

Using Methodological Dilemmas to Produce an Enriching Research Opportunity: Case of a Study on Therapeutic Withdrawal in End-of-Life Care in Togo

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Abstract

This article focuses on a survey on the “therapeutic withdrawal” of diabetics and/or cancer patients living an end-of-life experience in Togo who have undergone a methodological transformation from a mixed method to a “tinkering” method integrating a narrative approach. The researcher’s immersion combined with narrative interviews provided a collection method based on a sense of trust that involved the researcher in the palliative support of these respondents, without impacting the objectivity of the data collected. This paper will discuss the methodological challenges that have disrupted the research process, how they have been circumvented, and the positive outcome that has emerged from this unforeseen pitfall. Overcoming these barriers inherent in this context where the provision of palliative care is struggling to enter the organization of formal health care provides a transferable research model in similar contexts.

Keywords

Methodological Challenges, Makeshift Method, End of Life, Narrative Interview, Palliative Care

1. Introduction

Research on therapeutic withdrawal of patients (diabetic and/or cancer patients) at the end of life was designed and carried out during the period of the coronavirus 2019 (COVID-19) based on a mixed methods approach, with a face-to-face administered questionnaire as a quantitative component. However, the “invisi-

bility” of patient records in the hospitals previously selected for the study and the quality of unexpected statistical results that emerged in the first days of data collection led the researchers to make modifications in the research process, such as designing another data collection tool. The design, practical use, and benefits of this tool will be discussed in this paper. This paper will present unexpected challenges in the research process, how they were addressed, and the positive results that emerged from this “tinkering” methodology.

Statistical constraints at the beginning of the research were overcome by reorienting the research design. This methodological shift is a clear example of the dilemmas that researchers face at all levels of the evidence-generation process. In fact, unpredictability should be embraced as a virtuous process within any research project (McArthur, 2012). Instead of appearing to be an obstacle, it can promote research and guide researchers to a better outcome when treated with care. Therefore, obstacles should be viewed as learning opportunities. This is because “mistakes, sideways turns, blind spots, uncertainty make the text more credible, not less.” (Mellor, 2001: p. 474). In other words, by acknowledging the methodological challenges of a study, the researcher gains credibility (Gadella Kamstra, 2022).

In Francophone countries, most published research ignores the methodological constraints and barriers that arise in the research process. By not producing knowledge about these challenges, researchers deprive junior and experienced researchers of gaining valuable solutions. On the other hand, this may be because researchers are often ashamed of the compromises they must make, not realizing that making compromises is an integral part of being a researcher (Dörnyei, 2007). This information is even more necessary for learning and for addressing methodological challenges in similar contexts by other researchers (beginners or experienced). In contrast to this practice, we set out to describe the obstacles, the challenges in the process of carrying out the research project whose methodology was initially predefined. Indeed, these challenges led to compromises, changes and improvements that ultimately led to a better understanding of therapeutic withdrawal of patients (diabetics and/or cancer patients) at the end of life and their families. The discussion provided in this article can enlighten beginning researchers and help them overcome their phobia of failure, when an unpredictable event (e.g., COVID-19 health crisis) occurs in the research process, or when they are faced with a context where the issue of “end of life” is both sensitive and taboo.

Previous studies in English-speaking settings recognize “bricolage methodology” as a crucial area of research where change occurs (Cook, 2009), because it produces a rigorous description of the research (Cook, 2009). Presenting candid descriptions of the research process, embracing “bricolage” and reporting it honestly as part of the inquiry will ensure the strength or validity of the research (Mellor, 2001) and a rigorous research process (Alvesson & Dan, 2011; Cook, 2009; Gadella Kamstra, 2022). However, she does not fail to point out that tinkering in the research process is difficult, not negligent (Mellor, 2001), and this

does not imply lazy or sloppy practices, but a thoughtful assessment of the challenges (Cook, 2009), that must be addressed by a skilled and competent researcher (McArthur, 2012; Mellor, 2001).

By highlighting unexpected obstacles and methodological challenges in this socio-anthropological inquiry, this article contributes to a better understanding of practices that can help overcome similar research challenges. From a disciplinary perspective, particularly in the Social Sciences and Humans (SSH), other researchers have also made significant changes to their inquiries while being immersed in the research process (Archibald et al., 2019; McKinley & Rose, 2016; Tangvald-Pedersen & Bongaardt, 2017), which led to positive results. In SSH, unexpected problems can be encountered by any researcher at any stage of his or her research due to the pervasive human factor. The study of McKinley and Rose (2016) and that of Gadella Kamstra (2021) are perfectly illustrative examples. Nevertheless, the challenges and limitations of sociology-anthropology research are often vaguely described or disguised in the form of careful descriptions of research projects.

However, through their methodological reflections, several sociologists and anthropologists have been able to demonstrate that there is no unanimity in the way to implement, for example, distancing, immersion, and a flexible methodology (Bluebond-Langner et al., 2014; Quinn, 2020). Others have focused their reflections on the relationship between the researcher and the sensitive field he is supposed to investigate (Bouju, 2015; Jaffré et al., 2020; Riedke, 2015). Following these reflections, the added value of this article is that it suggests solutions enabling the researcher to avoid the trap of methodological rigidity in the face of his field, without deviating from the intended objective.

The reflections in this article are based on the following aspects: redefining a research framework during a research project that has already begun; adopting a “researcher-helper” posture in immersing oneself in the survey space; and developing a new collection tool that can be used in mixed research surveys.

2. Methodology

2.1. Context and Participants

This paper is based on a larger mixed study on “therapeutic desistance” of diabetic and/or cancer patients at the end of life in Togo and Benin. This paper will only describe the research process in Togo. For this, 80 diabetic and/or cancer patients at the end of life were randomly selected, 35 family caregivers, nine volunteers in palliative care and seven traditional healers and pastors were selected by rational choice. Volunteers came from the Organisation Jeunesse pour le Développement Communautaire (ORJEDEC), which provided a database of all patients assisted over seven years.

In the principal study, all respondents were of Togolese nationality. The criteria for selecting diabetic and/or cancer patients at the end of life were two-fold: 1) they had to have left the palliative and/or end-of-life care offered in hospital by returning to the community or home; and 2) they had to receive palliative

and/or end-of-life care at home from an association (in this case ORJEDEC). As for the members of the patients' families, they had to be an adult member of the patient's family who had participated in the decision to leave the palliative care offered to patients in hospital in favour of alternative care in the community or at home. Traditional healers or spiritual guides were selected if they had been involved in spiritual guidance or the provision of herbal or prayer therapy to diabetic and/or cancer patients in the terminal phase of their illness, or to members of the patient's family.

2.2. Research Design

The research was planned to take place in northern Togo. The cities involved from the beginning were: Cinkassé, Kpendjal, Tone, Tandjouare (Savanes District), Assoli, Bassar, Dankpen, Doufelgou, Kéran and Kozah (Kara District). The referral hospitals in the Savanes and Kara regions should act as reference points for identifying patients.

Initially, a mixed approach was chosen. Quantitative and qualitative methods were combined to find answers to the research questions, as this allows a better understanding of the problem to be analyzed (Johnson & Onwuegbuzie, 2004). As a research tool for patients, a survey was designed because it would provide individual, group, and environmental data and would allow for comparison among respondents (Mackey & Gass, 2015). Also, it would promote a better static view of the social life of the patients, independent of the life of the populations around them (Alan, 2016). Finally, it would also have made it possible to generate new complementary conclusions following the comparison of the data collected with those from Benin.

2.3. Methodological Challenges

• Geographic inaccessibility: impacts of the COVID-19

The protocol validated between 2019 and 2020 was a great opportunity to understand social, managerial, and financial implications of the end-of-life issue. However, in the early days of the pandemic, there was an incessant questioning of whether it would be possible or appropriate to continue the field research, let alone travel north. These discussions were motivated by the government's response to the pandemic, including the state of health emergency "adopted on April 1, 2020, and recently extended until September 2022". Movement within the country has been restricted, borders are closed and some towns in northern Togo have been placed under quarantine (Ministry of Health, 2021). The sealing off the towns of Sokodé, Tchamba, and Adjengre, and the imposition of a 9:00 p.m. to 5:00 a.m. curfew in the prefectures of Tchaoudjo, Tchamba, and Sotouboua, did not facilitate access to cities in the Kara and Savanes districts.

It was important to reconsider the physical framework of research in Togo.

• Patient access: impasses and invisible targets

Unable to travel to northern Togo ourselves, we decided to contact by phone the health professionals working in the previously defined localities to map the

working context of the hospitals that would accompany patients at the end of life.

These interviews showed the limits of the health care system in Togo, notably the absence of patient files, the delay in integrating palliative care in the hospitals of northern Togo, despite the presence of cases. In addition, the behavior of physicians and nurses in informing patients and their families that there is no more hope and advising them to try other treatments.

This unexpected situation already illustrated the difficulties that could occur in the quest for access to patients through hospitals and health care providers.

- **Inconvenience in administering the survey!**

The survey administration revealed its complexity, in that each question led the patient to talk about his or her failures and successes, while perceiving them as happy or unhappy events. After reflecting on the contribution of a semi-directive interview, a guide was introduced to orient the discussions with the patients. But with no success, since, like the survey, it created phases of crying and moments of sadness in the patients that had to be managed.

The patient semi-structured interview guide was removed from the study, but the survey was not completely removed from the study. Some reliable elements of the questionnaire and key questions were retained.

Developing a data collection tool that could meet the challenges raised by administering the questionnaire and the semi-structured interview guide was important. The narrative approach was chosen.

2.4. Data Collection and Methodology Transition: Tinkering as a Solution

As mentioned above, the approach initially adopted was a mixed-method approach. However, in view of the methodological dilemmas, the principal investigator realized that the research required a more flexible and integrative approach. Faced with this situation, the researcher had to adopt a “bricolage” approach, adopting various qualitative and quantitative methodologies in response to the emerging dynamics of the field.

The initial intention was to concentrate research in the north of the country. But the state of emergency declared by the Togolese government in response to the COVID-19 pandemic-imposed curfews and the isolation of certain towns in the north, preventing the deployment of research in these towns as planned. This situation led the principal researcher to neglect his intention to undertake investigations in two environments (peri-urban) in which the practices, values and symbolism associated with chronic diseases, particularly diabetes and cancer, could be different (north Togo versus south Benin). Given the gravity of the pandemic and the state of emergency protocols, interviews with healthcare professionals were envisaged by telephone. But patients and family members were difficult to identify, and therefore difficult to sample. There were two reasons for this: 1) the strong stigma attached to chronic illness; and 2) the unavailability of patient records in the hospitals initially identified as the sample unit for tracing

patients and their families.

Faced with this situation, the principal researcher resorted to snowball sampling and sought out patient associations or associations that support patients and families in palliative and/or end-of-life care. ORJEDEC, an association pioneering palliative and end-of-life care in Togo, was identified by the principal investigator. A meeting was organized between the heads of the association and the principal investigator. To facilitate collaboration between these parties, a memorandum of expectations was signed, in which each party defined and accepted its role and responsibilities. This memorandum was important for the association because it had learned from a past mistake, following misunderstandings that arose between certain researchers and members of the association, in the context of interviews conducted with palliative care patients.

From then on, the association's areas of intervention, particularly in South Togo, were identified and mapped. The principal researcher travelled through them for around two to three months. It sampled and interviewed participants who met the above selection criteria. All interviewees agreed to participate voluntarily in the interviews. Firstly, the principal investigator obtained an exhaustive list of telephone numbers of family members and patients with diabetes and/or cancer in palliative and/or end-of-life care. Contact was made by telephone and appointments arranged according to respondents' availability. During this contact, the objectives, issues, and methodology of the research were explained to the patients' family members. Given the health context, contact was mainly made via social networks (e.g. WhatsApp) and by telephone. During this contact, interviews with family members were negotiated at later dates. The families took part in consecutive interviews once they had given their written consent. Interviews with patients were facilitated by discussions with members of their families and friends.

Following the interviews with the family members, the principal investigator asked them for permission to talk to their patient. They discussed with them (the patients) and gave feedback to the head of the association, who in turn took responsibility for informing the principal investigator whether or not the patient was available to take part in the research. The researcher then went to the patients' homes. In this approach, he administered the questionnaire to the patient, but this created situations that were difficult to manage, and sometimes led to the patient refusing to continue with the interview. Despite this dilemma, the questionnaire was kept because of the need to compare data from different contexts. It was important that certain reliable elements of the questionnaire and key questions were retained; for example, questions relating to the cost of care, income (individual and collective), were retained. However, in addition to this quantitative tool, a narrative interview guide was designed to facilitate the conversation between the principal investigator and the patients. The narrative approach was necessary: an approach at the crossroads of quantitative and comprehensive approaches (Breton & Passeggi, 2021). Narrative interviews place interviewees at the heart of the research. They are a way for the researcher to gath-

er people's stories about their experiences of health and illness (Anderson & Kirkpatrick, 2016). Narrative interviews can help researchers better understand people's experiences and behaviors (Anderson & Kirkpatrick, 2016). In this approach, the stories told by the interviewees enabled the principal researcher to get closer to the patients' perceptions of: 1) the context in which they were cared for; 2) their experience of the end of life and the withdrawal of treatment; and 3) their appreciation of life and death. The combination of the questionnaire and the narrative interview guide enabled a better understanding of the relationship between the phenomenon of therapeutic withdrawal, the end of life and palliative care.

Every time the association's volunteers visited patients' homes, the principal investigator was present to support the team in their work with patients and family members. In this process, the volunteer palliative care nurse administered the questionnaire containing the key questions during the patient's health check. Then, as soon as the time was right, without any specific questions determined in advance, the principal investigator initiated a conversation with the patient using the following question:

"I'd be delighted if you could tell me about what you did before, during and after you learned about your diagnosis or the terminal prognosis of your illness. This could be decisions you made, how you felt, what you did. Tell me about everything, even if you think it's insignificant."

At this stage, the principal investigator let the patient control the content of the interview at his or her own pace. However, this guide also included follow-up questions that addressed: 1) the patient's experience with the announcement of the terminal illness; 2) the personal, social, family, and professional upheaval caused by the onset of the terminal illness; and 3) the factors that guided the discussions and the decision to return home. In this way, the narrative interview made it possible to find a different way of giving patients the "power" to direct the interview at their own pace and to provide the researcher with the content they wanted. Unlike the questionnaire, the patients no longer stopped the interview. What's more, moments of crying, anger and regret hardly appeared at all during the discussions, which gave way to free conversation. The lead researcher's introductory question allowed a departure from the standard way in which interviews should be conducted. This question was open enough to leave the respondent free to express his or her views on the subject, but sufficiently precise as to what was expected of the researcher.

2.5. Data Analysis

The questionnaire administered to the patients was treated and analyzed using IBM SPSS v25 and its results led to a descriptive and analytical analysis. The recorded interviews were manually transcribed verbatim. The qualitative data was examined using NVivo. v12. This allowed for a thematic and content analysis of what the participants said about patient therapeutic desistance and end of

life care at home. As a complement, narrative analysis was invited to understand the stories and narratives extracted through the narrative interviews. This approach facilitated the identification of shared symbolism and interpretations to gain a deeper understanding of the realities. Analysis option is to focus on the “storyteller” and the “story” (Riessman, 2008).

Questions of validity have not been considered, as they are not directly applicable to narrative research (Bernasconi, 2015; Cruz Piñeiro & Ibarra, 2022). The advantage of using a narrative approach was that it gave each patient interviewed the freedom to recount their experiences with little intervention from the principal researcher. In fact, during the analysis of the data, this made it possible to contextualize and nuance the feelings, emotions, discourses, experiences, which would have been difficult with the questionnaire alone. As regards the objectivity of the data in the face of the researcher’s immersion and the subjective nature of the narrative data, the principal researcher adopted a posture of benevolent neutrality (Bernasconi, 2015; Nguimfack, 2016). This posture implies that the researcher processed and analyzed the data without becoming absorbed by the sensitivity of the participants’ experiences.

In the principal research, the reliability and validity of the data collected was based on three verification strategies. Firstly, the data was triangulated between the different tools used. Next, the principal investigator set up an analysis of the methodological process, often discussed with the PhD supervisor, to ensure rigour in the methodological approach. Finally, the reflexivity of the principal investigator throughout the research was an asset in terms of the reliability and validity of the data. It helped to raise awareness and reduce potential biases (Bernasconi, 2015).

3. Result and Discussion

3.1. Exploring South Togo: Redefining the Research Framework!

In May 2021, a manager of the coordination of the control of nontransmissible diseases contacted us again to direct us to an association that is a pioneer in palliative care in Togo: ORJEDEC, located in South Togo.

In south Togo, two categories of responses (official and unofficial) to palliative care are distinct, in the middle of which ORJEDEC acts as an intermediary. In this configuration, health care institutions (public, confessional or private) are used for the diagnosis of illnesses. ORJEDEC, on the other hand, represents a bridge for the patient and his or her family between one response and another.

Supported financially by organisms such as Worldwide Hospice Palliative Care Alliance (WHPCA), International Association for Hospice and Palliative Care (IAHPC) or “Médecin du Monde”, ORJEDEC initiated their project called “Palliative care for vulnerable people in the community during the period of COVID-19 in Togo” which the researchers took part in. In this context, we conducted our research in the maritime district of Togo, particularly in the communes of Agoe-Nyivé 2 and Agoe-Nyivé 3 (Figure 1).

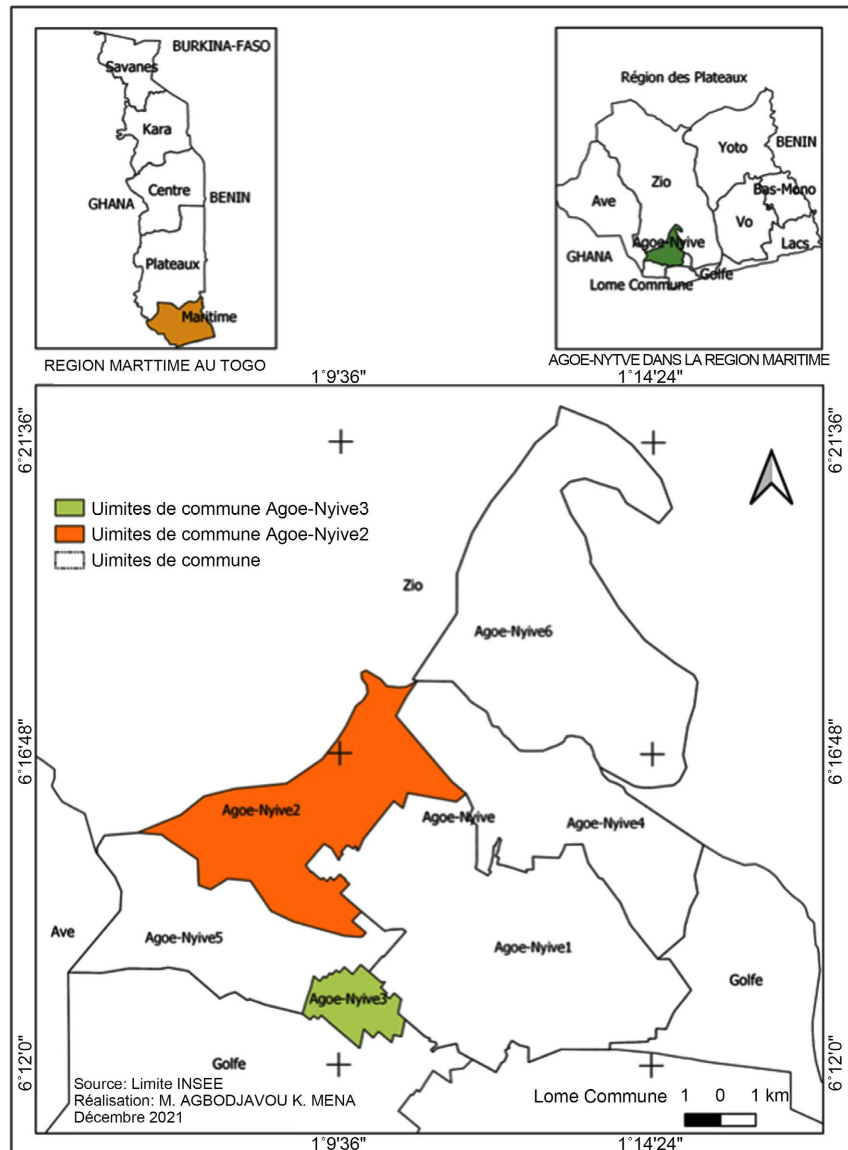


Figure 1. New research framework presenting the data collection sites.

3.2. Ethnographing Patients at the End of Life in the Home: Adapting the Immersive Method

- *Researcher-Observer or Researcher-Caregiver: what posture should be used to question the end of life?*

At the beginning of the NGO's project activities, we decided to start our interviews with patients. The contact with the parents of a patient, Lisa, diabetic for 12 years, 26 years old, suffering from metastatic breast cancer, was to create an awareness of the need for a total immersion with the patients. We negotiated an interview with Lisa and her parents. Despite the presence of ORJEDEC volunteers, our request was denied:

"I'm sorry, I don't know you! You come with Mr. X, and you want to ask us questions. You're going to take information about our child and us, take it

home, and we won't know what you're doing with what you took. I refuse! I don't know you" (Lisa's father, notebook, 2020)

Unexpectedly, an ORJEDEC volunteer would tell the parents, "He is an NGO intern who is training in palliative care". In some senses, these comments were a challenge, a window to act promptly and effectively to gain the trust of family and patients.

Lisa's parents' attitude had triggered our transition from the posture of researcher-observer to that of researcher-caregiver, assisting people at the end of life. Considering that socio-anthropological research is best conducted in spaces where the interactions, perceptions and logics of the actors serve as reference points for exchange and discussion, we should take this role seriously.

Becoming "engaged auditors" (Forsey, 2010), we assist patients and families at the end of life and use our various senses, including hearing and sight, to identify cues for discussion and observation. We needed to build on our empathetic ability to listen and assist a person at the end of life or their family. So, we agree, as Méliho et al. (2016), that it is not easy for the anthropologist to collect empirical material in an African context without adopting a researcher-caregiver posture, especially when it comes to questioning end-of-life care in an African context.

- ***Subjectivity, objectivity and distanciation:***

For the validity of the data to be collected in this researcher-caregiver posture, we always had to be careful about the line that exists between subjectivity and objectivity. To reduce the risk of becoming involved in subjectivity, we used the notion of "empathic disengagement" (Goss & Handwerk, 2002) to build our dual identities as researchers and palliative care volunteers. We were balancing empathy and objectivity, sometimes being close to and sometimes far from the participants (Brooks & Clark, 2001).

- ***Respect for "pragmatic ethics" beyond ethical advice***

The ethics notice obtained guaranteed the respect of confidentiality, the protection of privacy and the accuracy of the interlocutors' comments. But our posture in the field was revealing of the porous borders existing between the researcher and the caregiver that we are.

It was therefore necessary, beyond the provisions of the ethics notice, to consider the ethical dispositions specific to families, patients, and volunteers regarding their beliefs and values. First, it was necessary to ensure that the researchers and the patient were not related and had not at any time in their lives been intimate with the same woman, if at least both were male. Second, the researchers were required to remove their shoes before entering the patient's room, which was interpreted as: 1) respect for the patient and 2) the researcher's commitment to protecting the physical, emotional and health integrity of the patient in his or her living space.

Such as Barrett and Stauffer (2012), it was our responsibility as narrative researchers, both engaged in the practices of research and the interpersonal rela-

tionships we build: responsibility to the participants, to ourselves as researchers, to the professional and community field (ORJEDEC's engaged activities). In certain respects, this approach, imposed by the values and beliefs of the participants, refers to an ethical position of "standing with" proposed by Das (2003).

3.3. Using Storytelling in the Study: Narrative Interviews Instead of Questionnaires

The end-of-life experience is traumatic for the family as well as the dying person. Faced with this difficulty, we opted for narrative interviews. These interviews are based on the patients' stories and their lives (Thunberg, 2022). But different traditions within the narrative approach and methodology propose different approaches. For example, Plummer (2001) uses a life story perspective to describe what a story is and differentiates between long and short stories. Long stories focus on the participant's life from their earliest memory to the present, while short stories focus on a specific time in life, such as a traumatic event, and build the interview around the participant's story from that event to the time of the interview.

Whatever type of narrative is used, the stories are co-created within the social framework of the interview (Plummer, 2001). The researcher uses open-ended questions to allow participants to tell their stories in their own words (Hydén, 2016). This can be understood as a refinement of the narrative interview to focus more closely on the "storyteller" and the interaction with the researcher (Hydén, 2008). The consensus among these traditions is that they all aim to capture how one event leads to another (McAllum et al., 2019).

For the data collection, on which this article is based, the choice was made to balance these different perspectives within the narrative methodology, using a narrative course focused on a traumatic event—the announcement of terminal diabetes and/or cancer or of a family at the end of life. Using this approach, participating patients were formally declared to be terminally ill or at the end of life with diabetes and/or cancer. The interviews took place in the patients' place of residence.

3.4. Telling One's "Story" during Interviews: What "Means" for the Researcher's Story?

Narrative interviewing puts the researcher in the position of interviewer and the participant in the position of "storyteller" (Hydén, 2016; McAllum et al., 2019). But narrative interviews depend on the willingness of participants to share their stories with the researcher (Thunberg, 2022). Regarding the end of life especially, it is important that the social setting of the interview makes patients feel that they can trust the researchers, that the researchers understand their emotions, that they can say as much about their traumatic experience and still be comfortable with the researchers.

But this is easier said than done, due to the potential power imbalance in this situation, which can lead to patients at the end of life feeling compelled to an-

swer all the questions of a researcher, whose goals are other than to help their families after they have gone to the afterlife. It creates a tension between the needs of the research method, which depends on the sharing of sensitive stories by patients at the end of life, and the ethical need to protect the dying from potential emotional suffering in this traumatic end-of-life experience.

To reduce this risk, the main “entry point” in each interview was to tell patients the story of our own experience with palliative care. We ourselves lost a relative to terminal lung cancer with edema of the feet, whom we assisted for about seven months. This experience served as a bridge to the world of the patient at the end of life, in his emotional sphere, to gather the necessary information, without being able to avoid the feeling of pain for the patient. Having repeated this with patients and those experiencing the loss of a family, participants found in the interviewer (AKM), someone who understood their own pain, able to empathize with their suffering, without necessarily looking for a special interest. As one patient, Elliot, a 57-year-old patient with terminal lung cancer and a diagnosed time to live of five months, would say at the end of a day’s interview, “I love this report of truths, confessions, and stories that we shared, [...]” (Elliot, end of life cancer patient, Field note, 2021). This approach is in line with the work of Hartman (1995), according to which, faced with a traumatic experience lived by the participants of his study, the researcher’s task is always to break the relationship that the patient constructs between what he talks about (the subject), the way in which he returns to what has affected him (the repetition) and the place where his whole problem began.

The researchers found themselves in a position that posed a moral, ethical, and intellectual challenge, open to questions of representation of suffering as the lived, but also, on how the anthropologist could respond to suffering, when the conditions of inquiry prompted constructive, collaborative, and conciliatory action. Without a doubt, the anthropology of the end-of-life experience is seen as a humanistic sensibility (Murphy, 2015). It examines the knowledge, know-how and life skills of researchers in the social space of patients and families and rests on being there, listening, negotiating, and transcending (total immersion).

European researchers in political science have established based on “difficult” field experiences that ethnographic methodology induces methodological tinkering that is at the root of the transformation of the research object as initially envisaged by the researcher (Boumaza & Campana, 2007). Our experience of questioning the end of life in diabetic and/or cancer patients in the terminal phase necessarily required a methodological “way of being and doing” in the field of “self-help” often found among social science researchers in palliative care (Castra, 2010; Goss & Handwerk, 2002; Quinn, 2020).

4. Limits

The adoption of a tinkering methodology had a significant impact on the results of the research. Firstly, it enabled the researcher to effectively grasp the com-

plexity of the experiences of the participants in the study, and to reveal nuances that might have been overlooked using more traditional methods. However, there are limits to this. Firstly, the generalizability of the results. Faced with this limitation, the principal researcher took care to contextualize the conclusions of the research within the limits of the methodology used. Secondly, although the patients interviewed were informed in advance of the research objectives and the central theme of the interview, they always took a different turn at each interview. Indeed, the question of the end of life and withdrawal from treatment can bring back painful memories of the experience of illness. As a result, some people were able to deflect certain questions or avoid certain parts of their experiences. By incorporating narrative interviews, subjective notions were introduced into the re-research, given that it is interested in people's experiences and changes in the care environment. The researcher had to adopt a posture of distancing to remain objective in the research work.

5. Conclusion

Apart from reporting on the empirical reality in the process of research on “therapeutic desistance” in palliative care in Togo, the present work was also intended to prove the validity of the data collected. It consisted in revealing the difficulties inherent not only to the object of study but also to the study methods. To overcome these barriers, the researchers relied on a comprehensive and statistical approach, based on a methodological tinkering between participatory immersion, the narrative approach, and the administration of questionnaires on key issues.

Consequently, this approach allowed us to identify the representations, perceptions and popular practices surrounding the issue of “therapeutic desistance” and end-of-life care through a combination of analytical approaches such as statistical analysis, thematic and content analysis combined with narrative analysis.

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Author Contributions

MKA: Conceptualization, Data collection, Data curation, Formal analysis, Investigation, Methodology, Project administration, Resources, Supervision, Validation, Writing—original draft, Writing—review & editing. PCM & EAA: Formal analysis, Validation, Writing editing. ACK: Conceptualization, Validation, Writing editing.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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