

Review:

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Abstract: MORSE, SWANSON, and KUZEL's book provides a useful framework for exploring qualitative research from the vantage point of evidence. By providing perspectives on evidence and dimensions of qualitative and quantitative research, the chapter authors use well known tensions between qualitative and quantitative research to argue for an approach to evidence-based medicine that integrates both approaches as well as experience as useful sources of evidence. The text is divided into five parts that address the nature of evidence, the nature of questions, the nature of standards, the nature of analysis and interpretation, and the nature of utilization. The value of this book comes from the timely discussion of what counts as evidence in terms of evidence-based medicine. By arguing that qualitative research provides important contributions to clinical practice, the authors broaden the dialogue about the evidence in evidence-based medicine. The book has utility in the areas of practice, education and research. Clinicians can use the discussions as a springboard to understanding the role of qualitative research in practice. As a teaching and learning tool, the book provides the traditional issues and challenges with qualitative research in an easily accessible way. For research, the book facilitates discussions about research approaches and what counts as evidence. For the novice researcher, it is an easily read perspective. For the experienced reader, it provides a challenge to think about what really counts as evidence in practice.

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1. Context

In today's healthcare settings, the term *evidence based medicine* (EBM) is a politically correct term suggesting that provided care is situated within the context of evidence that assures care is state of the art. The dictionary defines evidence as "something that furnishes proof" (Merriam-Webster, 2002, online). Generally speaking, when one thinks of proof in medicine, the gold standard is the randomized clinical trial, the epitome of quantitatively focused experimental design. Does that mean that any other kind of systematic approach to developing knowledge or "proof" is unacceptable as the basis of evidence based practice? The editors and contributors of this book say the answer is a resounding "No!" [1]

Taking the commonly accepted definition of EBM developed by SACKETT, ROSENBERG, GRAY, HAYNES, and RICHARDSON (1996), the authors argue that not only is qualitative research useful for evidence-based practice—it is essential in order to provide a frame of reference and understanding in complex patient situations that are not amenable to *randomized clinical trials* (RCTs) or where there is no prior systematically generated knowledge and understanding of the phenomena involved in the care context. SACKETT et al. (1996) defined EBM as

"the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research ..." (p.170). [2]

The authors suggest that this definition does not preclude other research approaches. In arguing that qualitative research is appropriate evidence for EBM, MORSE et al. explicitly state that they wrote the book in order to "move the discipline forward by responding to the doubts about qualitative methods, critically examining qualitative inquiry from the perspective of evidence, and helping to find practical ways for clinicians to use qualitative inquiry" (p.xi). Some of these discussions have been long standing issues in the use of qualitative research versus quantitative research or a combination of the two approaches to knowledge development. They are not new to researchers or academics. Yet, this book offers a useful framework for re-exploring the issues from the vantage point of evidence. In today's context of care, this exploration is timely and yields interesting insights and challenges for how we decide exactly what is acceptable evidence. [3]

2. Contents

The book is divided into five parts that explore key components of EBM: evidence, questions, standards, analysis and interpretation and utilization. Each part includes chapters that situate the topic within the context of qualitative research as evidence. The chapter authors attempt to address areas that enhance our understanding of qualitative research as evidence. The following sections summarize key points in each part. [4]

2.1 Part 1: The nature of evidence

The focus of these two chapters is to introduce the idea of qualitative research as a viable form of evidence and to illustrate how our traditional assumptions about evidence have not considered the implications of context, understanding and clinician practice. In the first chapter, UPSUR considers the variations in current perceptions of what evidence is and offers a definition to frame a model of evidence that integrates evidence derived from qualitative and quantitative research and experience. He develops his definition through an exploration of the definition of evidence from legal, medical and EBM perspectives. Synthesizing these perspectives, he suggests that evidence is "an observation, fact, or organized body of information offered to support or justify inferences or beliefs in the demonstration of some proposition or matter at hand" (p.7). He then demonstrates the interaction and mediation of different approaches to evidence in the model. UPSUR begins the development of his Synthetic Model of Evidence by characterizing 11 distinctions that include, abstract and concrete, mathematical and historical, theoretical and practical, pure and applied, general and particular, collective and personal, descriptive and prescriptive, predictive and interpretative, algorithm and judgment, inference and decision and disinterested and interested. The first term, in each pair of distinctions, demonstrate one conception of scientific evidence while the second term illustrates the contextual or hermeneutic dimension of evidence. He goes on to develop a four-quadrant model that has meaning—measurement (the range of research methods) as the vertical axis, and particular—general (the context of evidence as the horizontal axis. Each quadrant is further described in terms of qualitative/personal, qualitative/general, quantitative/personal and quantitative/general. He follows the model with a table that illustrates the types of evidence found in each quadrant, and the reasoning style and disciplinary contexts where it is commonly found [5]

In the second chapter, MADJAR and WALTON, introduce the role of context in both the development of evidence as well as in its use. They indicate that evidence has political, social, and economic implications that create "complex individual and collective dynamics" (p.40) within the context of EBM. They summarize their discussion by suggesting that all means of inquiry should be mobilized to create "well grounded understandings and theories which will lead to more "informed and sensitive clinicians" resulting in "effective and appropriate health care" (p.43). [6]

2.2 Part 2: The nature of the question

RAY and MAYAN begin the second part of the book with an overview of the social landscape that researchers negotiate by describing presuppositions and power relations that influence the development and use of evidence in health care. This discussion focuses on audiences, constituencies and agendas that use their particular perspective, traditions and languages to identify and support research priorities. Graphically depicting categories of audiences and types of agendas powerfully demonstrates the complex nature of who decides what

counts as evidence and for what reasons. Presuppositions and power relations are explored within the context of disciplinary socialization, the perceived superiority of the RCT method, and definitional authority for problems. [7]

Consequences of the power relations and embedded presumptions are described for both the researcher and public. For the researcher, these presumptions include influences of disciplinary socialization, the power of language, access to data, external influence on research priorities, perceived superiority of RCTs, and who defines the problem. For the public, RAY and MAYAN argue that the involvement of the patient has declined. "Suppressed agency", or the loss of patient/family voice in what professional competence and therapeutic success is contributes to problems with appropriately defining the research problem/question. Additionally, exclusion from the research process and the omission of the rich source of family caregiver experience and expertise creates problems with determining what the research question actually should be. The discussion of consequences for the public concludes with a call for research approaches that are more inclusive of public agendas. [8]

Closing Part 2, SWANSON provides a comprehensive look at the role of questions in the research process, particularly focusing on qualitative research as evidence. Types of questions are discussed including not only the research question, but also data collection questions and data analysis questions. She suggests that research questions in qualitative research typically name the population to be studied, the area of study and the nature of the outcomes, while research questions in quantitative studies name variables and the population studied. Data collection questions in qualitative research depend on the research question and may change as the study progresses, while quantitative data collection questions are typically highly structured in terms of consistency of questions asked of subjects, and the sequencing of questions often closed ended. In qualitative work, data analysis questions vary during the data analysis process and depend on the qualitative approach used. Likewise, in quantitative studies, the sets of questions will change as the researcher works with the statisticians within the theoretical framework of the study. The discussion contextualizes the role of questions using investigations familiar to the author and concludes by exploring the types of questions in three different qualitative research approaches: phenomenology, ethnography, and grounded theory. SWANSON concludes with a discussion of the types of questions in qualitative research and particular uses. She discusses questions asked in the process of conducting qualitative research and developing theory, questions about illness used in practice, questions about treatment used in practice, and questions that will change policy. Examples are provided in each of the areas to illustrate their uses. [9]

2.3 Part 3: The nature of standards

With the beginning chapters setting the stage for using qualitative evidence in health care delivery, this part of the book considers the role of standards. KUZEL and ENGEL begin by presenting general considerations for thinking about

evaluating qualitative research, such as the role of language, disciplinary traditions, and the purpose for which the research will be used, then argue for a pragmatic perspective that synthesizes several current approaches in the evaluation of qualitative health research. From KUZEL and ENGEL's perspective, a pragmatic focus asks the question, Is this approach rational and useful for the practical concerns of patients, providers, and policy makers? They suggest that the practical application of research findings as evidence is a primary concern for clinicians. KUZEL and ENGEL suggest that in a pragmatic approach, several key elements can be used to inform evaluation of qualitative work. These elements include the following statements: that facts, theories values and interpretations are interrelated; granting presumptions is a necessary part of the process; a judicious approach to risk involving trust and experience is desirable; the role of a community of inquiry guided by democratic values is essential. [10]

THORNE follows, in chapter six, by exploring the implications of disciplinary traditions from the social sciences, phenomenology, grounded theory and ethnography, and the influence they have on the scope, direction, and style of inquiry, particularly in health science research. Exploring more deeply, THORNE discusses the implications of knowledge that is derived from various traditions and suggests that the differences "warrant a reexamination of the criteria" (p.152) used to deem a scientific study acceptable to the health sciences community. Specifically, she suggests that theoretical frameworks, sample size and data collection strategies be viewed both from a disciplinary perspective as well as a philosophical perspective. The point of THORNE's discussion is that rather than be solely locked into the rules and regulations of original method designers, we need to think about "developing and refining" those methods to meet disciplinary needs. THORNE suggests that this evolution of methods might result in the realization that there can be little collaboration between disciplines, but ends optimistically by noting that we could emerge with a better appreciation for complexity, disciplinary differences, and a higher level of self-confidence in "articulating the linkages between disciplinary traditions" (p.157). [11]

GIBSON, GIBSON and MACAULAY end Part 3 with a look at community-based research approaches, known as action and participatory research that are increasingly being used to develop and validate knowledge useful to community needs and interests. The authors offer a framework, the Agenda-Based Evaluation Model, demonstrating steps for planning and reviewing community based research. Specifically focused on gaining an understanding of research agendas in a project, the model provides a standardized approach to highlight evaluation as a key part of the process, identifying players, understanding contextual factors, identifying agendas, negotiating shared agendas and comparing the agendas and outcomes. Each step in the model is illustrated by case studies. [12]

2.4 Part 4: The nature of analysis and interpretation

In order to be counted as evidence, researchers must assure that the processes of research especially around data collection, analysis, and interpretation, are rigorous in order for the results to be worthy of consideration by clinicians and other researchers. MEADOWS and MORSE take the discussion of rigor and credibility of qualitative research beyond the traditional arguments by focusing on verification, validation and validity in terms of describing the credibility of evidence. Strategies for verification, validation and validity of the project as a whole are reviewed. MEADOWS and MORSE review common strategies for verification, including the role of the literature review, project design, bracketing, sampling, methodological coherence, and validation, including multiple methods, inter-rater reliability, computer-assisted data analysis, member checks and audit trails. Validity is discussed from a project perspective that draws on the above mentioned strategies in context. The concept of incremental evidence is offered suggesting that qualitative work builds from one project to another in a program of research and is validated iteratively through findings that support earlier work or raise questions that can be explored by asking questions during data analysis that "clarify limits and meanings of primary findings" (p198). [13]

MORSE continues the discussion of verification in chapter 9. Moving from the individual study, to research programs, meta-synthesis, meta-analysis and verification by implementation, she suggests that for qualitative research to become useful in ways approaching RCTs, it must go beyond theory development. The development of assessment guides based on developed theory is one strategy discussed. However, a more complete and substantially stronger statement of clinically useful evidence comes from a research program that develops theory, creates an assessment guide based on the theory, implements the guide, and, in an iterative fashion, folds the findings from the implementation back into theory development and validation of the assessment guide. This process also continues to reinforce, extend, or develop deeper understanding of findings from previous studies in the research program, thereby strengthening their use for evidence based practice. [14]

2.5 Part 5: The nature of utilization

SWANSON begins part 5 by defining outcomes and suggesting that both quantitative and qualitative outcomes have unique contributions to EBM. She offers a categorization for qualitative outcomes that describes the potential ways that one might think about qualitative outcomes. Three categories are described: instrumental, pragmatic, and theoretical. Outcomes from qualitative methods are often used to facilitate quantitative research being used in an instrumental way to enhance a quantitative project. Outcomes used for practical purposes are seen in program planning, development and evaluation. SWANSON describes theoretical outcomes as having the greatest potential and least recognition in the EBM movement. Theoretical outcomes provide theories and concepts that can be the building blocks of theory. Using epidemiology as a way to illustrate similarities, differences, successes and failures of quantitative approaches, SWANSON

concludes with a call for a paradigm shift that "calls for a focus on multi-paradigm research and theory as evidence based practice" (p.248). [15]

In chapter 11, OLSON focuses on the use of qualitative research in clinical practice. She argues that a more complete understanding of problems faced in health care environments can be obtained by using research that describes multiple vantage points, fills in gaps in our understanding with contextual information, and monitors the effectiveness of interventions beyond the numerical parameters usually monitored. Additionally, she notes that much can be learned from exploring the organizational aspects of care delivery including organizational behavior, organizational processes, change, and the influence of leaders' roles and functions. [16]

In the final chapter, ESTABROOKS concludes with a state of the art discussion of research utilization science that is inclusive of all types of research. Research findings have substantiated specific areas of our understanding and yet this understanding is not translated into practice. It is far more complex than just knowing. She argues that our task is to better understand how research is disseminated and used, whether the use of research findings make a difference in outcomes, and what can be deemed legitimate evidence. [17]

3. Evaluation

I have framed my personal evaluation of the book in the following areas of relevance, utility, practical comments, and a brief overall impression. [18]

3.1 Relevance

Evidence based medicine is a timely topic. A quick analysis of the term in a MEDLINE search demonstrated its presence in over 8500 citations with about ninety-six percent of them indexed since 1996. A search of EBM and qualitative methods yielded approximately 1800 citations suggesting that the articles had been indexed to both terms. Scanning the first few hits indicated that there was little discussion related to the nature of qualitative research as evidence. In this regard, the book has relevance for bringing the potential, issues, and challenges of qualitative research as evidence into an open discussion. [19]

From the perspective of the definition of EBM and health services research, the book is valuable in advancing the argument that evidence is not limited to one particular source and, as MORSE et al. suggests, should integrate the best from every available source of systematic research in ways that are useful to the clinician. [20]

3.2 Utility

I suggest that the book has utility in three major areas, practice, education, and research. In the area of practice, clinicians looking for guidance in what constitutes legitimate evidence could use the information from the book to explore

qualitative research as evidence from the perspectives of people who are reputable sources. Granted, one could argue that they are biased towards a qualitative approach; however, a quick look at their credentials (provided at the back of the book) indicates that they are well respected in the health sciences and function in roles where quantitative and qualitative research exists in collaborative, albeit perhaps wary, relationships. The book provides several models (Taxonomy of Evidence, Agenda-Based Evaluation Model) and rubrics (Categories of qualitative outcomes, Evaluation questions from a pragmatic approach) that could be used to advance the understanding of an individual or clinical team in evaluating qualitative research as evidence. [21]

In the area of education, the book provides a unique vantage point that is not as pedantic as some of the more traditional textbooks on research methods and philosophies. By situating the arguments about qualitative research as evidence in the contemporary arena of EBM, students' perceptions of the utility of research in practice may be better served. For example, it is likely that they can identify with some of the examples illustrating how both methods of research are useful in understanding complex situational problems. One of the strengths of the book is how the authors consistently illustrate that the method should fit the research question and that the research question is by nature multidimensional and complex, furthering the notion that complex situations, problems and issues require complex multi-dimensional approaches to develop our understanding and knowledge about them. [22]

Finally, in the area of research, the book is useful because it explicitly places research methods and EBM on the table for dialogue and discussion. Whether one agrees with the authors or not, the discussion is an important one, and necessary, as ESTABROOKS argues, to move our understanding of research utilization forward. That premise suggests that this is not a book limited to the qualitative or EBP audience but, rather, has utility for all health services researchers. [23]

3.3 Practical comments

From a practical perspective, I found the book to be easy to read and logical in its layout of the topics. Sometimes I found the examples to be a bit lengthy in terms of illustrating the concept under discussion but not so much that, other than being bogged down, I stopped reading the chapter. Each chapter took around an hour to read so that someone with a basic understanding of qualitative research and EBM could read it in a weekend. [24]

From a reference point of view, I found the book easy to use if I wanted to quickly review an area of interest without re-reading the chapter or entire part. The table of contents and index provided easy navigation. This makes it useful for the user who is looking for specific information. The end-of-chapter references are valuable as resources in the areas of qualitative research and EBP and included classic citations in the topical areas lending to the authors' credibility as knowledgeable resources. [25]

3.4 Overall impression

I found this book to be a valuable addition to my bookshelf. Being easy to read made it useful in challenging my thinking and perspective of qualitative research as evidence. Because I teach undergraduates and graduate students in nursing, I found myself making mental notes of ideas and ways to use some of the information in my classes. For example, UPSURS's model of evidence with the distinctions provides a useful way to conceptualize scientific evidence in relation to contextual dimensions of evidence. RAY and MAYAN's categories of audiences and types of agendas in the discussion of what counts as evidence graphically illustrates players, agendas and suggests the presumptions that the players might bring to a research project. As a novice researcher, I found it useful in reminding me of areas that I had long since forgotten from my early methods classes. For these reasons, I would recommend it as a good buy and use of time to browse or read. [26]

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