

Keynote Address:

Eleventh Qualitative Health Research Conference

Reconceptualizing Qualitative Evidence

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As qualitative researchers, we have not explored our own work from the qualitative evidence perspective. The author suggests that qualitative researchers need to explore the conflicting agendas of evidence-based medicine and qualitative inquiry, compare the anatomy of qualitative data and evidenced-based data, and explore the autonomy of qualitative inquiry within the context of evidenced-based medicine. By attending to and communicating the differences in qualitative and quantitative evidence, and by accepting the differences in our research agendas, qualitative researchers will achieve the legitimacy that they deserve and which they require.

Keywords: *qualitative research; qualitative evidence*

In 2005, qualitative health research is finding itself in an interesting, but difficult, period. We are no longer ignored by medical researchers or by granting bodies. At least, most—but not all—of our colleagues have *heard* of qualitative research, most know that it consists of more than one method, and most know that the goal is to describe the patient's experience.

Unfortunately, medical researchers continue to consider qualitative inquiry to be subjective, biased, and opinion based, situated at Cochrane's (1972/1989) lowest level of evidence. Hence, they consider it a weak design, not recommended for implementation, not very useful, and not recommended for funding. While those who control research funding acknowledge that understanding the patient's experience is important, it is not a part of their primary agenda of *cure*, and so it is outside their identified priorities for funding.

Elsewhere, Lerner (2004) notes that these debates are "not a matter of evidence or no evidence, but what is considered evidence and by whom" (p. 20) Hence, our type of evidence, the type that qualitative researchers produce and use, is not considered *real evidence*. Our evidence is considered soft, based on perceptions,

AUTHOR'S NOTE: This was titled "Qualitative Research in the Era of Evidenced-Based Medicine" and was presented as the closing plenary address at the Eleventh Qualitative Health Research Conference, Utrecht, The Netherlands, May 11-13, 2005.

QUALITATIVE HEALTH RESEARCH, Vol. 16 No. 3, March 2006 415-422
DOI: 10.1177/1049732305285488
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subjective assessments, opinions, and biases. It is considered not valid, not replicable, and not acceptable.

Although qualitative researchers use strategies to ensure that their research is *rigorous*, using techniques of validation and using methods of logic and common sense, our research remains on the fringes of science.

But we ourselves have failed in this regard. We have failed to communicate the nature of qualitative evidence to the larger scientific community. We have failed to communicate the use or application of qualitative inquiry, and we have failed to *sell* qualitative inquiry to the public. Finally, we have failed to truly understand it ourselves. We have remained timid and silent, fearing to breach ethics by speaking to the press about our data. We fear embarrassment, reprisals and jeers, accusations of “racism” or “stereotyping,” or, even more frightening, the challenge of “Yes, but *how do you really know?*”

Today, I will explore qualitative inquiry with respect to the priorities of evidence-based medicine, examining the conflicting **agendas** of qualitative research and evidenced-based medicine, the differences in the **anatomy** of qualitative evidence and evidenced-based data, and the **autonomy** of qualitative inquiry within the context of evidenced-based medicine. I will argue that these three dimensions—the agenda, the anatomy, and the autonomy—are domains by which we can easily demonstrate the utility and rigor of qualitative inquiry but that we ourselves have not explored our own work from this perspective. By exploring the **agenda** of qualitative research, we separate our purpose from that of quantitative inquiry. This will help us to carve out a separate domain of research problems that quantitative researchers do not even conceive as researchable. Examining the **anatomy** allows us to develop and explicate the types of data that qualitative researchers use as evidence, and that will assist others to appreciate qualitative inquiry as solid. By delineating the **autonomy** of qualitative inquiry, we will communicate the fact that qualitative inquiry is not only something that precedes the quantitative study, or, as in mixed-method design, something that enriches a quantitative study, but is something that can stand on in its own merits, enriching our own lives. As I do not believe that qualitative researchers will be able to exempt themselves from the *evidence* debate, our priority for the next decade must be to sell qualitative inquiry as a necessary and essential research method that makes a solid contribution to health care, that reduces morbidity and mortality, and that makes the provision of health care humanistic.

Presently, qualitative researchers are in a minority position; in this mouse-and-elephant situation, the mouse is acutely aware of the jeopardy of its position, but the elephant is quite unaware of the mouse. Our response to this crisis of evidence-based medicine in the next few years will be critical to the development of qualitative inquiry in general. Here, I discuss qualitative inquiry within these three dimensions of agenda, anatomy, and autonomy. I do not have all of the solutions to our problems, but at least exposing and considering these *problems* is a reasonable place to start.

THE AGENDA OF QUALITATIVE INQUIRY

I believe the problem that qualitative researchers face is not with qualitative inquiry itself but with mainstream medicine’s entrapment in clinical drug trials, experi-

mental design, and quantitative analysis—in other words, their perception of their discipline as a biological/physiological rather than a humanistic discipline. Thus, the assumptions underlying evidenced-based medicine are a poor fit with the assumptions of qualitative inquiry. This results in conflicting research agendas: While the epidemiological and experimental designs for clinical drug trials seek to decontextualize, qualitative research, by its very nature, must consider the context. Qualitative health researchers and medical researchers have different definitions and agendas for “providing care”: Medical researchers focus on drug therapy and whether the pill reduces morbidity and mortality, while qualitative researchers focus on patient behavior—why the patient decides whether or not to swallow the pill, accepting, rejecting, or modifying the prescribed treatment; in other words, how treatment impacts on patients’ lives. Both perspectives are equally important for “efficacy” but are complementary rather than information to be incorporated into the same review.

I maintain that despite the recent rise of humanistic medicine, medicine’s unwavering adherence to randomized drug trials, epidemiological designs, and insistence on the criteria outlined by Cochrane (1972/1989) as *The Standard* is taking place at the expense of more significance advances—advances that may make even greater contributions in reducing morbidity and mortality. I maintain that medical granting agencies’ discrimination against qualitative inquiry, and their refusal to acknowledge, respect, and fund qualitative modes of inquiry and to accept alternative evidences, will impede advances in health care. Nurses know that **attaining health is a behavior, a lifestyle, an attitude, not solely the success of drug therapy.**

But the discrimination continues. We have trouble getting our research approved, funded, taught, published, read, and implemented. We also have a more serious problem: Many researchers and policy makers have no idea what qualitative research *is* and what it is for. They do not know what kinds of problems can be addressed qualitatively and how the product of qualitative inquiry may contribute to a healthy society. Furthermore, we must insist that our research be reviewed by those who not only understand our methods but who also have an appreciation for our substantive agenda.

THE ANATOMY OF QUALITATIVE EVIDENCE

From the humanistic and qualitative research agenda comes an appreciation for the different types of data required, the different modes of analysis, and the different results—that is, types of evidence produced. Excellent qualitative inquiry is contextualized, rich, dense, theoretical, and fascinating, and it is these very qualities, hallmarks of qualitative excellence, that make qualitative inquiry unappealing to policy makers and planners. Policy makers and planners perceive qualitative research to be cumbersome, with lengthy explanations, and to be too detailed. Yet, without this detail, it cannot be understood and appreciated.

Efficiency is important in the communication of our research to these policy makers and planners, and we live in a “sound bite” society. Yet, while quantitative results can be reduced to a sound bite (“there is a significant relationship between this and that”; “some percentage of the population does this or that”), in comparison, communicating qualitative findings requires the attention span of a

documentary. If we attempt to reduce qualitative findings to a sound bite, it appears as though we are stereotyping. The difficulty of communicating qualitative research in a forum where time is of the essence has become one of the problems working against qualitative inquiry. These problems are related to the narrative and theoretical structure of qualitative findings—findings that are based on data of various degrees of subjectivity—something I am calling the **anatomy of qualitative evidence**.

Describing a phenomenon qualitatively requires three basic types of data: direct, semidirect, and indirect.

1. Direct data. These are descriptions of the *actual, concrete* phenomena. Unfortunately, the direct data, while considered the most valid data, are also the most evident. Direct data therefore by definition reveals little that is new, is mostly obvious, mundane, and often even boring.

2. Semidirect data. These data take the form of perceptions and emotions—that is, the direct reporting of nonconcrete, subjective phenomena. They include the participant's reporting of dreams, recalled events, and conversations, for example. These data may be subject to some inaccuracies or "error," but the participant's perception of the event is generally considered in qualitative inquiry to be the perceived experience as it occurred.

Indirect data. Indirect data are inferential data, consisting of signs (such as nonverbal indicators of meaning, sarcasm, covering), signals (such as the use of shadowed data; Morse, 2001), and symbols (representations, such as metaphors)—types of data that, by definition, are more likely to lack validity or simply be wrong. Yet it is these data that reveal the implicit which are inferential, and which contribute to concept and theory development. They are inferential and symbolic. And it is the analyses of these data that make good qualitative data stimulating, surprising, exciting, and innovative.

Our failure to examine the role of our data in types of analyses has resulted in empty debates and disagreements in qualitative inquiry. Briefly, it is essential that direct data represent the actual phenomenon exactly, so that in research using direct data, reliability and replication are important. In this type of research, methods of validation, such as taking transcripts back to the participant for verification or coding using interrater reliability, are important. But as we move into research that uses more interpretive types of analyses via indirect data, such methods of verification are no longer pertinent and may even invalidate the analysis, keeping it superficial (Morse, 1997). In this case, research insight and immersion in the data allow the interpretation and provide the authority of analysis, shifting the responsibility of demonstrating validity to the principal investigator.

Note that these three forms of data are used in different combinations in various forms of qualitative inquiry. For instance, *direct data* play a less important role in phenomenology, which has its strength in *semidirect data* (perceptions) and *indirect data* (signs and symbols), giving it strength and enabling reflection and inference. Evaluation research and ethnography use *direct data* as documentation. For

instance, ethnography documents cultural rites and customs, and, with the exception of cognitive anthropology, relies less on indirect data. Grounded theorists use *semidirect data*, relying less on indirect data. Concepts and theories are constructed by noting actual connections between these data points, or by making logic and commonsense linkages between categories and theories. But these direct, semidirect, and indirect forms of data are *not* results in their own right—it is the way they form the narrative. It is the linkages between data and the various forms of data that make the theoretical structure—which is crucial. Indicators, or meanings from data, form categories and themes, and finally, through the use of common sense and the literature, concepts are formed and, ultimately, a cohesive theory. The qualitative researcher constructs themes and categories, concepts and theories by linking data in new and powerful ways using direct, semidirect, and indirect forms of data.

On the other hand, the anatomy of *quantitative* inquiry is the repeated scoring of narrow, specific direct data. If indirect data are used, they are treated as direct data. It is this transformation of data (or the scoring of two multiple data points) that enables measurement and the correlations that builds quantitative evidence by supporting or not supporting hypothesized relationships. These data are considered fact.

In contrast to qualitative inquiry, quantitative theory and frameworks come from the researcher's experience, by extending prior research, or from the library (using another researcher's framework), or by combining concepts in a new way. Quantitative researchers are restricted in their measurement abilities by the number of instruments available, or they must place their research effort on hold while they construct the necessary instrument(s). Data collection consists of measurement—counting—according to those variables, and perhaps demonstrating relationships in varying degrees of complexity. In comparison to qualitative analysis, quantitative analysis is simple, rule bound, and straightforward. But, as stated previously, it is this simplicity that enables the rapid-fire communication of quantitative findings. And policy makers and the general public have been attuned to thinking in percentages, associations, and relationships. The psychology of quantitateness has been, and continues to be, embedded in our society.

Note that quantitative data consist of direct and semidirect data, but these are treated as valid (direct) data. Quantitative researchers transform perceptions and emotions into direct data by asking the participant to score the event numerically, disregarding differences in the weighting of perceived scoring systems. For example, over the past decade, clinicians have been taught to objectify patients' pain experience by asking patients not to report pain in complex facial grimaces and colorful adjectives but to rank their pain using a numerical scale, with 10 being the worst pain ever experienced.

Elsewhere, I have argued that removing the patient's prerogative of graphically describing the pain removes the sharing of the pain experience—the transmissions of the compathetic response with the caregiver (Morse, Mitcham, & van der Steen, 1998)—as well as saving a remarkable amount of time. But is the amount of pain experienced by the patient communicated and appreciated by the clinician when a number is used? In an editorial, I asked, Imagine if such techniques were used in everyday life?

“How do I love thee?”

“Oh, 4.5.” (Morse, 2005, p. 144)

THE AUTONOMY OF QUALITATIVE EVIDENCE

Does qualitative knowledge stand alone? Or do we need quantitative research to test our theories, or to assist in determining the frequency or distribution of our identified phenomena. The answer is qualitative research sometimes stands alone, but it must never always be partnered with quantitative research.

The randomized clinical trial—Cochrane's (1972/1989) gold standard—is transformed into Sackett's (1993) class A evidence only with replication, and smaller trials are transformed into evidence (class B) only with the blessing of meta-analyses. Yet qualitative researchers do not intentionally replicate (except in certain circumstances), for to do so violates the tenet of induction and invalidates the research program. Thus, qualitative meta-analyses have been conducted, have worked, with a small number of studies.

In qualitative inquiry, there is a tension between the uniqueness of findings and the application and generalizability of the findings. I maintain that if the study is of reasonable scope, if it has been conducted rigorously, and if it is developed theoretically, then such a study can stand on its own and be recontextualized and applied to settings that have similar problems. Such studies are autonomous, solid, and partly confirmed in the literature. In fact, it is the literature that adds to its power, contributing the work of others to our concepts and theories.

I believe that in qualitative inquiry, our meta-analytic studies should be conducted differently. I believe that they should be conducted by increasing the study laterally, deliberately, by linking concepts. Qualitative studies are, by their very design, small studies of limited focus. Yet we can increase the scope of the study by linking concepts with studies that border our concepts. For instance, I have linked emotional suffering with hope, to show how people emerge from suffering (Morse & Penrod, 1999). Such linkages form the trajectory that mirrors the phenomenon as it is experienced in life. Such techniques add validity and add opportunities for application.

But the fact remains that our studies are difficult to communicate: Narratives are cumbersome and cannot be summarized in a way that does them justice, enabling them to be communicated adequately for implementation. The narrative form itself makes it difficult to communicate to policy makers and clinicians. It does not stand alone as a sound bite.

CONCLUSIONS

What about qualitative research, qualitative evidence in the era of evidence? I have made an argument that we must attend to the different nature of qualitative evidence. The world has been trained by the media and our present educational system to accept quantitative evidence as the only correct form of evidence, ignoring the description, inference, logic, and common sense used in qualitative inquiry. In qualitative inquiry, the differences in our research agenda add to our isolation, the different structure, or the anatomy, of our evidence places us apart, and we must attend to the autonomy of qualitative studies. In qualitative inquiry, we must remember that . . .

The agendas of qualitative and quantitative inquiry are different. Quantitative inquiry addresses the efficacy of treatments, and qualitative inquiry addresses complex problems, such as the perceptions of care.

The anatomy of qualitative inquiry are different. Data in qualitative inquiry are direct, semi-direct and indirect, with direct data least used. The result is that qualitative inquiry is considered “soft.” Narrative findings are structurally cumbersome and awkward to communicate in “sound bites.” We must change our strategies, learning from anthropology and archeology, to communicate through documentaries to the general public, so that everyone learns the nature of qualitative research.

Qualitative methods have autonomy. We know that both qualitative and quantitative inquiry are embedded in previous knowledge, especially at the beginning of the research project. However, while some qualitative research may be combined with quantitative methods as mixed-method designs, generally qualitative methods are rigorous enough to stand on their own.

Another comment. Qualitative researchers assume that everyone knows what qualitative research is. Yet this is not necessarily so, judging by the questions I receive from fellow academics and by the number of inappropriate submissions to *QHR*. We must learn to communicate our research, findings—or, even more urgent, what qualitative research *is*—to the general public. We need to follow the lead of Margaret Mead (1930/2001) or Stephen Hawking (1988), or of archeology or medicine, to communicate what we do, and why, to everyone. This must be a priority for our agenda.

Alternatively, we can take a lesson from our quantitative colleagues. How does medicine communicate? Ironically, they use qualitative techniques—they organize a news release, use a single patient or groups of patients who have undergone a certain treatment, and have them tell their story. This “pull on the heartstrings” stimulates funders, enabling physicians to obtain support, sympathy, and donations for their research, treatment program, clinic, or hospital.

Qualitative researchers do not generally use their participants in this way, for it may be very close to violating their consent and promise of confidentiality. Alternatively, we could write a trade book, one that would appear in the psychology or self-help section of the bookstores and be distributed directly to the general public. Qualitative research begs for this type of dissemination.

My conclusion, that qualitative evidence is not well appreciated, used, or disseminated, is not entirely the fault of the Cochrane Collaboration and their criticisms of the qualitative nature of our evidence. We have failed to make it clear that the Cochrane agenda is not our agenda and that our contribution to health care is elsewhere. Where? It is in the explication of the experiential and behavioral components of illness and health care; it is in the context of care and in the provision of care. Developing our understanding of these domains is crucial. But the onus is on us to communicate *what qualitative research can offer and can do*. It is our right to have this evidence accepted, funded, and published, but it is our responsibility to keep a high profile with respect to health care research and policy in this era of evidence-based medicine.

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