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Qualitative Research Findings as Evidence: Utility in Nursing Practice

Wendy R. Miller, MSN, RN, CCRN

1311 N Street, Bedford, IN 47421, wrtruebl@iupui.edu, Indiana University School of Nursing

Abstract

Background—The use of qualitative research methods in nursing research is common. There is a need for Clinical Nurse Specialists (CNSs) to become informed regarding how such qualitative findings can serve as evidence for nursing practice changes.

Purpose—To inform CNSs of the meaning and utility of qualitative research findings. Implications for qualitative research findings as evidence in nursing practice are particularly discussed.

Keywords

qualitative research; evidence-based practice; nursing

Introduction

As the use of qualitative research methods proliferates throughout health care, and specifically nursing research studies, there is a need for Clinical Nurse Specialists (CNSs) to become informed regarding the potential utility of qualitative research findings in practice. In this column, the questions of what qualitative findings *mean*, how the ever-increasing amounts of qualitative research evidence can be used, and how such findings can contribute to evidence-based nursing practice, are considered. First, to provide readers with a context for the discussion, a brief overview of qualitative research and its theoretical underpinnings is included.

What is Qualitative Research?

Qualitative research refers to a method of inquiry in which the researcher, acting as data collection instrument, seeks to answer questions about *how* or *why* a particular phenomenon occurs. Questions regarding of *what* a phenomenon is comprised may also guide qualitative research¹. The most fundamental assumption underlying qualitative research is that reality is something socially constructed on an individual basis². Varied methods of qualitative research exist. Examples of qualitative methods employed in nursing research include grounded theory, phenomenology, ethnography, and qualitative description. Each method has its own assumptions and purposes and an appropriate method is chosen based on the research question. For example, a researcher investigating the process involved in the occurrence of a phenomenon would likely choose grounded theory, while a researcher interested in the meaning of the phenomenon would utilize phenomenology. Regardless of

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method, participants are purposefully enrolled based on their familiarity with the phenomenon. Data are generally collected via one or a combination of three mechanisms: interviews, observation, or document/photograph review. Data are analyzed inductively via specific, rigorous techniques and then organized in a manner which best answers the research question³. Importantly, the objective of qualitative research is not the accumulation of information, but the growth of understanding about phenomena of concern to nursing⁴.

The Nature of Qualitative Research Findings and their Use as Evidence

The way in which qualitative findings appear in research reports varies depending on the method utilized. Experts (Sandelowski and Kearney) in the field recommend categorizing qualitative findings in terms of the knowledge they generate, regardless of methodological origin. Sandelowski and Barroso⁵ have developed a typology of qualitative research findings. In this typology, findings exist on a continuum. Categories on the far left side of the continuum (“no finding,” consisting of a report of raw data, and “topical survey,” consisting of an organization of the data in a table of contents format) are considered to be not research and not qualitative research, respectively. The remaining three categories on the right side of the continuum (“thematic survey,” consisting of patterns found in the data, “conceptual/thematic description,” in which concepts and themes are used to link and illuminate concepts in new ways, and “interpretive explanation,” the defining feature of which is a transformation of data into theories or full explanations of a phenomenon) are considered exploratory, descriptive, and explanatory, respectively. While the authors note that the goal of the typology is not to judge the *quality* of findings, the typology can assist readers in determining which types of findings should be omitted from evidence influencing practice (no finding and topical survey) and those which may be more sophisticated, furthest from the data, and potentially applicable to practice.

Kearney⁶, too, has put forth a categorization mechanism for qualitative findings based on their degree of complexity and discovery and asserts that their application as evidence in practice is based on the category in which they fall. Findings “bound by a priori frameworks” are produced via the application of existing sets of ideas to data without identifying new insights. These findings cannot serve as evidence. Findings comprised of “descriptive categories” are similar to those in the “topical survey”⁵ and serve as a type of evidence that provides a map for previously unstudied experiences. “Shared pathway or meaning” findings portray linked themes or concepts, as well as an analyst’s ideas for practice implications. Findings that situate under the category of “depiction of experiential variation” not only describe the essence of an experience but portray how that experience varies depending on context. Finally, findings characterized as a “dense explanatory description” are considered the gold standard and explain human behavior and choice-making.⁶ Findings in this category are most readily applied to clinical practice.

Now that the types of qualitative findings have been described, it is possible to discuss how such findings are used in nursing practice. A common misconception is that qualitative research findings are, by default, preliminary to quantitative studies, cannot stand alone, and lack generalizability⁴. Qualitative findings, however, can be complete by themselves. Sandelowski⁴ differentiates between the generalizability of quantitative findings versus that of qualitative findings. Regarding quantitative findings, generalization is characterized by establishing universal laws for populations based on information from samples deemed to be similar to those populations, which cannot, nor is it meant to, be achieved with qualitative findings. Qualitative findings are not generalizable in the prevalent sense of the word—they do not provide laws or relationships that can be taken from a single sample and applied to entire populations. Rather, they are generalizable in a way that is particularly pertinent to nursing practice, in which there is an expectation that scientific findings, and nursing care

itself, be tailored to unique individuals in their distinct contexts. That is, qualitative findings provide idiographic knowledge about human experiences to *readers*, who can apply qualitative findings to the care of individuals who are in situations similar to that of those in the sample from which findings came⁴. A prime example of the generalizability of qualitative findings is seen in Conrad's⁷ study, which reframed the problem of "non-compliance" to "self-regulation" whereby patients with epilepsy changed medication practices in order to exert control over their disease. The findings from this study have been generalizable in that they have, in the form of a self-regulation theory, helped in understanding the origins of seemingly self-destructive behavior associated with a wide range of "noncompliant" behavior related to childhood immunizations, safe sex practices, and self-management of asthma and diabetes⁸. As the above example demonstrates, a CNS who reads qualitative research can potentially gain insight into the behaviors, needs, and experiences of his or her patient population, informing CNS practice. For example, an obstetrics/neonatal CNS who learns about the etiologies of prenatal "non-compliance" behavior via reviewing qualitative research findings is armed with information to help him or her develop etiology-specific nursing interventions for mothers living this experience, rather than relying on more general interventions to improve treatment adherence.

Sandelowski⁹ notes that qualitative findings can demonstrate instrumental, symbolic, and conceptual utility. Instrumental utilization refers to the concrete application of findings that have been made into new forms such as clinical guidelines, standards of care, appraisal tools, algorithms, and intervention protocols. Symbolic utilization is less concrete and does not result in a true practice change, but rather findings are used to legitimate a position or practice. Symbolic utilization of findings is often a precursor to instrumental utilization. Conceptual utilization is very intangible, and leads to the way in which a user *thinks* about providing care.

Qualitative findings have demonstrated independent instrumental utility in leading to key changes in clinical communication practices. The results of one study eventually led to the recommendation that active listening, appraisal, teaching, and social support be included in patient-family-provider communication. These findings were executed into practice directly and have led to improved outcomes¹⁰. A CNS could similarly directly apply qualitative findings to practice. For example, an oncology CNS who learned, via reading qualitative research, that oncology patients prefer a certain type of communication style at the end of life could work in the nursing sphere to educate nurses and develop with them a communication guide for these particular patients. The CNS could then measure pertinent outcomes associated with the intervention (patient satisfaction, for example). Qualitative findings also demonstrate instrumental utility by refining quantitative research. Qualitative findings often underlie the concepts measured in quantitative instruments.⁹ Further, qualitative findings provide knowledge about how individual and contextual factors affect the impact of an intervention¹¹ and can explain subject variation on targeted outcomes of an intervention¹². That is, qualitative methods can be used to investigate unexpected quantitative results or to explain why the effectiveness (success of an intervention in a research study) is not equal to its efficacy (success of an intervention in practice). For example, qualitative findings might inform a CNS of potential reasons a particular evidence-based intervention has not been effective in his or her patient population or for a specific patient. Conceptually and symbolically, qualitative findings are useful by increasing nurses' *understanding* of patients' experiences, thereby allowing for more tailored interventions in care, as well as the anticipation of problems that might be encountered by a particular patient in a particular context⁹. Qualitative findings inform a CNS' understanding of patients' experiences, improving his or her ability to develop specific, tailored interventions, particularly in the patient and nursing spheres, that will improve patient outcomes. For instance, a CNS who learned, via reading qualitative research, that ventilated patients' chief

concern is their inability to communicate while intubated could devise and implement nursing interventions that would allow for the use of alternative communication strategies for these patients. In effect, the experiences of patients in a certain situation (as captured via qualitative methods) have informed, and potentially improved, the care provided to other patients in that situation.

Kearney⁶ has made explicit statements regarding the ways in which qualitative findings can directly impact nursing practice. First, findings can lead to *clinical insight or empathy*. In this simplest mode of application, nurses can learn “what it feels like” to be in a given illness situation, common factors encountered by patients in that situation, and different ways patients view an illness. Armed with this understanding, the nurse pays attention to new cues from the patient, can make sense of certain presumably aberrant behaviors, and provide support in a more informed way. Qualitative findings can also contribute to *assessment of patient status or progress*. Findings which portray a trajectory of illness can inform the development of clinical assessment tools for individual patients or, with further testing, a particular patient population. For example, if a nurse reads that there are five reactions from teenage mothers immediately following birth, he or she can monitor for specific cues and form questions to determine the patient’s reaction and possible needs. Qualitative findings can also be applied via *anticipatory guidance*. This type of application is somewhat interventionist, as nurses share qualitative findings directly with clients, offering a research-based perspective on what patients might be experiencing and how others have described that experience. Findings at the “shared pathway” level are needed for this application. *Coaching* is achieved when the nurse shares qualitative findings with clients and further advises regarding steps they should consider taking to reduce stress/symptoms and improve adaptation. This application requires higher-complexity findings.

Evaluating the Validity of Qualitative Research

How does one know if he or she can trust the results of a qualitative study? Unlike in quantitative research, in which there are checklists and p values available to guide such a decision, the evaluation of qualitative research is less clear-cut. While researchers have created checklists to ease the process by which the validity of qualitative findings is assessed¹³, experts in the field struggle to come to a consensus regarding the appropriate criteria for evaluating qualitative studies because, according to Sandelowski¹⁴ and others^{15–16}, no criteria can uniformly address quality in the many various methods used in qualitative research. That is, quality “looks different” from one qualitative method to the next. Sandelowski and Barroso¹⁶ prefer that the quality of qualitative studies be judged based on criteria specific to the method being used. These authors offer a *reading guide*, to which readers of this journal are referred, which guides readers through evaluating the features of any qualitative report most relevant to its quality and use¹⁶.

Conclusion

Undeniably, qualitative methods have become a standard way in which researchers generate knowledge pertinent to nursing practice. Thus, CNSs are surrounded by much qualitative evidence with which they might lack familiarity in utilizing. Here, the discussion, though admittedly non-exhaustive, has hopefully illuminated to readers the value and potential utility of qualitative findings as evidence in nursing, including ways in which such findings can be immediately applied to practice. Further, readers have been exposed to the evaluation of qualitative studies and it is hoped that they will seek out the suggested sources in helping them to learn to read and critique qualitative studies so that data generated from such studies can be added to the CNS’s repertoire of evidence.

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Biography

Wendy Miller is an Adult Health Clinical Nurse Specialist and a PhD in Nursing Science student at the Indiana University School of Nursing. She is studying the self-management of older adults with epilepsy and is supported by a T32 pre-doctoral training grant.

References

1. Gantley, M.; Harding, G.; Kumar, S.; Tissier, J. Introduction to qualitative methods for health professionals. In: Carter, Y.; Shaw, S.; Thomas, C., editors. Master Classes in Primary Care Research Series. London: Royal College of General Practitioners; 1999.
2. Creswell, J. Research Design: Qualitative & Quantitative Approaches. Thousand Oaks, CA: Sage Publications; 1994.
3. Speziale, H.; Carpenter, D. Qualitative Research in Nursing: Advancing the Humanistic Imperative. Philadelphia: Lippincott; 2007.
4. Sandelowski M. "To be of use": Enhancing the utility of qualitative research. *Nurs Outlook* 1997;45:125–132. [PubMed: 9210160]
5. Sandelowski M, Barroso J. Classifying the findings in qualitative studies. *Qual Health Res* 2003;13:905–923. [PubMed: 14502957]
6. Kearney M. Levels and applications of qualitative research evidence. *Res Nurs Health* 2001;24:145–153. [PubMed: 11353462]
7. Conrad P. The meaning of medications: Another look at compliance. *Soc Sci Med* 1985;20:29–37. [PubMed: 3975668]
8. Barbour R. The role of qualitative research in broadening the "evidence base" for clinical practice. *J Eval Clin Prac* 2000;6(2):155–163.
9. Sandelowski M. Using qualitative research. *Qual Health Res* 2004;14:1366–1386. [PubMed: 15538005]
10. Cohen M, Kahn D, Steeves R. Making use of qualitative research. *Western J Nurs Res* 2002;24:454–471.
11. Greenhalgh T. Integrating qualitative research into evidence based practice. *Endocrin Metabl Clin* 2002;31:583–601.
12. Sandelowski M. Using qualitative methods in intervention studies. *Res Nurs Health* 1996;19:359–364. [PubMed: 8773558]
13. Cohen D, Crabtree D. Evaluative criteria for qualitative research in health care: controversies and recommendations. *Ann Fam Med* 2008;6(4):331–339. [PubMed: 18626033]
14. Sandelowski M, Barroso J. Reading qualitative studies. *IJQM* 2002;1(1):5.
15. Sparkes A. Myth 94: Qualitative health researchers will agree about validity. *Qual Health Res* 2001;11:538–552. [PubMed: 11521610]
16. Whittemore R, Chase S, Mandle C. Validity in qualitative research. *Qual Health Res* 2001;11:522–537. [PubMed: 11521609]