finished. When a quotation or a reading turns on one line, go back and listen to that line.
- Decide full verbatim or cleaned before you type a word. Write the choice at the top of each transcript, and use the same one for all five pilots. There is no one best style. For a pilot, this course advises full verbatim, because the point of a pilot is to hear your own interviewing, and cleaning takes out the fillers, interruptions and half-questions that show it.
- Budget three to more than eight hours of typing for every hour of recording.
- Speech-to-text software gives you a first draft, not a transcript. Check every line of a machine draft against the recording. Before a patient's voice leaves your own recorder, ask your institutional ethics committee where it may be kept.
- A transcript holds only what the recorder caught: not faces, gestures or the room. For those go to your field notes, and say when a reading rests on them.
- Putting their words into English is a second round of choices on top of transcription. This course's advice: transcribe in the language spoken, translate only the passages you quote, and note who translated and any word left untranslated. Say which version any count or quotation comes from, so that anyone checking you can find the words.
- Some papers say only "interviews were recorded and transcribed". Ask who transcribed, full verbatim or cleaned, and whether anyone checked the text against the audio.

EXERCISE 1 (calculation). Your first pilot recording runs 47 minutes. McMullin's range is three hours to over eight hours of work for one hour of audio. Work out how long transcribing it could take at each end. Give the answers in hours, to one decimal place, and say which of the two you would plan around.

Record your confidence as a percentage before turning to the answer.

EXERCISE 2 (critique). Here is the whole of what a made-up draft report says about its transcripts.

> *Interviews were conducted in Chhattisgarhi with twelve patients, recorded, and transcribed.*

List what a reader cannot tell from this sentence, and say for each why it matters to someone judging the findings.

11 · Who did the talking: the talk share

DEFINITION. A turn is one unbroken stretch of speech by one speaker in a transcript. A word, for this count, is whatever stands between two spaces in the transcript being counted. Speaker labels and bracketed marks are not counted. A broken-off word and an "Mm-hm" are.

The interviewer's talk share for one interview is the number of words the interviewer says, divided by the number of words everyone says, multiplied by one hundred. The respondent's talk share is one hundred minus the interviewer's. The respondent-to-interviewer ratio is the respondent's words divided by the interviewer's words.

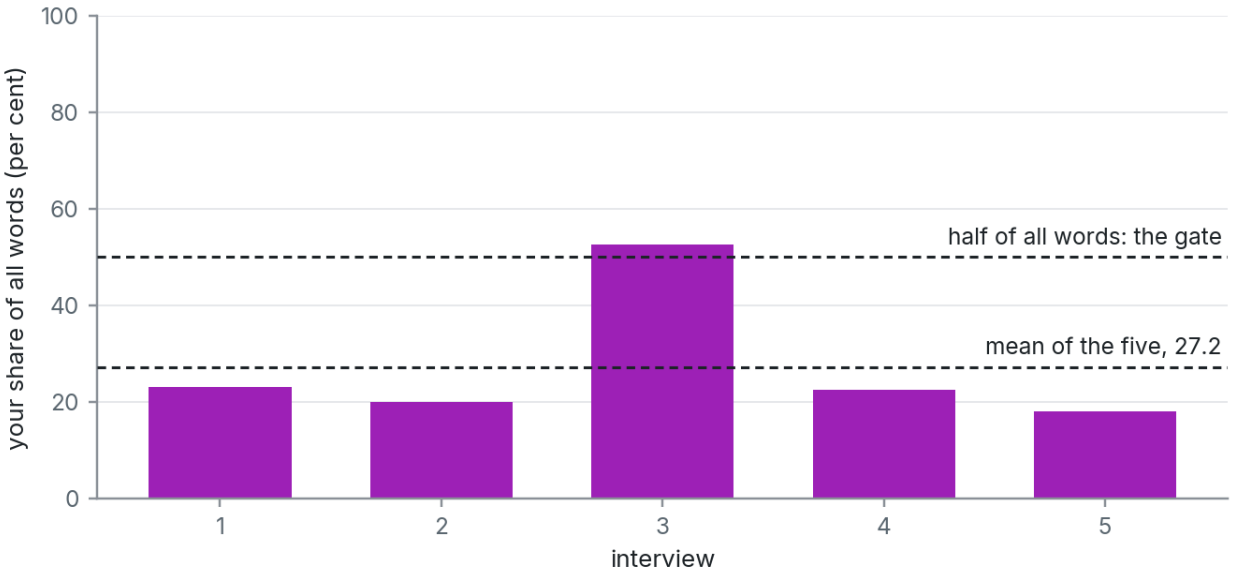
Across several interviews, the mean share is the sum of the interviewers' shares divided by the number of interviews. The pooled share is all the interviewer's words across the interviews divided by all the words. The two can differ when the interviews differ in length. When every interview is the same length, they are equal. [204, 174, 205]

IN PLAIN TERMS. This book ends with a simple test. In your interview, did the respondent speak more than you did?

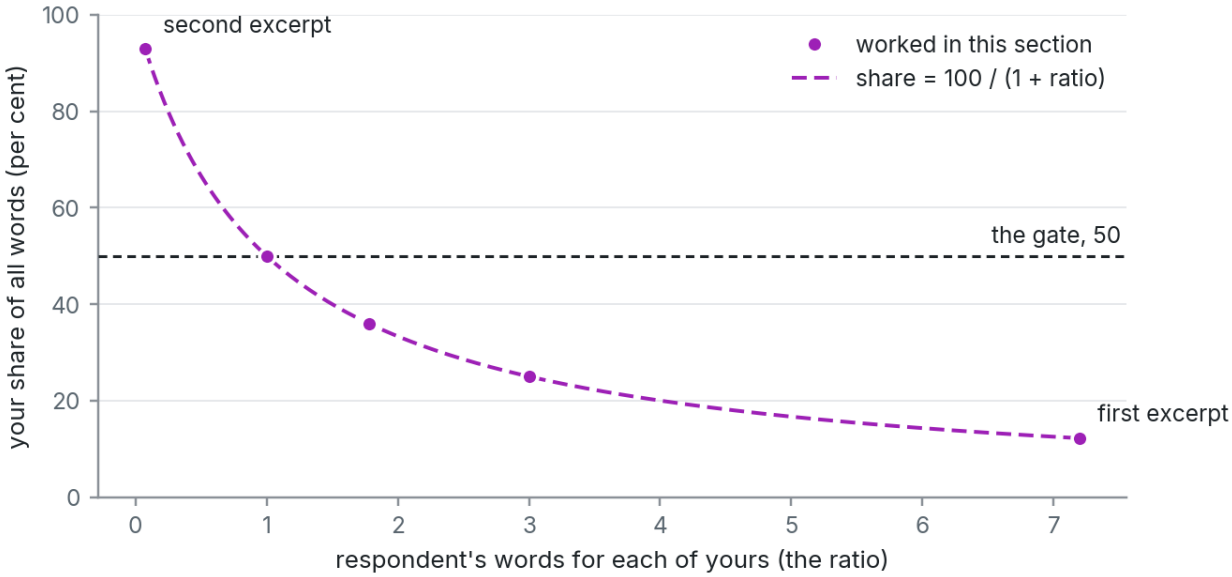
Your words divided by all the words, times a hundred, is your share. If it is under 50 per cent, the respondent spoke more.

Count words, not turns.

A low share is good news about one thing only: who spoke more. It cannot tell you whether your questions pushed the answers in one direction. For that you read the questions.



Your share of the words in each of five made-up pilot interviews: 23.0, 20.0, 52.5, 22.5 and 18.0 per cent. Their mean, 27.2 per cent, sits well under half. Interview 3 is over half on its own.



The share and the ratio are two readings of the same count. Your share is 100 divided by 1 plus the respondent's ratio. A ratio of 1 is a share of 50 per cent, the gate. R1's 7.2 is your 12.2 per cent; R2's 0.0769 is your 92.9.

Illustration 1. Suppose you have interviewed two women at the district hospital non-communicable disease (NCD) clinic in Chhattisgarh. Both have stopped coming back for follow-up. Here are two made-up stretches of those interviews, put into English from Chhattisgarhi. `I` is you.

The first one.

Speaker	Words
I	What happened after your last visit here?
R1	I went home with the tablets and the diet paper. The tablets finished in a month. To get more I had to come back, and coming back means a whole day. My husband drops me at the bus stand at seven, and the clinic bus is often full.
I	A whole day?
R1	Yes. By the time the doctor sees me it is afternoon. Then there is the line at the pharmacy. I reach home after dark and the cooking is not done.
I	Tell me more about that.
R1	My mother-in-law does not say anything, but I can see she is tired. So the next month I thought, let the tablets wait. And then I did not come again.

The second one.

Speaker	Words
I	Last time you were here the doctor gave you tablets and a diet chart and asked you to come back in a month, and you did not come, so I wanted to ask whether it was the distance or the cost or something about the clinic itself, because many patients tell us the waiting is very long?
R2	The distance.

I	The distance. So is it the bus fare, or is it more that it takes the whole day and you have work at home and cannot leave the children?
R2	The whole day.
I	I see. And did anyone at home say anything about you coming here, or did they support you?
R2	They support me.

Here is the trap. Count the turns first. In each excerpt you spoke three times, and the respondent spoke three times. By turns, both are an even split. By turns, the two interviews look the same.

Now count words. A word is whatever stands between two spaces, so “mother-in-law” is one word. Count each turn, then add up each speaker’s turns.

```
first excerpt, you: 7 plus 3 plus 5 = 15 words
first excerpt, R1: 48 plus 30 plus 30 = 108 words
second excerpt, you: 57 plus 29 plus 18 = 104 words
second excerpt, R2: 2 plus 3 plus 3 = 8 words
```

Now each share. Your words, divided by all the words, times a hundred.

```
15 plus 108 = 123 words in the first excerpt
15 divided by 123 = 0.1219…
0.1219… times 100 = 12.2 per cent
104 plus 8 = 112 words in the second excerpt
104 divided by 112 = 0.9285…
0.9285… times 100 = 92.9 per cent
```

Excerpt	Your turns	Respondent’s turns	Your words	Respondent’s words	All words	Your share (per cent)
first	3	3	15	108	123	12.2
second	3	3	104	8	112	92.9

The same three turns each. In one you said about an eighth of the words. In the other you said more than nine words in every ten.

The ratio says the same thing another way. Divide the respondent’s words by yours.

```
108 divided by 15 = 7.2
8 divided by 104 = 0.0769…
```

In the first, R1 said 7.2 words for each one of yours. In the second, R2 said less than a tenth of a word for each of yours. Above 1 means the respondent spoke more.

The ratio gives your share back. For each 1 word of yours, R1 said 7.2. So all the words come in parts of 1 plus 7.2, and your part is 1 of them.

```
100 divided by (1 plus 7.2) = 12.2 per cent, your share again
```

Look at what the second interviewer did with all those words. The answers are offered inside the questions, the distance or the cost, and R2 picks one. The section on open, closed and leading questions showed why that happens.

WHERE THIS PICTURE BREAKS. Both excerpts are made up and short. A real interview runs to thousands of words, and the share over a whole interview can differ from the share over any stretch of it.

The counts are of the English version. The same talk counted in Chhattisgarhi would give other numbers. The two speakers' counts need not change by the same amount, so compare shares only when both were counted on the same version.

Illustration 2. Now suppose you have done all five pilot interviews for this book and transcribed them. The word counts below are made up, to show the move.

Interview	Your words	Respondent's words	All words	Your share (per cent)
1	1,150	3,850	5,000	23.0
2	800	3,200	4,000	20.0
3	2,730	2,470	5,200	52.5
4	1,080	3,720	4,800	22.5
5	900	4,100	5,000	18.0

Work out each share the same way as before. Here is interview 3, the one that stands out.

```
2,730 divided by 5,200 = 0.525
0.525 times 100 = 52.5 per cent
```

Now the mean of the five shares, as Book 0 taught the mean: add them, then divide by how many there are.

```
23.0 plus 20.0 plus 52.5 plus 22.5 plus 18.0 = 136
136 divided by 5 = 27.2 per cent
```

A mean of 27.2 per cent sounds like a clear pass. It hides interview 3, where you said more than the respondent did. Four interviews passed the gate and one did not.

So open transcript 3 and find where your words went. Suppose you find it quickly. Halfway through, the respondent asked what the numbers on her report meant. You spent several minutes explaining them, as you would in clinic. That is a useful thing to find in a pilot. The respondent asked a clinical question, and you slipped from interviewing into consulting.

Why aim well below half, and not just below it? Your counts depend on choices from the last section. A cleaned transcript drops your "Mm-hm"s and her repeats. A count on the English version differs from a count on the Chhattisgarhi one. A share of 48 per cent can become 52 per cent under a different counting rule. A share of 25 per cent is very unlikely to. The gate asks only that the respondent speak more. A wide margin means the answer does not depend on how you counted.

You can also work backwards, from a share and one count to the other count. Suppose you know only that in interview 2 the respondent said 3,200 words and your share was 20 per cent. Her words are the other 80 per cent of all the words.

```
100 minus 20 = 80 per cent
3,200 divided by 0.80 = 4,000 words in all
4,000 minus 3,200 = 800 words, yours
```

That is interview 2's row in the table.

You will not find this rule in the methods papers. DeJonckheere and Vaughn advise "prioritising listening over talking", and they set no number. The 50 per cent line is this course's own gate for this book.

WHERE THIS PICTURE BREAKS. The five counts are made up. Real pilot interviews vary more in length than these, and the more they vary, the further the mean share can sit from the share of all your words taken together.

Nothing in the table says whether the respondents' long answers were their own. A respondent can speak at length in answer to a leading question and still have the gate met.

MUST KNOW POINTS FOR YOU.

- Count words, not turns. Turns alternate, so they split close to evenly in almost any interview.
- The share and the ratio are different numbers. Say which one you are quoting.
- A low talk share does not show that you did not lead. Once the share passes, read your own questions for leading, turn by turn. The count cannot do that part for you.
- A mean share across five interviews can pass while one interview fails. Report each interview's share, and open the transcript of any that sits near or above half.
- Aim well under half, not just under it. Write down how you counted beside every share you report.
- The 50 per cent line is this course's gate, not a published standard.
- When a trainee says "I barely spoke", ask for the two word counts.

EXERCISE 1 (interpretation). Do this on the transcript of your first pilot interview (section 14). Until then, use the two excerpts above. Count your words and the respondent's, and work out your talk share. Then find your three longest turns and read them. For each, say what you were doing with those words, and whether the respondent's next answer took up your words or her own.

PRACTICE. Eleven problems on this technique, easiest first. Work them on paper before turning to the answers, which are in the appendix at the back under this section's name.

1. In a transcript, the interviewer says 450 words and the respondent says 1,350. Work out the interviewer's talk share, the respondent's talk share, and the ratio of the respondent's words to the interviewer's.

2. A respondent's talk share is 64 per cent. What is the interviewer's share? What is the ratio of the respondent's words to the interviewer's?

3. Count the words in each line, then give the first speaker's share of all the words, to one decimal place.

> *What did you eat yesterday, from morning to night?*

> *Tea in the morning, then rice and dal at noon, and roti at night.*

4. Here is a made-up stretch of a transcript from the NCD clinic, put into English from Hindi.

Speaker	Words
I	How did you first come to this clinic?
R4	The health worker in our village told me. She checked my pressure at the village centre and said it was high, and that I should get my sugar tested at the district hospital.
I	What was that first visit like?
R4	Long. I left the children with my sister. The doctor was kind, but she wrote many things on the paper and I could not read all of it.
I	And what did you do with the paper?
R4	I kept it in the tin with the ration card.

Work out the interviewer's talk share over this stretch, and say whether it would meet the gate.

5. Here are the word counts from five practice interviews.

Interview	Interviewer's words	All words
A	600	4,000
B	1,400	3,500
C	900	4,500
D	700	5,000
E	2,100	3,000

Work out the interviewer's share in each, the mean of the five shares, and which interviews met the gate.

6. In a practice interview, the respondent said 3,500 words. You want your talk share to be no more than 30 per cent. What is the largest number of words you could have said?

7. Here is a worked answer. Find the step that broke.

```
interviewer: 22 turns, 1,100 words
respondent: 22 turns, 4,400 words
22 turns each, so the interviewer's share is 50 per cent
so the gate was not met
```

8. Here is a worked answer. Find the step that broke.

```
I said 1,200 words and R2 said 4,800 words
1,200 divided by 4,800 = 0.25
so my talk share was 25 per cent
```

9. Here is a worked answer. Find the step that broke.

```
interview A: I said 200 words, the respondent 800, so my share was 20 per cent
interview B: I said 3,000 words, the respondent 2,000, so my share was 60 per cent
20 plus 60 = 80
80 divided by 2 = 40
so across the two interviews I said 40 per cent of all the words
```

10. A trainee hands you this note about a practice interview, with the stretch of transcript it is about. The exchange is made up.

> *I barely spoke in this part. R3 did nearly all the talking.*

Speaker	Words
I	Most of our patients tell us the diet is too hard to follow when you are cooking for a whole family, so I think you also found it hard, no? Tell me about that.
R3	Yes, it is hard. I cook for six people. They want rice and I am told to eat less rice, so I make two things, and that is too much work, so I stopped.
I	So the diet was the reason you stopped coming?
R3	Yes, the diet.

Decide what to compute, compute it, and say what your answer does not establish.

11. A colleague's pilot report says:

> *All five of my pilot interviews met the gate. My average talk share was 38 per cent.*

The appendix gives the five shares as 22, 31, 64, 35 and 38 per cent. Decide what to compute, compute it, and say what your answer does not establish.

12 · Reading a transcript, and what a code is

DEFINITION. Reading a transcript for analysis starts with reading all of it once. On the second reading you mark each passage that bears on the study question. You write a short label beside it. That label is a code.

A memo is a note, written while you read, of what you notice and what you want to ask next. Field notes (section 8) are written straight after the interview. Some authors call both memos.

A passage that runs against the pattern the other passages seem to show is a deviant or negative case. It is kept and marked, not dropped, because it is what tests and sharpens the pattern. [206, 206, 207, 208, 208, 209, 210, 211, 211, 212, 173, 213, 213]

IN PLAIN TERMS. First, read the whole transcript once, start to end, with the pen down.

Then read it again, line by line. When a passage bears on your question, mark it. Write a short label in the margin saying what it is about. That label is a code.

A passage is the stretch that says one thing. It bears on the question if it says something about why the person came or stopped.

Keep a memo as you go.

Watch for the passage that does not fit. Mark it and keep it. It tells you where your pattern stops being true.

Last, you do not wait until every interview is done. You read the second transcript before the third interview, and what you read changes what you ask.

ILLUSTRATION. Suppose you are running the practice interviews for the clinic question: why do adult patients with obesity stop coming back to a district hospital clinic in Chhattisgarh? The exchange below is made up, and translated from Hindi. The respondent, R2, is a woman in her fifties who came for a year and then stopped.

Speaker	Words
I	Tell me about the last time you came to the clinic.
R2	It was in the rains. The bus from our village goes only in the morning, so I lose the whole day. My son has to take leave to bring me.
I	Mm.
R2	And that time the sugar was fine. The doctor said it is under control. So I thought, if it is fine, why go every month?
I	You said the sugar was fine. What was coming every month for, then?
R2	Standing in the line for the weighing. Everybody is there. The sister reads the number out loud. I did not want the whole line to hear it.

Read all six lines first, pen down.

Passage	Code
The bus goes only in the morning, so I lose the whole day	a whole day lost to one visit
My son has to take leave to bring me	needs family to take time off
If it is fine, why go every month?	"if it is fine, why go"
The sister reads the number out loud	weighed in front of the line

The third label is her own words, because nothing you could write names it better.

Then write a memo. For example: "Distance came up first, but she did not stop when the bus was hard. She stopped after she was told her sugar was under control. Next time, ask what a visit is for, in their words. Ask what happens from the moment they arrive, and do not name the weighing first."

Suppose, last, that R4, a man in his sixties, lives further out than R2 and has not missed a visit. Mark it and keep it. It tells you distance alone does not decide who stops, and it gives you a question: what does R4 have that R2 does not?

WHERE THIS PICTURE BREAKS. A code here is your own label for finding and comparing passages. It is not yet a finding. Suppose two transcripts out of five carry "weighed in front of the line". That does not tell you what share of the clinic's patients stop for that reason. The five were chosen, not drawn at random (the section on who you talk to).

The labels also belong to one reader. The next level of this subject takes up checking them with a second person.

MUST KNOW POINTS FOR YOU.

- Coding is not counting. If you tally how many transcripts carry it and report a percentage, you have made a rate out of people who were chosen, not drawn. Write "two respondents described..." and say who they were, not "two in five patients".
- Read the whole transcript once before you mark anything. An early label can steer how you read the rest.
- Label with the respondent's words or a plain description of what happened, never with the clinic's verdict. "Non-compliance" names the patient as the problem before you have understood her reason.
- Keep the case that does not fit, and mark it.
- Write a memo after each transcript, before the next interview, and let it change the topic guide.
- Many researchers check first codes by having a second person apply them; whether that is required is disputed. Until your codes have been checked in some way, present them as your working notes.

EXERCISE 1 (interpretation). Here is a made-up passage from a practice interview for the clinic question, translated from Hindi. R5 is a man in his forties.

Speaker	Words
I	What happens on a clinic day, from when you leave home?
R5	I leave before six. At the clinic there is a token, then a long wait. By the time the doctor sees me it is afternoon. The shop stays closed that day.
I	Tell me more about the shop.
R5	It is my shop. If it is closed, nobody earns that day. My wife says go, your health comes first. But she is not the one who has to open the shop late.

Read it through once. Then write a code beside each passage that bears on why people stop coming, using his own words for at least one of them. Then write a one-line memo for your next interview.

EXERCISE 2 (critique). A colleague has read five practice transcripts from the clinic and hands you this note:

> *Codes: non-compliance (4 of 5). Main reason: distance, 80 per cent. R4 left out, as he is not typical.*

Say what is wrong with the note, point by point, and what the note should say instead.

Record your confidence as a percentage before turning to the answer.

13 · The quotation as data

DEFINITION. In a qualitative report, a quotation from a respondent is evidence offered for a claim the author makes about the data. It is not decoration.

A reader checks a quotation with the four acts used on any reference. Find the transcript. Confirm the speaker is the one named. Find the passage. Read whether it says what it was quoted for.

Cutting a quotation so that it fits fails the last of those checks. Choosing only the quotations that fit passes all four. You catch it only by reading the other transcripts for what runs against the claim. Both are cherry-picking. [214, 214, 215, 216, 217, 218, 219]

IN PLAIN TERMS. A report on interviews usually carries quotations: a respondent's own words, set in quotation marks. They make the page come alive. That is not their job.

Their job is to be evidence. The author claims something about what people said. The quotation is offered as a reason to believe it. The words may not be what the person said, or not what they meant. Or they may be true, and still not carry the claim built on them.

So you check a quotation the way you check any reference (Book 0, the section on checking a reference). Find the transcript. Confirm the speaker is the person named. Find the lines. Then read them, and read the lines around them, and ask: does this say what it was quoted for?

Illustration 1. Suppose a colleague has drafted a short report on practice interviews at the district hospital clinic in Chhattisgarh, where adult patients with obesity stop coming back. Everything below is made up, and the respondent's words are translated from Hindi. The report says:

> *Patients stop coming because the clinic is too far. As one woman put it, "The bus is the problem" (R3, woman, 40s).*

Check it with the four acts, one at a time.

First, find it. Open R3's transcript. Search inside it for "bus". There is a hit.

Second, confirm the speaker. Read the line before the hit, not only the hit itself.

Speaker	Words
I	So it is the bus that is the problem?
R3	The bus is the problem, yes. But I came for two years on that bus.
I	Mm.
R3	I stopped when I started work at the brick kiln. They do not give a day off. If I go to the clinic, I lose the job.

R3 did say "The bus is the problem". But the words were the interviewer's first. They arrived in a leading question, and she agreed with it (the section on open, closed and leading questions). The quotation is hers only in the sense that she repeated it.

Third, find the exact place. You have it: her first answer.

Fourth, read it, with the lines around it. The rest of her answer says the bus was not the reason. She rode it for two years. She stopped when a job came that gives no day off. The quotation is real, spoken by the right person, found at the right place. It says the opposite of what it was quoted for.

Now write it as evidence. The claim changes, and the quotation carries its context:

> *R3 (woman, 40s) had managed the bus journey for two years. She stopped when she began work that gives no day off: "If I go to the clinic, I lose the job."*

WHERE THIS PICTURE BREAKS. Inside a study, you can open the transcripts. A reader of a published report usually cannot. They see only the lines the author chose, so the author's label, context and statement of typical or exception are all they have. That is why reporting standards for quotations exist, and they are taught at the next level of this subject.

The four acts also test only whether a quotation matches the transcript. They cannot test whether the transcript matches the recording, or whether a translation kept the sense. When a claim turns on one quotation, ask for that passage of the audio, and the words in the language spoken.

Illustration 2. Take the corrected claim from the first case and ask the next question: what does the quotation stand for? Suppose there are five practice transcripts, R1 to R5, all made up.

Read each one for anything about work and clinic days. Here is what you find, set out by respondent.

Respondent	What they said about work and clinic days
R1	Nothing about work.
R2	Her son takes unpaid leave to bring her.
R3	Stopped when she began kiln work with no day off.
R4	Works too, and still comes. The clinic's Saturday session fits his shift.
R5	Keeps the shop closed on clinic days, and nobody earns that day.

Three people tie a clinic visit to a lost day of work, their own or a relative's. One, R4, runs the other way. He works and still comes, because a session fits his shift.

So a fair report says who said what. For example: "R2, R3 and R5 each described a clinic visit costing a day of paid work, their own or a family member's. R4 also works, and has kept coming because the Saturday session fits his shift." R3's quotation goes under that sentence, marked as one of the three.

Look at what R4 does to the report. Without him, the page reads as "work stops people coming". With him, it reads as "a visit that costs a working day stops people coming, and a session outside

working hours may let them keep coming". That second sentence is something the clinic could test.

WHERE THIS PICTURE BREAKS. "Three of five" here describes these five people and nobody else. They were chosen for what they could tell you, not drawn at random (the section on who you talk to). So the count says how the pattern sits inside this set of transcripts. It does not say how common the reason is among the clinic's patients.

MUST KNOW POINTS FOR YOU.

- A vivid quotation does not show that something is common. It shows that one person said it, in those words.
- Run the four reference checks on any quotation you are handed. Expect the failure at the last act, where the words are real and the claim is not.
- Read the line before a quotation. If the interviewer said the words first and the respondent agreed, the quotation is the interviewer's idea in the respondent's mouth.
- Give enough of the surrounding talk for the sense to be clear. Say whether others said something like it. Tie it to a label such as R3, never a name.
- Before a service is changed on the strength of a quoted reason, ask for the transcript lines around the quotation. Moving the clinic nearer does nothing for R3, whose reason was a job with no day off.
- Keep the quotation that runs against the author's claim in the report, beside the ones that support it.
- These checks tell you whether a quotation is faithful to the transcript. When a claim rests on one quotation, check that passage against the audio and the words in the language spoken.

EXERCISE 1 (critique). A draft report on practice interviews at the clinic says, with no other quotation on the topic:

> *Patients feel judged by the staff. "They look at me like I have done something wrong" (R2).*

Here are the lines around it in R2's transcript. They are made up, and translated from Chhattisgarhi.

Speaker	Words
I	How do the staff treat you?
R2	The sister is good to me. Only once, at the registration desk, a new boy was there. He looked at me like I had done something wrong. The next time it was the usual lady and it was fine.

Run the four checks, and say what the report should write instead.

Record your confidence as a percentage before turning to the answer.

EXERCISE 2 (teaching). A health secretary has read a district report. It quotes one patient saying "The clinic is too far to come every month". On that basis the secretary proposes to fund a mobile van. Write the one page you would send, with no methods section: answer first, then what to ask for, then what would change the answer.

14 · Five pilot interviews: what they test and what you do after each

DEFINITION. A pilot interview is a practice run of the whole procedure of an interview study, done with a few people before the study proper. It tests the topic guide and the interviewer, and it is your first real use of the recorder and the consent talk. It does not test an answer to the study question.

The task that finishes this level of the subject is five pilot interviews. Before the first, get an ethics committee's written answer (section 7). Then each pilot runs the same seven steps, in order.

1. Consent, including separate agreement to be recorded.
2. The recorded interview.
3. Field notes, written the same day, before you listen to the recording.
4. A transcript.
5. A first reading, with rough codes and a memo.
6. The interviewer's talk share.
7. A revised topic guide, before the next interview. [220, 221, 173, 222, 223, 224, 225, 226, 186, 227, 228, 229, 213]

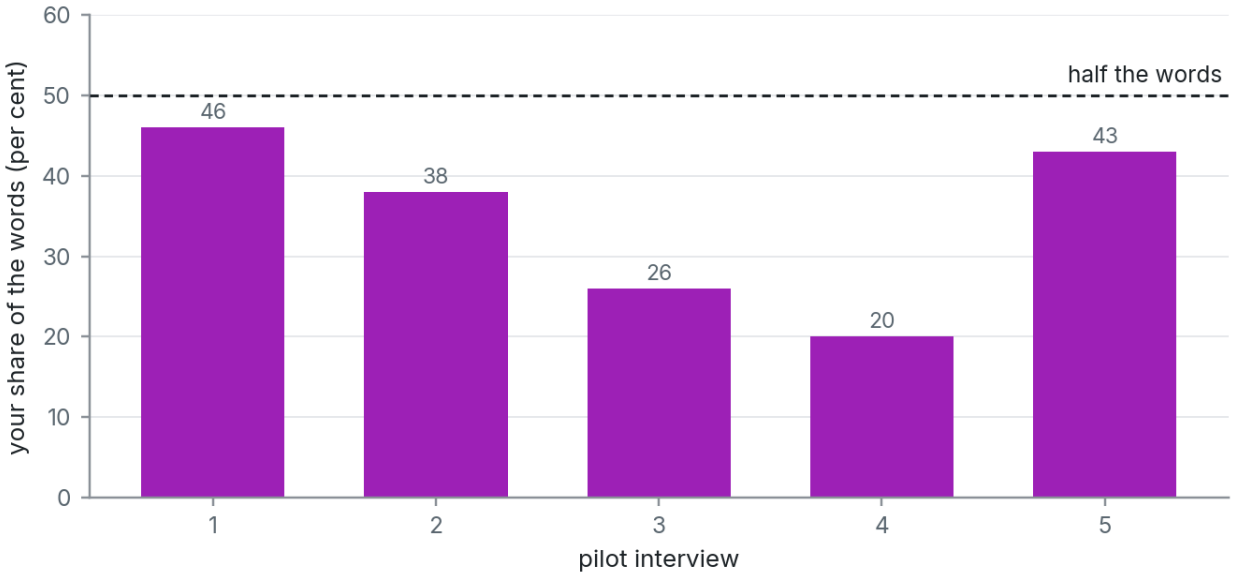
IN PLAIN TERMS. A pilot is a practice run. You are not yet finding out why patients stop coming to a clinic. The thing under test is you and your topic guide.

Choose five people you can reach who know the topic from their own lives. Avoid your own patients if you can. A patient may worry that what they say will change their care. Ask through someone who is not their doctor, because then saying no costs them nothing. Say what the talk is for, how long it takes, and that no is a fine answer.

Before each pilot, test the recorder where you will talk. Place it where it hears both voices. Carry spare batteries. The consent talk has worked when the person can tell you, in their own words, what they agreed to.

Transcribe each pilot yourself. One interview can take several hours and fill 20 to 40 pages.

Then look across the five. Which questions fell flat every time? Where did you lead? Is your share of the words falling as you get better at waiting?



Your share of the words in five made-up pilot interviews: 46, 38, 26, 20 and 43 per cent. All five are under the dashed line at 50 per cent, where you and the respondent would speak equally. The rise at pilot 5 is explained by its transcript, not by the chart.

ILLUSTRATION. Here is how five pilots might go. Everything below is made up: the people, the counts and the changes.

After pilot 1 you count the words in the transcript. You said 1,150 words and R1 said 1,350. Your share is your words divided by all the words.

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1,150 plus 1,350 = 2,500
1,150 divided by 2,500 = 0.46
0.46 times 100 = 46 per cent
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Your share is 46 per cent. You asked "Don't you find the clinic timings difficult?" and R1 said "Yes." Later you spent two minutes explaining why the clinic wants monthly visits. That is advice, not listening (the section on running the interview without leading it).

So you change two things before pilot 2. The timings question becomes "Tell me about a clinic day, from when you leave home." And you write at the top of your guide: do not explain the clinic.

Pilot	Your words	Respondent's words	All words	Your share (per cent)
1	1,150	1,350	2,500	46
2	950	1,550	2,500	38
3	780	2,220	3,000	26
4	600	2,400	3,000	20
5	1,290	1,710	3,000	43

The share falls across the first four pilots, from 46 per cent to 20. Then pilot 5 jumps back to 43 per cent. Your own words more than doubled, from 600 to 1,290.

R5 is a man in his forties who answers in short lines. Each time he stopped, you filled the silence with a new question. You stopped waiting. The change for next time is the pause: ask, then wait, and let the silence do the asking (the section on running the interview).

Pilot 3 also had a question that fell flat. “What does the clinic do for you?” drew one-word answers. A question has fallen flat when it gets yes, no or one word, or is answered as a different question.

WHERE THIS PICTURE BREAKS. A falling share shows only that you spoke less. It does not show that you led less. Read the transcript for the questions themselves.

Nothing a pilot finds about the clinic is a finding. It is a question to ask properly in the study itself.

MUST KNOW POINTS FOR YOU.

- A pilot tests your guide and you, not the study question. Do not report what five pilot respondents said as the reason patients stop coming.
- Avoid your own patients if you can. If a patient of yours does take part, tell them plainly that nothing they say will affect their care, and tell them they may say what they really think.
- Transcribe and read each pilot before the next one. If you run them all and read them afterwards, you have done one pilot five times.
- When your talk share moves, read the transcript before you explain it. A rise can mean you stopped waiting, or that one respondent speaks briefly.
- Listen to your own recording for four things. How much you steered. Whether you asked leading questions. Whether you picked up what the respondent offered. Whether you gave them time to say what they meant.
- Keep a dated copy of your topic guide after every pilot, with a line saying what changed and why.
- You plan to keep the transcripts for the next level’s analysis. So say so when you take consent, and keep them only if the person agrees. Ask an ethics committee (section 7 says which) before the first pilot, and keep its answer in writing.

EXERCISE 1 (build). Conduct five pilot interviews on a topic you can reach respondents for. The clinic question used in this book is one choice. Avoid your own patients if you can.

For each interview, produce seven things.

- The signed consent form, which carries the name, kept apart from the recording and transcript.
- The recording.
- Field notes written the same day, before you listen to the recording.
- A transcript with speaker labels and no names.
- Your codes and a memo.

- Your talk share, with the working.
- The topic guide you will use next, with a line saying what changed and why.

Then write one page across all five. Which questions fell flat? Where did you lead? How did your talk share move, and what does each transcript say about why?

EXERCISE 2 (design). Here is a question from a made-up first-draft topic guide for the clinic study, and the lines it produced in pilot 1, translated from Hindi.

Speaker	Words
I	Do you think the clinic should give appointments, so people don't have to wait all day and lose work?
R1	Yes, that would be good.

Say what went wrong, and rewrite the question, with two probes, for pilot 2.

EXERCISE 3 (critique). A trainee reports after five pilots: "Four of my five respondents said the clinic is too far. So the pilots show distance is the main reason people stop. My talk share was 45, 44, 47, 46 and 45 per cent, so I passed the gate." What would you say?

Record your confidence as a percentage before turning to the answer.

References

1. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 1.2 Science, Social Science, and Sociology: qualitative and quantitative methods defined. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

2. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 1.2 Science, Social Science, and Sociology: the two kinds as complementary, with different goals. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

3. Pope, Catherine and Mays, Nicholas. Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. 1995. p. 43, 'What are qualitative methods?', second paragraph: the questions qualitative studies answer. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550091/ (accessed 2026-09-24).

4. Pope, Catherine and Mays, Nicholas. Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. 1995. p. 43, 'What are qualitative methods?', third paragraph: the randomised controlled trial. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550091/ (accessed 2026-09-24).

5. Pope, Catherine and Mays, Nicholas. Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. 1995. p. 43, 'What are qualitative methods?', third paragraph: classification before measurement. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550091/ (accessed 2026-09-24).

6. Pope, Catherine and Mays, Nicholas. Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. 1995. p. 44, 'How can qualitative methods complement quantitative ones?', first way: before a survey. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550091/ (accessed 2026-09-24).

7. Pope, Catherine and Mays, Nicholas. Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. 1995. p. 44, 'How can qualitative methods complement quantitative ones?': finding the words for a survey. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550091/ (accessed 2026-09-24).

8. Pope, Catherine and Mays, Nicholas. Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. 1995. p. 44, Box 3, heading of its second stage: a sociological study explaining an epidemiological finding (a four-word heading only; the box is not reproduced). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550091/ (accessed 2026-09-24).

9. Pope, Catherine and Mays, Nicholas. Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. 1995. p. 45, final paragraph before 'Further reading': neither kind superior. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550091/ (accessed 2026-09-24).

10. Green, Judith and Britten, Nicky. Qualitative research and evidence based medicine. PMID 9583929, PMC1112988. Free to read in PMC; no licence stated. Quoted from the PMC article page. second paragraph of the article: different research questions. https://pmc.ncbi.nlm.nih.gov/articles/PMC1112988/ (accessed 2026-09-24).

11. Green, Judith and Britten, Nicky. Qualitative research and evidence based medicine. PMID 9583929, PMC1112988. Free to read in PMC; no licence stated. Quoted from the PMC article page. second paragraph of the article: questions not easily answered by experiment. https://pmc.ncbi.nlm.nih.gov/articles/PMC1112988/ (accessed 2026-09-24).

12. Green, Judith and Britten, Nicky. Qualitative research and evidence based medicine. PMID 9583929, PMC1112988. Free to read in PMC; no licence stated. Quoted from the PMC article page. Summary points, fourth point. https://pmc.ncbi.nlm.nih.gov/articles/PMC1112988/ (accessed 2026-09-24).

13. Green, Judith and Britten, Nicky. Qualitative research and evidence based medicine. PMID 9583929, PMC1112988. Free to read in PMC; no licence stated. Quoted from the PMC article page. Conclusion: evidence beyond the meta-analysis of randomised controlled trials. https://pmc.ncbi.nlm.nih.gov/articles/PMC1112988/ (accessed 2026-09-24).

14. Green, Judith and Britten, Nicky. Qualitative research and evidence based medicine. PMID 9583929, PMC1112988. Free to read in PMC; no licence stated. Quoted from the PMC article page. Assessing qualitative research: anecdote against qualitative research. https://pmc.ncbi.nlm.nih.gov/articles/PMC1112988/ (accessed 2026-09-24).

15. Green, Judith and Britten, Nicky. Qualitative research and evidence based medicine. PMID 9583929, PMC1112988. Free to read in PMC; no licence stated. Quoted from the PMC article page. Assessing qualitative research: what rigorous qualitative research rests on. https://pmc.ncbi.nlm.nih.gov/articles/PMC1112988/ (accessed 2026-09-24).

16. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 7.2 Sampling in Qualitative Research: Nonprobability Sampling. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

17. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 7.2 Sampling in Qualitative Research: Types of Nonprobability Samples, the purposive sample. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

18. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 7.2 Sampling in Qualitative Research: Types of Nonprobability Samples, the convenience sample. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

19. Mays, Nicholas and Pope, Catherine. Qualitative research in health care: assessing quality in qualitative research. PMID 10617534, PMC1117321. Free to read in PMC; no licence stated. Quoted from the PMC article page. Box 'Some questions about quality that might be asked of a qualitative study', the Sampling question (one sentence; the box is not reproduced). https://pmc.ncbi.nlm.nih.gov/articles/PMC1117321/ (accessed 2026-09-24).

20. Pope, Catherine and Mays, Nicholas. Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. 1995. p. 43, Box 1 (glossary), entry for purposive or systematic sampling (one phrase). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550091/ (accessed 2026-09-24).

21. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 253, 'Identifying interviewees', first paragraph. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

22. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 2: identifying participants. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

23. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Introduction, first paragraph: a meaningful project with few participants (carries the must-know point's 8 to 12). https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

24. Pope, Catherine and Ziebland, Sue and Mays, Nicholas. Qualitative research in health care: analysing qualitative data. PMID 10625273, PMC1117368. Free to read in PMC; no licence stated. Quoted from the PMC article page. 'The analysis', first paragraph: relative frequencies. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117368/ (accessed 2026-09-24).

25. Pope, Catherine and Ziebland, Sue and Mays, Nicholas. Qualitative research in health care: analysing qualitative data. PMID 10625273, PMC1117368. Free to read in PMC; no licence stated. Quoted from the PMC article page. 'The analysis', first paragraph: simple counts as a summary. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117368/ (accessed 2026-09-24).

26. Pope, Catherine and Ziebland, Sue and Mays, Nicholas. Qualitative research in health care: analysing qualitative data. PMID 10625273, PMC1117368. Free to read in PMC; no licence stated. Quoted from the PMC article page. 'Software packages designed to handle qualitative data', second paragraph: sample size. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117368/ (accessed 2026-09-24).

27. Green, Judith and Britten, Nicky. Qualitative research and evidence based medicine. PMID 9583929, PMC1112988. Free to read in PMC; no licence stated. Quoted from the PMC article page. Assessing qualitative research: generalisability. https://pmc.ncbi.nlm.nih.gov/articles/PMC1112988/ (accessed 2026-09-24).

28. Mays, Nicholas and Pope, Catherine. Qualitative research in health care: assessing quality in qualitative research. PMID 10617534, PMC1117321. Free to read in PMC; no licence stated. Quoted from the PMC article page.

'Clear exposition of methods of data collection and analysis'. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117321/ (accessed 2026-09-24).

29. Mays, Nicholas and Pope, Catherine. Qualitative research in health care: assessing quality in qualitative research. PMID 10617534, PMC1117321. Free to read in PMC; no licence stated. Quoted from the PMC article page. 'Attention to negative cases'. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117321/ (accessed 2026-09-24).

30. Mays, Nicholas and Pope, Catherine. Qualitative research in health care: assessing quality in qualitative research. PMID 10617534, PMC1117321. Free to read in PMC; no licence stated. Quoted from the PMC article page. 'Fair dealing'. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117321/ (accessed 2026-09-24).

31. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 9.2 Qualitative Interview Techniques and Considerations: opening paragraph. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

32. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 9.2 Qualitative Interview Techniques and Considerations: Conducting Qualitative Interviews, the opening question. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

33. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 251, 'Types of qualitative interview', first paragraph: the three types. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

34. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 251, 'Types of qualitative interview', second paragraph: the structured interview. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

35. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 251, 'Types of qualitative interview', second paragraph: 'unstructured' is misleading. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

36. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 251, 'Types of qualitative interview', third paragraph: the semistructured interview. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

37. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 251, 'Types of qualitative interview', fourth paragraph: the in-depth interview. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

38. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 251, 'Types of qualitative interview', fourth paragraph: questions built on what the interviewee said. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

39. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 251, fifth paragraph: the clinical task. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

40. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 251, fifth paragraph: the aim of a qualitative research interview. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

41. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 253, 'Box 5 - Common pitfalls in interviewing', one item (the box is not reproduced). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

42. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 252, 'Conducting interviews', paragraph on interviewing one's own patients: not correcting. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

43. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 252, 'Conducting interviews': a respondent who is a patient may answer to please the doctor. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

44. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 252, 'Conducting interviews': the respondent's questions answered at the end. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

45. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 252, ‘Researcher as research instrument’: reviewing recordings of one’s own interviews. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

46. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Background, Table 2, DiCicco-Bloom and Crabtree’s definition. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

47. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Background, paragraph after Table 2: order and wording changed to fit. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

48. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Background, sentence just after Table 2: the most common type of interview. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

49. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Background, paragraph after Table 2: the most common form. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

50. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Purpose of semistructured interviews. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

51. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 4: planning logistical aspects, on audio recording. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

52. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 12.1 Focus Groups, opening paragraphs. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

53. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 12.1 Focus Groups, on strengths and weaknesses. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

54. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 12.1 Focus Groups, on confidentiality. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

55. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 299, “Rationale and uses of focus groups”, first paragraph (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

56. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 299, “Rationale and uses of focus groups”, first paragraph, on talking to one another (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

57. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 301, “Running the groups”, first paragraph, on the facilitator (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

58. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 301, “Running the groups”, first paragraph, on group size and length (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

59. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 301, “Running the groups”, on exercises with statements on cards (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

60. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 301, “Running the groups”, last paragraph, on recording (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

61. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 299, “Rationale and uses of focus groups”, on the forms of everyday talk (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

62. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 299, “Rationale and uses of focus groups”, on participants own words and priorities (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

63. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 300, “Rationale and uses of focus groups”, on the downside of group dynamics (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

64. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 300, “Sampling and group composition”, on hierarchy within the group (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

65. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 300, “Rationale and uses of focus groups”, on sensitive topics (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

66. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 302, Conclusion, on choosing between methods (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

67. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 302, Conclusion, on questionnaires (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

68. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 302, Conclusion, on authenticity (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

69. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 299, standfirst, on people who cannot read or write (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

70. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 300, “Rationale and uses of focus groups”, on the shift from self-blame (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

71. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. p. 301, “Analysis and writing up”, on percentages and consensus (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

72. Kitzinger, Jenny. Qualitative research: introducing focus groups. 1995. figures quoted in the text. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550365/ (accessed 2026-09-24).

73. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. figures quoted in the text. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

74. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 9.2 Qualitative Interview Techniques and Considerations, “Conducting Qualitative Interviews”, on open-ended questions. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

75. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 9.2, “Conducting Qualitative Interviews”, open against closed-ended questions. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

76. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 9.2, “Conducting Qualitative Interviews”, on leading questions. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

77. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 9.2, “Conducting Qualitative Interviews”, on “why” as a follow-up. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

78. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 5: developing the interview guide, first paragraph. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

79. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 7: conducting the interview, Table 6, row “Leading”. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

80. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 251, “Types of qualitative interview”, on structured interviews (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

81. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 251, “Types of qualitative interview”, on semi-structured interviews (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

82. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 252, “Conducting interviews”, on Patton’s qualities of a good question (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

83. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 252, “Researcher as research instrument”, on what a novice interviewer should notice (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

84. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 9.2 Qualitative Interview Techniques and Considerations, “Conducting Qualitative Interviews”, the interview guide defined. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

85. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 9.2, “Conducting Qualitative Interviews”, on the order of questions. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

86. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 9.2, “Conducting Qualitative Interviews”, on an over-detailed guide. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

87. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Background, the paragraph after Table 2, on sequencing and wording. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

88. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 5, Table 5, row “Grand tour”. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

89. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 5, Table 5, row “Core questions”. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

90. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 5, Table 5, row “Planned follow-up questions”. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

91. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 5, the paragraph before Table 5, on order. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

92. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 1: determining the purpose and scope of the study, second paragraph. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

93. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 5, first paragraph, on language. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

94. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 5, the paragraph after Table 5, on piloting. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

95. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 5, last paragraph, on changing the guide during the study. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

96. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 252, “Conducting interviews”, on order and wording (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

97. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 252, “Conducting interviews”, on the respondent’s own vocabulary (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

98. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 252, “Conducting interviews”, on starting with easy questions (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

99. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 252, “Conducting interviews”, on questions from the interviewee (OCR text layer). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

100. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Title page (publisher and date). https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

101. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Copyright page. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

102. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 2.2, Informed consent process. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

103. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 5.0. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

104. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Box 5.1, essential element 9. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

105. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Box 5.1, essential element 6. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

106. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 2.3.2. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

107. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 5.3.10. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

108. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 5.3.13. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

109. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 5.2.1. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

110. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 5.3.8. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

111. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 5.4.3. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

112. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 5.4.4. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

113. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 9.2.2, Box 9.3, item 2. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

114. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 4: planning logistical aspects. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

115. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 2.3, Privacy and confidentiality. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

116. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 2.3.3. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

117. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 9.2.3, Risk assessment. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

118. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 9.2.12, Qualitative research. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

119. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 4.8.1, Box 4.4 (b), protocol item 12. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

120. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 2.1.4, Table 2.1 Categories of risk, row "Minimal risk". https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

121. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 4.8, Table 4.2 Types of review, row 1 "Exemption from review". https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

122. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 4.8.3. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

123. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 9.2.12, Qualitative research, third bullet. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

124. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 9.2.12, Qualitative research, third bullet, continued after Box 9.5. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

125. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 9.1.4, Box 9.1, item 1. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

126. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 9.2.6, Box 9.4, item 4 (Participant refusal). https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

127. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Box 5.1, essential element 1. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

128. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Box 5.1, essential element 2. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

129. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Box 5.1, essential element 3. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

130. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Box 5.1, essential element 5. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

131. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Box 5.1, essential element 10. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

132. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 2.3.6. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

133. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 2.3.5. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

134. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 1.1.10, principle of transparency and accountability. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

135. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 2.3.3, second sentence. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

136. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 2.1.4, Table 2.1 Categories of risk, row “Minimal risk” (definition). https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

137. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 2.1.4, Table 2.1 Categories of risk, row “Minor increase over minimal risk or Low risk”. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

138. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 4.8.1. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

139. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 4.8.1, Box 4.4 (a), item 4. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

140. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 4.8.1, Box 4.4 (a), item 5. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

141. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 4.8.3, last sentence. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

142. Government of India. The Digital Personal Data Protection Act, 2023. 2023. Enacting formula, Act No. 22 of 2023. Gazette of India, via the Ministry of Electronics and Information Technology. https://www.meity.gov.in/static/uploads/2024/06/2bf1f0e9f04e6fb4f8fef35e82c42aa5.pdf (accessed 2026-09-25).

143. Government of India. The Digital Personal Data Protection Act, 2023. 2023. Section 2(t). Gazette of India, via the Ministry of Electronics and Information Technology. https://www.meity.gov.in/static/uploads/2024/06/2bf1f0e9f04e6fb4f8fef35e82c42aa5.pdf (accessed 2026-09-25).

144. Government of India. The Digital Personal Data Protection Act, 2023. 2023. Section 2(j). Gazette of India, via the Ministry of Electronics and Information Technology. https://www.meity.gov.in/static/uploads/2024/06/2bf1f0e9f04e6fb4f8fef35e82c42aa5.pdf (accessed 2026-09-25).

145. Government of India. The Digital Personal Data Protection Act, 2023. 2023. Section 2(i). Gazette of India, via the Ministry of Electronics and Information Technology. https://www.meity.gov.in/static/uploads/2024/06/2bf1f0e9f04e6fb4f8fef35e82c42aa5.pdf (accessed 2026-09-25).

146. Government of India. The Digital Personal Data Protection Act, 2023. 2023. Section 2(x). Gazette of India, via the Ministry of Electronics and Information Technology. https://www.meity.gov.in/static/uploads/2024/06/2bf1f0e9f04e6fb4f8fef35e82c42aa5.pdf (accessed 2026-09-25).

147. Government of India. The Digital Personal Data Protection Act, 2023. 2023. Section 18(1). Gazette of India, via the Ministry of Electronics and Information Technology. https://www.meity.gov.in/static/uploads/2024/06/2bf1f0e9f04e6fb4f8fef35e82c42aa5.pdf (accessed 2026-09-25).

148. Government of India. The Digital Personal Data Protection Act, 2023. 2023. Section 17(2)(b). Gazette of India, via the Ministry of Electronics and Information Technology. https://www.meity.gov.in/static/uploads/2024/06/2bf1f0e9f04e6fb4f8fef35e82c42aa5.pdf (accessed 2026-09-25).

149. Ministry of Electronics and Information Technology. Notification G.S.R. 843(E): Commencement of the Digital Personal Data Protection Act, 2023. 2025. G.S.R. 843(E), heading (date). Gazette of India. https://www.meity.gov.in/static/uploads/2025/11/c56ceae6c383460ca69577428d36828b.pdf (accessed 2026-09-24).

150. Ministry of Electronics and Information Technology. Notification G.S.R. 843(E): Commencement of the Digital Personal Data Protection Act, 2023. 2025. G.S.R. 843(E), clause (a). Gazette of India. https://www.meity.gov.in/static/uploads/2025/11/c56ceae6c383460ca69577428d36828b.pdf (accessed 2026-09-24).

151. Ministry of Electronics and Information Technology. Notification G.S.R. 843(E): Commencement of the Digital Personal Data Protection Act, 2023. 2025. G.S.R. 843(E), clause (c). Gazette of India. https://www.meity.gov.in/static/uploads/2025/11/c56ceae6c383460ca69577428d36828b.pdf (accessed 2026-09-24).

152. Ministry of Electronics and Information Technology. The Digital Personal Data Protection Rules, 2025. 2025. Rule 1(4). Gazette of India. https://www.meity.gov.in/static/uploads/2025/11/53450e6e5dc0bfa85ebd78686cadad39.pdf.

153. Ministry of Electronics and Information Technology. The Digital Personal Data Protection Rules, 2025. 2025. Rule 16. Gazette of India. https://www.meity.gov.in/static/uploads/2025/11/53450e6e5dc0bfa85ebd78686cadad39.pdf.

154. Ministry of Electronics and Information Technology. The Digital Personal Data Protection Rules, 2025. 2025. Second Schedule, standard (a). Gazette of India. https://www.meity.gov.in/static/uploads/2025/11/53450e6e5dc0bfa85ebd78686cadad39.pdf.

155. Ministry of Electronics and Information Technology. The Digital Personal Data Protection Rules, 2025. 2025. Second Schedule, standard (b). Gazette of India. https://www.meity.gov.in/static/uploads/2025/11/53450e6e5dc0bfa85ebd78686cadad39.pdf.

156. Ministry of Electronics and Information Technology. The Digital Personal Data Protection Rules, 2025. 2025. Second Schedule, standard (c). Gazette of India. https://www.meity.gov.in/static/uploads/2025/11/53450e6e5dc0bfa85ebd78686cadad39.pdf.

157. Ministry of Electronics and Information Technology. The Digital Personal Data Protection Rules, 2025. 2025. Second Schedule, standard (d). Gazette of India. https://www.meity.gov.in/static/uploads/2025/11/53450e6e5dc0bfa85ebd78686cadad39.pdf.

158. Ministry of Electronics and Information Technology. The Digital Personal Data Protection Rules, 2025. 2025. Second Schedule, standard (e). Gazette of India. https://www.meity.gov.in/static/uploads/2025/11/53450e6e5dc0bfa85ebd78686cadad39.pdf.

159. Ministry of Electronics and Information Technology. The Digital Personal Data Protection Rules, 2025. 2025. Second Schedule, standard (f). Gazette of India. https://www.meity.gov.in/static/uploads/2025/11/53450e6e5dc0bfa85ebd78686cadad39.pdf.

160. Ministry of Electronics and Information Technology. The Digital Personal Data Protection Rules, 2025. 2025. Second Schedule, standard (h). Gazette of India. https://www.meity.gov.in/static/uploads/2025/11/53450e6e5dc0bfa85ebd78686cadad39.pdf.

161. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 9.2 Qualitative Interview Techniques and Considerations, Conducting Qualitative Interviews. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

162. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 9.4 Issues to Consider for All Interview Types, Researcher-Respondent Relationship. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

163. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 7: conducting the interview, Beginning the interview. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

164. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 5: developing the interview guide. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

165. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 7: conducting the interview, Active listening. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

166. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 7: conducting the interview, Continuing the interview. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

167. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Table 6, Probing techniques, row “Wait time”. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

168. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Table 6, Probing techniques, row “Echo”. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

169. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Table 6, Probing techniques, row “Verbal agreement”. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

170. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Table 6, Probing techniques, row “Expansion”. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

171. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Table 6, Probing techniques, row “Explanation”. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

172. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Table 6, Probing techniques, row “Leading”. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

173. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 8: memoing and reflection. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

174. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Conclusions. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

175. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 251, Types of qualitative interview (semistructured interviews). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

176. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 252, Conducting interviews. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

177. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 252, Researcher as research instrument. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

178. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 253, Box 4, Maintaining control of the interviews. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

179. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 253, Box 3, Whyte’s directiveness scale, items 5 and 6. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

180. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 253, Box 5, Common pitfalls in interviewing, item “Teaching”. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

181. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 253, Box 5, Common pitfalls in interviewing, item “Counselling”. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

182. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 9.2.8, Duty to disclose sensitive information. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

183. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 9.2.8, first bullet. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

184. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 253, Identifying interviewees. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

185. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 253, Box 5, Common pitfalls in interviewing, one item. https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

186. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 3: considering ethical issues. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

187. Mays, Nicholas and Pope, Catherine. Qualitative research in health care: assessing quality in qualitative research. PMID 10617534, PMC1117321. Free to read in PMC; no licence stated. Quoted from the PMC article page. Reflexivity. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117321/ (accessed 2026-09-24).

188. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 9.4 Issues to Consider for All Interview Types, Power. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

189. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 9.4 Issues to Consider for All Interview Types, Location, Location, Location. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

190. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 9.2.1, Box 9.2, item 3. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

191. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. s. 9.2 Qualitative Interview Techniques and Considerations, Analysis of Qualitative Interview Data, first paragraph. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

192. Pope, Catherine and Ziebland, Sue and Mays, Nicholas. Qualitative research in health care: analysing qualitative data. PMID 10625273, PMC1117368. Free to read in PMC; no licence stated. Quoted from the PMC article page. opening paragraph. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117368/ (accessed 2026-09-24).

193. McMullin, Caitlin. Transcription and qualitative methods: implications for third sector research. 2023. Audio Transcription - What We Know, subsection Qualitative research and transcription, second paragraph. https://pmc.ncbi.nlm.nih.gov/articles/PMC8432276/ (accessed 2026-09-24).

194. McMullin, Caitlin. Transcription and qualitative methods: implications for third sector research. 2023. Audio Transcription - What We Know, subsection Qualitative research and transcription, third paragraph. https://pmc.ncbi.nlm.nih.gov/articles/PMC8432276/ (accessed 2026-09-24).

195. McMullin, Caitlin. Transcription and qualitative methods: implications for third sector research. 2023. Epistemological and Ethical Considerations, first paragraph. https://pmc.ncbi.nlm.nih.gov/articles/PMC8432276/ (accessed 2026-09-24).

196. McMullin, Caitlin. Transcription and qualitative methods: implications for third sector research. 2023. A Framework for Undertaking and Reporting on Transcription, How to Transcribe?, second paragraph. https://pmc.ncbi.nlm.nih.gov/articles/PMC8432276/ (accessed 2026-09-24).

197. McMullin, Caitlin. Transcription and qualitative methods: implications for third sector research. 2023. A Framework for Undertaking and Reporting on Transcription, How to Transcribe?, third paragraph. https://pmc.ncbi.nlm.nih.gov/articles/PMC8432276/ (accessed 2026-09-24).

198. McMullin, Caitlin. Transcription and qualitative methods: implications for third sector research. 2023. Technology and Transcription, third paragraph. https://pmc.ncbi.nlm.nih.gov/articles/PMC8432276/ (accessed 2026-09-24).

199. McMullin, Caitlin. Transcription and qualitative methods: implications for third sector research. 2023. A Framework for Undertaking and Reporting on Transcription, Before Transcribing - Ethics and Data Management. https://pmc.ncbi.nlm.nih.gov/articles/PMC8432276/ (accessed 2026-09-24).

200. McMullin, Caitlin. Transcription and qualitative methods: implications for third sector research. 2023. Transcription and Third Sector Research, third paragraph (review of 133 Voluntas articles). https://pmc.ncbi.nlm.nih.gov/articles/PMC8432276/ (accessed 2026-09-24).

201. McMullin, Caitlin. Transcription and qualitative methods: implications for third sector research. 2023. A Framework for Undertaking and Reporting on Transcription, Writing about Transcription, first paragraph. https://pmc.ncbi.nlm.nih.gov/articles/PMC8432276/ (accessed 2026-09-24).

202. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 3, planning logistics, the paragraph after Table 4. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

203. McMullin, Caitlin. Transcription and qualitative methods: implications for third sector research. 2023. figures quoted in the text. https://pmc.ncbi.nlm.nih.gov/articles/PMC8432276/ (accessed 2026-09-24).

204. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. s. 12.1 Focus Groups, first paragraph after the learning objectives. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

205. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 7, conducting the interview, Continuing the interview (quoting DiCicco-Bloom and Crabtree, p 317). https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

206. Pope, Catherine and Ziebland, Sue and Mays, Nicholas. Qualitative research in health care: analysing qualitative data. PMID 10625273, PMC1117368. Free to read in PMC; no licence stated. Quoted from the PMC article page. The analysis, paragraph 2. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117368/ (accessed 2026-09-24).

207. Pope, Catherine and Ziebland, Sue and Mays, Nicholas. Qualitative research in health care: analysing qualitative data. PMID 10625273, PMC1117368. Free to read in PMC; no licence stated. Quoted from the PMC article page. The analysis, paragraph 3. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117368/ (accessed 2026-09-24).

208. Pope, Catherine and Ziebland, Sue and Mays, Nicholas. Qualitative research in health care: analysing qualitative data. PMID 10625273, PMC1117368. Free to read in PMC; no licence stated. Quoted from the PMC article page. Relation between analysis and qualitative data. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117368/ (accessed 2026-09-24).

209. Pope, Catherine and Ziebland, Sue and Mays, Nicholas. Qualitative research in health care: analysing qualitative data. PMID 10625273, PMC1117368. Free to read in PMC; no licence stated. Quoted from the PMC article page. The analysis, paragraph 1. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117368/ (accessed 2026-09-24).

210. Pope, Catherine and Ziebland, Sue and Mays, Nicholas. Qualitative research in health care: analysing qualitative data. PMID 10625273, PMC1117368. Free to read in PMC; no licence stated. Quoted from the PMC article page. Five stages of data analysis in the framework approach, stage 1. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117368/ (accessed 2026-09-24).

211. Pope, Catherine and Ziebland, Sue and Mays, Nicholas. Qualitative research in health care: analysing qualitative data. PMID 10625273, PMC1117368. Free to read in PMC; no licence stated. Quoted from the PMC article page. Inter-rater reliability. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117368/ (accessed 2026-09-24).

212. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 9: analysing the data, paragraph 2. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

213. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 9.2 Qualitative Interview Techniques and Considerations, Analysis of qualitative interview data. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

214. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 11: presenting findings in a paper or report. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

215. Mays, Nicholas and Pope, Catherine. Qualitative research in health care: assessing quality in qualitative research. PMID 10617534, PMC1117321. Free to read in PMC; no licence stated. Quoted from the PMC article page. Assessing the validity of qualitative research, Clear exposition of methods of data collection and analysis. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117321/ (accessed 2026-09-24).

216. Mays, Nicholas and Pope, Catherine. Qualitative research in health care: assessing quality in qualitative research. PMID 10617534, PMC1117321. Free to read in PMC; no licence stated. Quoted from the PMC article page.

Assessing the validity of qualitative research, Attention to negative cases. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117321/ (accessed 2026-09-24).

217. Mays, Nicholas and Pope, Catherine. Qualitative research in health care: assessing quality in qualitative research. PMID 10617534, PMC1117321. Free to read in PMC; no licence stated. Quoted from the PMC article page. Assessing the validity of qualitative research, Fair dealing. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117321/ (accessed 2026-09-24).

218. Pope, Catherine and Ziebland, Sue and Mays, Nicholas. Qualitative research in health care: analysing qualitative data. PMID 10625273, PMC1117368. Free to read in PMC; no licence stated. Quoted from the PMC article page. Software packages designed to handle qualitative data, paragraph 1. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117368/ (accessed 2026-09-24).

219. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 9.2 Qualitative Interview Techniques and Considerations, Table 9.1 and the paragraph introducing it. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

220. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 5: developing the interview guide, paragraph 5. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

221. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 5: developing the interview guide, paragraph 6. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

222. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 4: planning logistical aspects, paragraph 1. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

223. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 4: planning logistical aspects, table 4 (Familiarity and Backup rows). https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

224. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 5.3, Responsibility of researchers, 5.3.7. https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

225. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. 2017. Section 5.2, list of what an informed consent form must include, item 9 (p. 50). https://www.icmr.gov.in/icmrobject/custom_data/pdf/resource-guidelines/ICMR_Ethical_Guidelines_2017.pdf (accessed 2026-09-24).

226. DeJonckheere, Melissa and Vaughn, Lisa M. Semistructured interviewing in primary care research: a balance of relationship and rigour. 2019. Step 2: identifying participants, paragraph 1. https://pmc.ncbi.nlm.nih.gov/articles/PMC6910737/ (accessed 2026-09-24).

227. Britten, Nicky. Qualitative interviews in medical research. 1995. p. 252, column 1 (running text). https://pmc.ncbi.nlm.nih.gov/articles/PMC2550292/ (accessed 2026-09-24).

228. Pope, Catherine and Ziebland, Sue and Mays, Nicholas. Qualitative research in health care: analysing qualitative data. PMID 10625273, PMC1117368. Free to read in PMC; no licence stated. Quoted from the PMC article page. Opening paragraph. https://pmc.ncbi.nlm.nih.gov/articles/PMC1117368/ (accessed 2026-09-24).

229. Blackstone, Amy. Principles of Sociological Inquiry: Qualitative and Quantitative Methods. 2012. 7.2 Sampling in Qualitative Research, Nonprobability sampling. https://saylordotorg.github.io/text_principles-of-sociological-inquiry-qualitative-and-quantitative-methods/ (accessed 2026-09-24).

Appendix · Worked answers

1 · Two kinds of question: how many, and why and how

EXERCISE 1. 1. How many. A share of a group is a count divided by a total. Count it from the clinic register, or from a random sample of patient files. 2. How and why. It asks how people reach a decision. Ask patients who kept dates and patients who did not, and listen to how they describe it. 3. How much. It asks how large a difference a change makes. Compare the share who come back with the stairs and without them. When the whole clinic moves, chance cannot decide which patients get the ground floor. So this is likely to be a before-and-after comparison, weaker than a trial. It is still a counting question. 4. What. It asks what a word means to the people who hear it. Ask them. Pope and Mays note that the simplest use of this kind of work is to find which words people understand before a survey uses them. If "follow-up" means nothing to patients, a survey that asks about it counts nothing. 5. Both. "Which patients" is a how-many question: count, from the register, who stops. "Why" is a why question: ask the people who stopped. Split it and give each half its own method.

EXERCISE 2. Premise: interviews are the weakest kind of evidence. Conclusion: wait for a trial before looking at why patients leave.

Test the inference first, as Book 0's section on argument taught. Weakest for what? To test whether a treatment works, a trial beats asking people, because only a trial lets chance decide who is treated. To learn why patients leave, a trial gives no answer at all. So "weakest" has quietly moved from one kind of question to another.

There is a second fault. A trial tests a fix that already exists. To run one, you must already know what to change. Finding out why patients leave is how you would learn what fix to test. So waiting for the trial first puts the steps in the wrong order.

A fair version of the officer's worry survives: an interview study cannot say how common each reason is. That is a reason to count after asking, not a reason not to ask.

EXERCISE 3. Start with the kind of question. Some questions are about how many: how many patients stop coming to a clinic. You answer those by counting. Others are about why: why they stop. No count answers that, because you do not yet know what to count. You have to ask the people who stopped, and listen.

Then separate it from opinion. A good study does not collect whatever people happen to say. It chooses people on a stated plan, including those whose story may not fit. It works through what they said step by step. And it looks for explanations that would prove its first idea wrong.

Be honest about the limit. It tells you what the reasons are and how they work, not how common each one is.

A quotable sentence: "Counting tells you how many patients stop coming; only asking them tells you why."

2 · Who you talk to, and what the answers can claim

EXERCISE 1. First the arithmetic behind the 60 per cent.

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60 divided by 100 = 0.6
0.6 times 15 = 9
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So nine of the fifteen women spoke about waiting times. That count is probably right. What is wrong is the move from nine women to "60 per cent avoid clinic visits". The fifteen were chosen for what they could say, not drawn at random from women with obesity in Raipur. Choose fifteen others and the nine changes. So the share describes the choice, not the city.

Here is a rewrite that claims only what the study can support. "In interviews with 15 women with obesity in Raipur, long waits at the clinic came up as one reason for staying away. The women described how the wait costs them: [what they said]. Some gave other reasons." The rewrite names the reason and how it works. It says who was asked. It makes no claim about how common the reason is.

EXERCISE 2. One reasonable list, made up for this answer; others are as good if each row has a reason.

Choose some who…	Because…
work for a daily wage	a clinic day may be a day's pay lost
have salaried jobs with fixed hours	the clinic's hours may clash with work
live more than an hour away	travel may be a reason
live close to the clinic	if they stopped too, travel is not the whole story
came once only	the first visit may have put them off
came for months, then stopped	something may have changed later

The row that might break a first guess is the men who live close by. If you expect distance to explain most of it, these men will show you if it does not. Mays and Pope call searching for such contradicting cases one of the tests of a good study.

Notice what the list is not. It is not a random sample, and it will not tell you what share of men stop for each reason. It is built to find the range of reasons.

EXERCISE 3. Answer first: do not use "14 of 20" to size the budget. Use the study to decide what to count, and count it.

Why: the 20 patients were chosen on purpose to cover a range of situations, not drawn at random. Fourteen of twenty is 70 per cent of that chosen group.

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14 divided by 20 = 0.7
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A different choice of 20 would give a different share. The figure tells you about the choice, not about the district.

What the study does give you is worth having. It shows that fares are a real reason. It shows how they work: for example, whether patients pay for a companion too, or lose a day's wage as well. That tells you what a bus pass would need to cover.

What to do: add one question on fares to the clinic's follow-up call, or check a random sample of patient files, and count. That count sizes the budget. What it costs is staff time on calls and files, not a new study.

3 · The interview: structured, semi-structured, in-depth

EXERCISE 1. 1. Structured. The questions were fixed, read from a form, and the answers were chosen from a fixed scale. These answers are for counting. 2. In-depth. There was one broad opening question, and everything after it came from what the respondent said. 3. Semi-structured. A short guide of open questions fixed the areas. The order and the follow-up questions were left to the interviewer.

EXERCISE 2. The interviewer left the research interview at the second line. The respondent gave her own reason for stopping: she believed her sugar was fine. The interviewer treated that as a clinical error. The line asks for a reading, which is diagnosing, and warns about hidden high sugar, which is correcting. The respondent then has nothing to say but that she does not remember.

What got lost is the respondent's own way of seeing it. How she decided her sugar was fine is exactly the kind of reason the study is looking for.

A rewrite of the second line: "Your sugar was fine. How did you know it was fine?" Or: "Tell me more about that." Either asks her to go on in her own words. If her belief worries you clinically, say so after the interview, not during it.

EXERCISE 3. Draw two columns on the board: "history" and "research interview". In each, write what the talk is for.

Under history: fit the problem into a medical category, then choose a treatment. The doctor steers, because time is short and a diagnosis is the goal.

Under research interview: find how the person sees the matter, in their own words. The interviewer avoids steering the account into the interviewer's categories, because that replaces the person's account with the interviewer's.

Then act out the first exchange of this section's second illustration with the resident as R1. Ask "Which knee? Is it worse in the morning?" and let them feel the conversation close. Run it again with "Tell me more about that" and wait.

Finish with the three things a history does that an interview must not: diagnose, advise, correct. Many history skills carry over: listening, and noticing what is left out. The habit of steering is what has to be unlearned.

4 · The focus group, and choosing between it and the interview

EXERCISE 1. It is working as a focus group. The moderator asks the group one question and then stays out.

Mark the respondents' turns. R2's first turn answers the moderator. R6 answers R2, R2 answers R6 with a question, and R6 answers it. R3 goes back to the moderator's question. R1 answers R3. Four of the six turns answer another participant.

What it shows that an interview with R2 alone could not:

- that people compare how they get the sheet read, and that some have nobody to read it;
- a norm, voiced by R3 and R1 and not challenged: R3 and R1 do not take the "no rice" line on the sheet as meant.

What you could not write:

- "Most patients cannot read the diet sheet." Two people mention reading. A group gives no count, and Kitzinger advises against percentages from focus groups.

- "Patients agree the diet sheet is unrealistic." R1 speaks for "nobody", and the others do not reply. Silence after a confident line is not agreement. You would need to see whether anyone, given the chance, said otherwise.

EXERCISE 2. 1. A focus group. The question is about shared words and what people say to each other. That is the talk between participants, which only a group produces. 2. An interview. It is one person's own story over time. It may include things he would not say in front of other patients. 3. Neither. It is a count, and the clinic's register answers it. Asking people in a group or an interview would give reasons, not a number, and the number would not be trustworthy.

5 · Open, closed and leading questions

EXERCISE 1. 1. It is closed (yes or no). It is also not really a question. It is advice, with a premise the respondent is being asked to agree with. It turns the interview into a consultation. 2. It is open in form. It takes for granted that the person decided to stop. It asks them to justify that, as if they owed the clinic an explanation. 3. It is closed: it offers three answers and leaves no room for a fourth. It is leading, because it supplies the reasons.

One opening question that avoids all three: "Tell me about the last time you came to the clinic." It is open, it asks about an event rather than a judgement, it gives no advice, and it asks one thing.

1. +————————+———+——————————————————————————————+ | Check | Result | Because | +————————+———+——————————————————————————————+ | form of the answer | closed | it can be answered yes or no | +————————+———+——————————————————————————————+ | leading | no | it takes nothing about the person's experience for granted, and shows no preferred answer | +————————+———+——————————————————————————————+ | double | no | it asks one thing | +————————+———+——————————————————————————————+

2. +————+———+———+———+——————————————————————————+ | Question | Form | Leading | Double | Because | +————+———+———+———+——————————————————————————+ | a | open | no | no | it needs the person's own words and takes nothing about the visit for granted | +————+———+———+———+——————————————————————————+ | b | closed | no | no | the answer is a number | +————+———+———+———+——————————————————————————+ | c | closed | yes | no | yes or no, and "don't you" shows the answer expected | +————+———+———+———+——————————————————————————+ | d | open | yes | no | open in form, but it takes for granted that the walking is hard | +————+———+———+———+——————————————————————————+

Question d is the one to notice. It passes check 1 and fails check 2.

3. +————————+———+————————————————————————+ | Check | Result | Because | +————————+———+————————————————————————+ | form of the answer | closed | each half can be answered yes or no | +————————+———+————————————————————————+ | leading | no | neither half shows a preferred answer | +————————+———+————————————————————————+ | double | yes | it asks whether the doctor explained, and whether the person followed | +————————+———+————————————————————————+

A "no" could mean the doctor did not explain, or the person did not follow, or both. Split it, and ask each half as an event.

- What did the doctor tell you about the diet?
- What happened with the diet after that?

4. +————————+———+——————————————————————————————+ | Check | Result | Because | +————————+———+——————————————————————————————+ | form of the answer | closed | it can be answered yes or no | +————————+———+——————————————————————————————+ | leading | yes | it supplies the reason, "too far", and takes for granted that the person decided to stop | +————————+———+

————————————————————————————————+ | double | no | it asks one thing | +————————+———+ ————————————————————————————————+

Replace it with a question about an event: “Tell me about the last time you came to the clinic.” If distance matters to this person, it will come up in their account, in their words. If it does not come up, you can ask a plain factual follow-up later: “How do you get here?”

5. +————————+———+————————————————————————————————+ | Check | Result | Because | +==================+========+== | form of the answer | open | R2 has to answer in her own words | +————————+———+ ————————————————————————————————+ | leading | yes | it takes for granted that she stopped, which she did not say, and asks her to justify it | +————————+———+————————————————————————————————+ | double | no | it asks one thing | +————————+———+————————————————————————————————+

R2 said a strip is still at home. She did not say she stopped. The question turns her words into an admission, and “why did you” asks her to defend it. She may hear the question a staff member asks before a telling-off, and give the answer that ends it fastest.

A better next line uses her own words and asks for more: “A whole strip is still there. Tell me about that.”

6. +——+———+———+———+————————————————————————————————+ | No. | Form | Leading | Double | Because | +=====+========+========+========+== | 1 | closed | no | no | a plain fact | +——+———+———+———+————————————————————————————————+ | 2 | open | no | no | asks for an account and takes nothing about the meal for granted | +——+———+———+———+ ————————————————————————————————+ | 3 | closed | no | no | yes or no, with no preferred answer shown | +——+———+———+———+————————————————————————————————+ | 4 | closed | yes | no | “don’t you” shows the answer wanted, and it carries the premise that a late dinner is bad for weight | +——+———+——— +———+————————————————————————————————+ | 5 | open | yes | yes | takes for granted that the family supports her, and asks about the diet and the walking together | +——+———+———+———+ ————————————————————————————————+ | 6 | open | yes | no | takes for granted that she eats after the others, and asks her to justify it | +——+———+———+———+ ————————————————————————————————+

Count each result.

```
open: questions 2, 5 and 6, so 3
closed: questions 1, 3 and 4, so 3
3 plus 3 = 6
leading: questions 4, 5 and 6, so 3
double: question 5, so 1
```

Rewrite the three leading questions first, 4, 5 and 6, because each one plants an answer. Question 5 is also double, so split it as you rewrite it. Only question 2 is both open and neutral as it stands.

7. Check 1 broke. Check 1 asks about the form of the answer, not the first words of the question. The answer to “do you eat rice at night?” is yes or no, so the question is closed. “Tell me” in front of it changes nothing about what the person can answer.

Checks 2 and 3 are right: it shows no preferred answer, and it asks one thing.

An open question on the same topic asks for an account: “What does a usual evening meal at home look like?”

Why the wrong answer looks reasonable: “Tell me about…” is a common way to open a question. So the words have come to feel like a mark of an open question. The words are a habit, not the test.

8. The last line broke. The rewrite removed the words that signalled the wanted answer. It kept the premise, “the diet is hard”. “How hard” can only be answered with an amount of hardness. A respondent for whom the diet is easy, or who stopped following it for some other reason, has no room to say so.

The first four lines are right. The rewrite is open, as line 5 says.

A rewrite that removes the premise too asks about the event: “Tell me about the diet since you were given it.” Or: “What has the diet been like for you?”

Why the wrong answer looks reasonable: the signal words are the most visible sign of a leading question, and removing them feels like fixing it. The premise is less visible, because it sits in a word that looks like a description.

9. Taken word for word, the line becomes “Do you find the diet hard?” That is closed, and it hands the respondent your word, “hard”. So do not ask it as written.

Ask about the diet as an event, and write follow-ups under it.

- Question: “Tell me about the diet the clinic gave you.”
- Follow-ups, if the respondent raises them: “What happened in the first week?” and “Who else at home eats the same food?”

If the diet is hard for this person, that will come out in their account, with the reasons.

What the answers still cannot show:

- How many of the clinic’s patients find the diet hard. The people you interview were chosen, not drawn at random, so a count of them is not a rate for the clinic.
- That the diet is why people stop coming. A respondent can find the diet hard and stop coming for a different reason. Your guide needs to ask about stopping separately, as an event.

10. Put each line through checks 1 and 2.

Line	Form	Leading	Because
1	open	yes	takes for granted that weight worries the person; “how much” asks only for an amount
2	open	yes	takes for granted that the advice helped
3	closed	yes	“how often” wants a number; it takes for granted that there is a regular evening walk, and that it gets missed
4	open	no	asks for an account of an event; that the person comes to the clinic is already known

```
open: lines 1, 2 and 4, so 3
closed: line 3, so 1
3 plus 1 = 4
leading: lines 1, 2 and 3, so 3
```

Neither half of the claim holds. Line 3 is closed, and 3 of the 4 lead. Starting with “how” settles neither check.

What this does not establish:

- That the respondents’ answers were distorted. For that you read the answers. A respondent may have said “it does not worry me” despite the question.
- That line 4 will get a truthful or full answer. A neutral question gives room. It does not guarantee what fills it.
- Anything about the colleague’s other transcripts. Four lines from one interview are a sample of their questions, not all of them.

6 · The topic guide

EXERCISE 1. Here is one guide for the example study question. Yours will differ. Check it against the list that follows the guide, not against this guide.

Part	Question	Prompts, only if not covered
warm-up	Tell me about the people who live in your home.	who eats together; who works outside
main 1	Tell me about yesterday's evening meal, from when it was first thought of to when it was eaten.	who decided; who bought; who cooked
main 2	How is it decided what to cook on a usual day?	who is asked; who has the last word
main 3	How is it different on a festival or when guests come?	who decides then; what changes
main 4	Has anyone at home ever asked for food to be cooked differently for their health?	what was asked; what happened next
main 5	What would make cooking for the family easier for you?	time; money; what others want
closing	Is there anything I have not asked about that I should have?	anything you want to ask me

```
5 plus 10 plus 10 plus 5 plus 10 plus 5 plus 5 = 50
```

A plan of 5, 10, 10, 5, 10, 5 and 5 minutes comes to 50 minutes.

Main 4 is closed as written (yes or no). It is kept because a "no" is itself informative, and the prompts turn a "yes" into an account. It is placed late, because it touches health.

Check your own guide:

- Does every main question come from a part of your study question?
- Is the first question easy, and the most personal question late?
- Is every main question open, or closed for a reason you can state?
- Does any question take the person's experience for granted, or ask two things?
- Are the words ones your respondents use?
- Does the time plan add up, and does most of it go to the main questions?

EXERCISE 2. 1. Question 4 matters most. It takes for granted that the person does not follow the diet, and "why don't you" asks them to defend it. Replace it with an event: "What happened with the diet after your last visit?" 2. Question 2 asks for an opinion on a medical category, in the clinic's word, as a closed question. It does not come from the study question, which is about coming back. Cut it. 3. The warm-up is five questions in one, and income is sensitive. It is a form, not a warm-up. Ask a plain fact such as age as a single short question, or on a sheet at the end. Leave income out unless the study needs it. Open with "Tell me about a usual day for you." 4. There is only one main question left that serves the study: question 3. Question 3 is good, but the guide needs more main questions, one for each part of the study question, with prompts under each. 5. The closing gives the respondent no last word. Add "Is there anything I have not asked about that I should have?"

Then pilot it before calling it ready.

7 · Consent, recording and privacy before you switch on the recorder

EXERCISE 1. A good script covers, in this order:

1. Who you are, and who you are not. “I work on this study. I am not your doctor. I will not tell the clinic who said what.”
2. What the study is, in the person’s own language. “We want to understand why some people stop coming back to this clinic. I will ask you about your visits and your life around them. Some questions may feel personal.” Then say how long it will take.
3. That taking part is free and can stop. “You can say no. You can stop at any time, or skip any question. Your treatment here stays exactly the same either way.”
4. What happens to their words, and its limits. “Only the study team will hear what you say. I will not use your name. There are rare exceptions. If a court orders it, or someone’s life or the public’s health is in danger, the ethics committee can allow it to be shared.”
5. Questions. “What would you like to ask me? If you have a question later, call [name] on [number].” Then wait.
6. Consent: a signature, or a thumb impression. If the person cannot read the form, an impartial literate witness who is not a relative is present.
7. The recorder, separately. “May I record our talk, so I do not miss anything? You can say no, and we will still talk.”

The recorder goes on only after step 7 gets a yes, and the first thing said on it is the label (R1), never the name.

Check your script against sections 5.3.10, 2.3.2 and 2.3.6 and Box 5.1 of the ICMR guidelines. Then check it against whatever your ethics committee asks for. Its form overrides this list.

EXERCISE 2. First, “minimal risk under ICMR”. Table 2.1 does give “routine questioning or history taking” as an example of minimal risk. But the colleague has placed the study in a category by themselves. Section 4.8.3 says a researcher cannot decide which review category their proposal falls in. The ethics committee decides. Table 2.1 also says identifiable personal data carry indirect risks, which can put the study in the next category up.

Second, “that means no ethics committee”. Even minimal risk is not the category Table 4.2 exempts from review. Exemption is for “less than minimal risk where there are no linked identifiers”. A recording of a named patient’s voice may well carry linked identifiers. And every proposal goes to the committee in any case (section 4.8.3).

Third, “I’ll record”. For interviews in social and behavioural research, the guidelines ask for prior permission from the ethics committee to record at all (Box 9.3).

Fourth, “the waiting area”. Other patients and staff can overhear. One of the main risks in this kind of research is information getting out (section 9.2.3). A private room protects her. Her comfort is better served by saying her treatment will not change.

EXERCISE 3. Draw three boxes: agree, record, afterwards.

Agree. Treat it as research and let the committee decide (section 4.8.3). The ICMR guidelines ask for informed consent. That has three parts: information, understanding, and freedom to say no. Write “your care will not change” in the box, because in a clinic that is the sentence patients need most.

Record. It is a separate yes, asked after the first. The guidelines also need the ethics committee’s permission to record interviews.

Afterwards. Where does the phone go? Who can open it? Write "labels, not names". Treat a talk like a publication: no identifiable clip without fresh consent. Section 2.3.3 says publication must not reveal who a person is, and needs "re-consent" if that was not obtained before.

Then draw an arrow above all three boxes to "ethics committee". Section 4.8.3 says the researcher cannot decide the review category. The resident sends the committee its forms (Box 4.4), and does not start until the committee replies.

8 · Running the interview without leading it

EXERCISE 1. The interviewer's second line does two things. It finishes her thought for her, since she had begun on the doctor and had not said what. It also agrees with a view she had not yet stated, that doctors are strict. A better line is a pause, or an echo in her words: "In front of everyone."

The third line is advice, and a correction of sorts. She is now a patient being told what to do, and her answer shrinks to "Yes". Drop the line. If her health comes up, leave it to the end and point her to the clinic.

The fourth line is a closed question that offers two answers, weighing or travel. Neither is her word: "travel" is new, and "the weighing that stopped you" puts a cause in her mouth. Ask instead: "What happened after that?", or go back to her unfinished sentence: "You said, then the doctor…"

Her replies shrink from a sentence to "Hmm" to "Yes". That shrinking is the sign to watch for. It also fits the consent section's warning that very short replies may mean a person wants to stop.

EXERCISE 2. Many answers work. For example:

- A pause, then waiting. The respondent may carry on with the daughter-in-law without any prompt.
- An echo: "Your daughter-in-law does not like to bring you."
- An expansion: "Tell me more about the bus stand."
- An explanation: "What do you mean when you say she does not like to?"

Check each against the rule. "Does not like to", "bus stand" and "daughter-in-law" are all the respondent's words. A probe such as "Is she too busy?" or "Is it the cost?" fails. It brings in a reason the respondent never gave.

EXERCISE 3. Write two lines on the board: "Yes… okay…" and "Right, exactly."

The first says: I heard you, go on. DeJonckheere and Vaughn list it as a probe, because it keeps a person talking.

The second says: that is the right answer. After the third time, the patient knows which answers get approval. They are talking to a doctor they want to please.

Then show them their own transcript. Point to the place where the patient's answers got shorter, or started to echo the resident's words. That is where the agreeing began to steer.

End with the move to practise: acknowledge the person, never the content. "Mm", a nod, or an echo of their words, and never "exactly".

9 · The interviewer is part of the data

EXERCISE 1. It shows what 12 patients said to a member of the clinic's own staff. That is a real finding about those conversations.

It does not show that the patients are satisfied, and still less that dissatisfaction plays no part in missed follow-up. A patient talking to clinic staff may, in Britten's words, wish to give the responses they think the staff want. That pull

runs in the same direction in all 12 interviews, so the uniform answer is what bias would produce, not evidence against it. Twelve out of twelve is agreement, not confirmation.

Ask first: who did the interviews, and where? What were people told about whether their answers would reach the clinic? Were they current patients of the person asking? Are there field notes on the interviewer's role? Then ask whether anyone without a link to the clinic spoke to people who had stopped coming. They are the people the question is about.

EXERCISE 2. The opening sentences should say who you are, who you are not, and what happens to the answers. For example: "I am training in research at the medical college. I do not work in this clinic, and I am not anyone's doctor here. Nothing you tell me will change your care, and the clinic will not know who said what." If you do work at the clinic, say so. A hidden role that comes out later does more damage than one stated at the start.

Headings for the field notes about yourself might be:

- who I am to this person: job, age, sex, anything they knew about me;
- what I wore, and where we sat;
- who else was in the room or could hear, and when;
- moments I agreed, advised, corrected or steered, with the time on the recording;
- anything the person seemed to say for my benefit.

Compare the headings across your five interviews. If the same heading keeps filling up, that is a habit of yours, and it is in all five transcripts.

EXERCISE 3. One quotable line: "What people tell you depends on who is asking."

If the clinic's own doctors or staff did the interviews, patients had good reasons to be polite. Their care depends on those people. So praise in those interviews is what you would expect, whether or not patients are happy.

Ask the hospital three things. Who did the interviews? Were the people interviewed told that the clinic would not know who said what? And did they talk to people who stopped coming, not only to people who still come?

Be fair to the hospital too. Friendly interviews are not proof of a cover-up. They just cannot prove that patients are happy. How much the interviewer changed the answers is something nobody can tell from the interviews alone.

10 · Recording and transcribing

EXERCISE 1. Turn the recording into hours first. There are 60 minutes in an hour.

```
47 divided by 60 = 0.7833… hours
```

Then multiply by each end of the range.

```
0.7833… times 3 = 2.35, about 2.4 hours at the quick end
0.7833… times 8 = 6.27, about 6.3 hours at the slow end
```

Plan around the slow end. The source says "over eight hours", so 6.3 hours is not even a ceiling. A first transcript is the slowest you will type, because the marks and the choices are new to you.

EXERCISE 2. Four things are missing.

Who transcribed. The researcher who sat in the room, or a typist who never met the respondents. McMullin says that, at a minimum, a report should say who transcribed.

Full verbatim or cleaned. A cleaned transcript has already dropped the pauses, repeats and false starts. Any claim about hesitation, or about how the interviewer spoke, cannot be checked from it.

What happened to the language. Were the transcripts typed in Chhattisgarhi and then translated, or typed straight into English? Who translated, and which version was analysed? Every quotation in the report depends on that answer.

Whether anyone checked the text against the recordings. A transcript nobody checked is one person's hearing of the tape, and a machine draft nobody checked is less than that.

The sentence is not dishonest. It is simply empty. The reporting standards that ask for these details (COREQ, the Consolidated criteria for Reporting Qualitative research) are taught at the next stage.

11 · Who did the talking: the talk share

EXERCISE 1. There is no single right number here, because the transcript is yours. The working has a fixed shape, though.

First the count. Add your words turn by turn, then the respondent's. Add the two for all the words. Your words divided by all the words, times a hundred, is your share. Write beside it which transcript you counted, full verbatim or cleaned, and in which language.

Then the three longest turns. Long interviewer turns in a first interview are often one of these four things. The first is a question with its possible answers built in ("was it the distance or the cost"). The second is an explanation or advice, which is the clinician coming back. The third is a summary of what the respondent said, which invites her to agree. The fourth is a story of your own. Name which one each turn is.

Then look at the answer that follows each long turn. If it repeats your words back ("yes, the distance"), the turn steered her. If it goes somewhere you did not mention, it did not.

If your share is under half and none of the three turns steered her, you have met the gate. If your share is under half and a turn did steer her, the share has passed and the interview has not. That second case is the one this exercise exists to catch.

1. All the words first.

```
450 plus 1,350 = 1,800 words
```

The interviewer's share.

```
450 divided by 1,800 = 0.25
0.25 times 100 = 25 per cent
```

The respondent's share is what is left of the hundred.

```
100 minus 25 = 75 per cent
```

The ratio, respondent's words over interviewer's.

```
1,350 divided by 450 = 3
```

Three words from the respondent for every one from the interviewer.

2. The two shares make a hundred between them.

```
100 minus 64 = 36 per cent
```

The ratio does not need the word counts. The shares are the counts scaled by the same amount, so their ratio is the ratio of the counts.

```
64 divided by 36 = 1.777…
```

The respondent said about 1.78 words for each word of the interviewer's. Above 1, so the respondent spoke more.

3. Count what stands between the spaces.

```
first line: 9 words
second line: 14 words
9 plus 14 = 23 words
```

The first speaker's share.

```
9 divided by 23 = 0.3913…
0.3913… times 100 = 39.1 per cent
```

Short exchanges often give the asker a large share. One question and one answer is not an interview, and the share only means something over a whole transcript.

4. Count each turn.

```
interviewer: 8 plus 6 plus 8 = 22 words
R4: 33 plus 28 plus 10 = 71 words
22 plus 71 = 93 words
```

The interviewer's share.

```
22 divided by 93 = 0.2365…
0.2365… times 100 = 23.7 per cent
```

Under half, and well under it, so this stretch would meet the gate. The questions are short and open. The respondent takes each one somewhere of her own: the health worker, her sister, the tin with the ration card.

Keep two limits in view. This is one stretch, not the whole interview. And the count is of the English version.

5. Each share: interviewer's words divided by all the words, times a hundred.

```
600 divided by 4,000 = 0.15, so 15 per cent
1,400 divided by 3,500 = 0.4, so 40 per cent
900 divided by 4,500 = 0.2, so 20 per cent
700 divided by 5,000 = 0.14, so 14 per cent
2,100 divided by 3,000 = 0.7, so 70 per cent
```

The mean of the five.

```
15 plus 40 plus 20 plus 14 plus 70 = 159
159 divided by 5 = 31.8 per cent
```

A, B, C and D met the gate. E did not: the interviewer said 70 per cent of the words, more than twice what the respondent said. B passed, but at 40 per cent it is the next one to read.

The mean of 31.8 per cent would pass on its own. It is the wrong number to report, because it hides interview E.

6. If your share is 30 per cent, the respondent's is what is left.

```
100 minus 30 = 70 per cent
```

So her 3,500 words are 70 per cent of all the words. Find all the words from that.

```
70 per cent = 0.70
3,500 divided by 0.70 = 5,000 words in all
```

Your words are what remains.

```
5,000 minus 3,500 = 1,500 words
```

Check it the forward way.

```
1,500 divided by 5,000 = 0.3, so 30 per cent
```

At most 1,500 words. Any fewer and your share drops below 30 per cent.

7. The step that broke is the third line. It counts turns where it should count words.

Redo it on words.

```
1,100 plus 4,400 = 5,500 words
1,100 divided by 5,500 = 0.2
0.2 times 100 = 20 per cent
```

The interviewer's share is 20 per cent. The respondent said four words for every one of the interviewer's, and the gate was met with room to spare.

Why the wrong answer looks reasonable: a turn feels like a fair unit of "speaking", and 22 each looks like balance. But turns alternate by the nature of an interview, so equal turns are almost guaranteed. They say nothing about how long each person spoke.

8. The division is right. The step that broke is the last line. It calls a ratio a share.

1,200 divided by 4,800 compares your words with hers. A share compares your words with all the words.

```
1,200 plus 4,800 = 6,000 words
1,200 divided by 6,000 = 0.2
0.2 times 100 = 20 per cent
```

Your share was 20 per cent. The 0.25 is the ratio of your words to hers: a quarter of a word from you for each of hers.

Why it looks reasonable: both numbers are "your words divided by something", and both come out small. Your words divided by hers is always the larger of the two, because it divides by less. So the mix-up always makes your share look bigger than it is. Here both numbers pass. At 2,000 words against 3,000 they would not agree. The real share is 2,000 divided by 5,000 = 0.4, which is 40 per cent, and passes. The ratio is 2,000 divided by 3,000, about 0.667, and read as 66.7 per cent it would fail.

9. The two shares are right, and so is their mean. The step that broke is the last line, which reads the mean of two shares as the share of all the words.

The mean of the shares gives each interview an equal say. But interview A has 1,000 words and interview B has 5,000. Pool the words instead.

```
200 plus 3,000 = 3,200 of your words
1,000 plus 5,000 = 6,000 words in all
3,200 divided by 6,000 = 0.5333…
0.5333… times 100 = 53.3 per cent
```

Across the two interviews you said 53.3 per cent of all the words, which is more than half. The worked answer said 40.

Why it looks reasonable: averaging two percentages feels like the natural way to combine them. It is right only when the two interviews are the same length. Here the long interview is the one where you talked most, so the pooled share is pulled up towards it.

And one thing neither number should hide. Interview B failed the gate on its own, whichever way the two are combined.

10. The claim is about who spoke more, so compute the trainee's talk share over this stretch.

```
trainee: 34 plus 9 = 43 words
R3: 34 plus 3 = 37 words
43 plus 37 = 80 words
43 divided by 80 = 0.5375
0.5375 times 100 = 53.75, about 53.8 per cent
```

The trainee said more than half the words in this stretch. "Barely spoke" is wrong, and so is "nearly all the talking". The trainee did not meet the gate here.

What the count does not establish is the bigger problem. Suppose the numbers had come out the other way, with R3 saying most of the words. The stretch would still be steered. The first question tells R3 what other patients say and what the trainee thinks she found. The second question hands her a conclusion to agree with. Her "Yes, the diet" is an answer to that, not a reason she offered.

So the count answers the trainee's claim and nothing more. It cannot tell you whether the diet is really why R3 stopped coming. After this exchange, nobody can.

11. Two claims are made. The average, and "all five met the gate". Check the average first.

```
22 plus 31 plus 64 plus 35 plus 38 = 190
190 divided by 5 = 38 per cent
```

The average is right. The first sentence is not. The third interview has a share of 64 per cent, so in that interview the colleague said more than the respondent. Four of the five met the gate.

The slip is reading an average below 50 as meaning every value is below 50. Book 0 warned about exactly this with means and cut-offs.

What the check does not establish. The report gives shares, not word counts, so you cannot work out the pooled share of all the words. You cannot tell whether the four passing interviews were free of leading questions, because a share cannot show that. And the shares may have been counted on cleaned or translated transcripts, so ask which version was counted before comparing them with anyone else's.

12 · Reading a transcript, and what a code is

EXERCISE 1. One reasonable set of codes, passage by passage:

- "I leave before six … it is afternoon": *a whole day for one visit*.
- "The shop stays closed that day … nobody earns that day": *"nobody earns that day"*, his own words, because they name the cost exactly.
- "My wife says go, your health comes first": *family urges him to go*.
- "she is not the one who has to open the shop late": *he carries the cost of going*.

His second turn carries two codes that pull against each other: the family pushes him to go, and the cost falls on him. Both belong on the page.

A memo, for example: "Waiting time, not travel, took his day. Ask the next person how long the visit itself takes, and who in the family decides whether they go."

Your labels need not match these words. Check three things. Did you label what he said rather than judge him? Did one label use his words? Did the memo end with something to ask next time?

EXERCISE 2. Three things are wrong.

First, the label. *Non-compliance* is a verdict from the clinic's side. It names the patients as the problem and says nothing about their reasons. Replace it with labels that describe what each person said, in their words where possible.

Second, the count. "80 per cent" turns five chosen people into a rate. The five were picked for what they could tell you, not drawn at random, so the percentage describes nobody beyond them. Write which respondents described distance, and what each said about it.

Third, R4. He is the case that does not fit, which is why he has to stay. Leaving him out makes distance look like the whole story. Keeping him asks the useful question: what lets him keep coming from further away?

A better note, for example: "R1, R2 and R5 described a whole day lost to a visit, from travel or the wait. R2 stopped after being told her sugar was under control. R4 lives furthest out and has not missed a visit. Next interview: ask what a visit is for, and what makes one possible."

13 · The quotation as data

EXERCISE 1. Find it: open R2's transcript and search for the quoted words. They are not there, which is the first failure. The nearest line is "He looked at me like I had done something wrong."

Confirm the speaker: that line is R2's own, and the question before it was open, so it is not an echo of the interviewer.

Find the place: the nearest line is her third sentence. The quotation is not her words. "He looked" became "They look". One person on one day became all the staff, every time.

Read it, with the lines around it: this is where the claim fails outright. R2 describes one occasion with one new person at the registration desk. She says the nurse ("the sister") is good to her, and that the next visit was fine. The draft turns that into "Patients feel judged by the staff": one incident into a habit, and one woman into all the patients.

The lines just before and after the quotation reverse its sense, and they were left out. That is cherry-picking, whether or not it was meant.

A fair version: "R2 described one visit on which a new person at the registration desk made her feel she had done something wrong. She said the nurse is good to her and that the next visit was fine." If other transcripts describe something similar, say which. If none do, say that too.

EXERCISE 2. The page should open with the answer. For example: “One quotation is not enough to fund the van on. Ask the team for three things first.”

Then the three things, in plain words:

1. The lines around the quotation, from the transcript. They may say more than the report shows. In this section, R3’s words about distance were followed by her real reason.
2. Which other patients said something about distance, and which said something else. One quotation can be the exception.
3. Whether the words were the patient’s own, or an answer to a question that suggested them.

Close with what would justify the van. Several patients would describe distance, in their own words, as the reason they stopped. And nobody in similar circumstances would keep coming. Then say what the interviews cannot tell them. They show reasons, not how many patients hold each one. How many patients a van would bring back needs a count of its own.

What not to write: an explanation of qualitative methods. The secretary needs the decision and the check, not the theory.

14 · Five pilot interviews: what they test and what you do after each

EXERCISE 1. There is no single right set of transcripts. The work is judged by what it contains, so check it against this list.

1. Five signed consent forms, kept apart from the recordings and transcripts, each with a separate yes to recording and to keeping the transcript. Your ethics committee’s written answer is filed with them.
2. Five transcripts, labelled I and R1 to R5, with no names or places that identify anyone.
3. Field notes dated the day of each interview.
4. Codes and a memo for each transcript, written before the next interview. The dates show this.
5. A talk share for each interview, worked as your words divided by all the words, times 100. The gate for this level is met when the respondent spoke more than you, that is when your share is under 50 per cent. Aim well under.
6. Five dated versions of the topic guide, each with its change and its reason.
7. The one-page reading across the five. It names at least one question you changed. It names one place you led, and what you did about it. And it explains each rise in your share from the transcript, not from memory.

If your share never fell below half, do not run a sixth interview straight away. Listen to your recordings first, then find the places where you explained, agreed, or asked a second question before the first was answered. Fix those, then run the next one.

EXERCISE 2. The question does three things wrong at once.

It is closed: it can be answered “yes”, and was. It is leading: it names the answer it expects, waiting and lost work, before R1 has said anything about either. And it is a double question, asking about appointments and about waiting in one breath. Her “yes” tells you only that she agreed with you.

A rewrite for pilot 2:

> *Tell me about your last clinic day, from when you left home to when you got back.*

Two probes to write under it, to use only if they are needed:

- "You mentioned [her words]. Tell me more about that."
- The pause: wait, and say nothing, when she stops.

Neither probe names waiting or work. If the wait matters to her, she will bring it up, and then it is her account rather than yours.

EXERCISE 3. Two separate problems.

The first is the claim about distance. A pilot tests the guide and the interviewer, not the study question. Five people chosen because they could be reached cannot show the "main reason" anyone stops. "Four of five" also describes only those five (the section on who you talk to). What the pilots do give is a question worth asking properly: is distance the reason, or the first thing people mention? And were the answers about distance given to an open question, or to one that named it?

The second is the share. Every figure is under 50 per cent, so the gate is technically met. But the share never fell, which means the pilots did not change the interviewing. Five pilots at a steady 45 per cent is one interview done five times. Ask for the transcripts and the guide versions. Then look for what the trainee changed between pilots, and where they explained, agreed or led.

Glossary

Every term of art this book teaches, in the plain words it gets where it is first used, and the section that teaches it.

Term	Plain words	Section
cherry-picking	choosing only the quotations that fit a claim, or cutting a quotation so that it fits; the first you catch only by reading the other transcripts for what runs against the claim	13
cleaned transcription (intelligent verbatim)	a transcript that tidies speech into readable sentences and drops the fillers and repeats	10
closed question	a question that fixes the possible answers before the respondent speaks: yes or no, a number, or one of a set of options the question supplies	5
closing question (in a topic guide)	the last question of a topic guide, such as "Is there anything I have not asked about that I should have?"	6
code (in a transcript)	a short label written beside a passage of a transcript that bears on the study question, saying what it is about; the reader's own label for finding and comparing passages, not yet a finding	12
conceptual generalisation	what carries beyond a qualitative study: an idea, a reason and how it works, that a reader can test in another setting, as against a statistical estimate of how common something is in a population	2
confidentiality	the researcher's duty to keep safe what a person told them, including "from unauthorized access, use, disclosure, modification, loss or theft" (ICMR 2017, section 2.3)	7
Data Fiduciary	under the Digital Personal Data Protection Act, 2023, whoever "alone or in conjunction with other persons determines the purpose and means of processing of personal data" (section 2(i))	7
Data Principal	under the Digital Personal Data Protection Act, 2023, "the individual to whom the personal data relates" (section 2(j)); in an interview, the person recorded	7
deviant case (negative case)	a passage that runs against the pattern the other passages seem to show; kept and marked, not dropped, because it is what tests and sharpens the pattern	12
double question	a question that asks two things in one sentence; split it	5
ethics committee (EC)	a group of people at a hospital, college or research body that reads a researcher's plan before any research starts and can say yes, no, or change this first; the committee, not the researcher, decides the kind of review	7
field notes	notes written the same day as an interview, before you listen to the recording: what happened, where, how it felt, what surprised you	8

Term	Plain words	Section
focus group	a form of group interview in which a moderator asks the participants to talk to one another, and that talk between them is the data	4
full verbatim	a transcript that keeps everything: every filler, every repeated word, every broken-off sentence	10
group interview	several people interviewed at once, each answering the researcher in turn	4
in-depth interview	an interview in which almost nothing is decided in advance: one broad opening question about one or two issues, and everything after that comes from what the person has said	3
informed consent	a process with three parts: the person is given the information, understands it, and is free to say no (ICMR 2017, section 2.2); in writing, with a signature or thumb impression, except in exceptional cases an ethics committee approves	7
leading question	a question that shows the answer the asker expects, or takes for granted part of what it is asking about; it can be open or closed	5
main question (in a topic guide)	one of the questions a study turns on, each coming from the study question (DeJonckheere and Vaughn's "core question")	6
mean share (of talk)	across several interviews, the sum of the interviewer's talk shares divided by the number of interviews	11
memo	a note, written while you read a transcript, of what you notice and what you want to ask next	12
moderator	the person who runs a focus group (Kitzinger's "facilitator")	4
open question	a question the person answers in their own words, not by picking from a list; it leaves the form of the answer to the respondent	3, 5
passage (of a transcript)	the stretch of a transcript that says one thing	12
personal data	under the Digital Personal Data Protection Act, 2023, "any data about an individual who is identifiable by or in relation to such data" (section 2(t)); a recording or transcript that can identify someone is personal data	7
pilot interview	a practice run of the whole procedure of an interview study, done with a few people before the study proper; it tests the topic guide and the interviewer, not an answer to the study question	14
pooled share (of talk)	all the interviewer's words across several interviews, divided by all the words in them; it differs from the mean share when the interviews differ in length	11
power calculation	the sum a survey or trial does to decide how many people it needs	2
privacy	the person's right to control what is collected about them and who sees it	7

Term	Plain words	Section
probe	a short follow-up that asks for more of what the respondent just said without suggesting what that should be, such as a pause, repeating their words, or "tell me more"	8
prompt (in a topic guide)	a short note under a main question of something you hope the answer covers, used only if the respondent does not get there on their own; it names a topic, never an answer	6
qualitative research	research that asks what something is, what it means to the people involved, how it comes about and why, by gathering people's own words and actions and analysing them without turning them into counts	1
quantitative research	research that asks how many or how much: how common something is, how large a quantity is, or how large a difference a treatment makes	1
quotation (in a qualitative report)	a respondent's own words, offered as evidence for a claim the author makes about the data, not as decoration	13
randomised controlled trial	a way to test a treatment in which chance decides who gets it, and then the groups are compared	1
reflexivity	"sensitivity to the ways in which the researcher and the research process have shaped the collected data" (Mays and Pope 2000)	9
research interview	a conversation in which a researcher asks a respondent about a topic to gather the respondent's account of it; not a clinical consultation	3
respondent	a person who answers in a qualitative study, chosen on purpose for what they can tell the researcher about the question	2
respondent-to-interviewer ratio	the respondent's words in an interview divided by the interviewer's words	11
semi-structured interview	an interview that follows a short guide of open questions: the topics are decided, the path is not, and the order and wording change to suit the person	3
speaker label	a label such as R1 that stands in for a person's name on the recording, the file name and the transcript	7
structured interview	a questionnaire read aloud, with everything decided in advance and most answers picked from a list; its answers are counted	3
talk share	the interviewer's words in one interview divided by the words everyone says, times one hundred; the respondent's talk share is one hundred minus the interviewer's	11
topic guide	the written list of areas and questions an interviewer takes into a semi-structured interview; a guide, not a script	6
transcript	a written version of an interview recording, made by a person or a program; the text that analysis works on	10
turn	one unbroken stretch of speech by one speaker in a transcript	11

Term	Plain words	Section
warm-up question	an easy first question on something the respondent knows all about, to get them talking	6

The series: all 196 books

In build order: Book 0 first, then every Introductory rung, then every Intermediate rung, and so on; within a level, a subject comes after the subjects it depends on. "done" means that book's version 1 is finished. This is Book 3.

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0	Ground floor	done
INTRODUCTORY		
1	Energy balance and dynamic weight-change modelling · Rung 1	done
2	Mathematics for modelling and inference · Rung 1	done
3	**Qualitative and mixed methods · Rung 1 ◀ you are here**	**done**
4	Food systems, value chains and Indian food policy · Rung 1	done
5	Policy process, framing and advocacy craft · Rung 1	done
6	R, reproducibility engineering and data management · Rung 1	
7	Question selection and research strategy · Rung 1	done
8	Teaching, mentorship and coalition building · Rung 1	done
9	Scientific writing, visualisation and public communication · Rung 1	
10	Epistemics: philosophy of science and calibration · Rung 1	
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OBESITY EXPERTISE · BOOK 3

Qualitative and mixed methods · Rung 1

A short book on qualitative research for someone trained on numbers. It covers what qualitative research is for and why it is not a weaker kind of evidence, the semi-structured interview and the focus group and how they differ, writing a topic guide of open questions, interviewing without leading, and recording, transcribing and reading what was said, with the quotation treated as data rather than decoration.

Book 3 of the series' 196 books, free to read at drharshmaheshwari.com.

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