Perspective

What Can Qualitative Studies Offer in a World Where Evidence Drives Decisions?

Sally Thorne

School of Nursing, University of British Columbia, Vancouver, BC, Canada

Corresponding author: Sally Thorne, PhD, RN, DSc (Hon), FAAN, FCAHS

School of Nursing, University of British Columbia, Vancouver, BC, Canada

Tel: 1-604-822-7482

E-mail: sally.thorne@nursing.ubc.ca

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ABSTRACT

In an environment in which evidence-based practice is the espoused norm, nurses have understandably sought to frame the knowledge they deem relevant to practice decisions, including the findings of their qualitative studies, as a form of evidence. However, since cancer patients face a significant challenge interpreting various evidence claims, it is important to recognize that the results of our qualitative studies reflect a different form of knowledge from that which an evidence-based practice definition of evidence presumes. Thus, we need to rethink our relationship to what qualitative studies offer to the evidentiary dialog. An approach to qualitative inquiry that derives from a nursing disciplinary logic model is, therefore, presented as an alternative means by which to generate the kinds of knowledge nurses need to practice and to gain expertise in clinical wisdom. Drawing on cancer communications research as an example, a nursing angle of vision on how best to use qualitative approaches to interpret evidence and inform practice emerges.

Key words: Cancer care, communication, evidence-based practice, interpretive description, oncology nursing, qualitative

Oncology nurses are well aware of the influence of strong evidential claims, especially those made on the basis of carefully constructed trials based on large sample sizes, reliable measures, and strong statistical probability. However, they also realize that evidence alone is insufficient for many actual decisions in relation to individual patients;[1] instead they also require knowledge of the patient perspective and the kinds of insights that derive from established clinical wisdom. Taken together, these three species of knowledge build strong and defensible decisions as to cancer policy and also cancer care.

In their attempt to achieve evidence-informed practice, as the gold standard ideal,[2] nurses have often compromised the care context by using the term "evidence" in reference to ways of knowing that are not evidentiary in the sense of being "justified beliefs" substantiated by established systematic processes, but instead are based on claims for which the warrants for their truth value have been

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based on processes such as aesthetic knowing, personal knowing, or emancipatory knowing.[3-5] Using evidence language in this slippery manner actually complicates the challenge, especially in our modern world where our patients are being exposed to various evidence claims by their healthcare professionals, their friends and family, the internet, and other media. To ensure that we maintain the trust and credibility that patients have in our profession, it is of utmost importance that members of our profession avoid confusing the "evidence" dialog by using that term as a descriptor for all of the various knowledge we attain through our collective professional experiential wisdom or from the knowledge we gain about patients and clinical contexts through the use of qualitative methods.

The knowledge nurses need to conduct their practice includes formal evidence, but also so much more. We need to understand how to think about each patient in the sense of "wholes and parts" in interaction. Certainly, we might focus our special expertise on the cancer illness, but as nurses, we never lose sight of the whole person living with, through and beyond that illness. We appreciate that there are common patterns of experience across patients with similar health conditions, but we also know that each new patient raises the possibility of new diversities that may shape what constitutes optimal care. We further recognize that everything we do in our nursing of that patient will take place within a dynamic context of their family and social realities as well as the multidisciplinary health team context within which their cancer is being managed. Thus, the kind of knowledge nurses need to balance that which derives from the formal (large population) evidence is that which is manifest in the skillsets that comprise the capacity to respond to individuals within their unique and distinctive context.

When nurses first began using qualitative methods, they hoped that the insights they could surface would inform that nursing capacity to imagine, engage with, and respond to individual conditions in the care context. However, many of the established and conventional qualitative methodologies – those that we inherited from the social sciences– were designed to build strong theorizing rather than to support the very different kind of complex thinking that is needed for excellent nursing practice.[6] Many of the qualitative study designs included components that were intellectually counter to a nursing epistemology or way of knowing. For example, they often assumed commonality and homogeneity and oriented the scholar to seek out unifying features rather than variations. They required that new knowledge is built on prior theorizing (meaning, in most cases, social theorizing, not the intellectual structure of nursing). Moreover, they assumed that the point of the research was to establish knowledge that stood the test of time, rather than taking a more nursing view that clinical insights will inevitably evolve and become more rich and complex over time, a dynamic process that nursing celebrates. Due to this, many nurses using qualitative methods found that they had to choose between methodological rigor and study designs that were more consistent with a nursing logic. We can see in the literature too many smaller studies, studies that either overgeneralize or resist any general implications, and studies that reveal considerable confusion as to whether the point of them is formal theorizing or informing healthcare.

Into this confusion, a new era of applied qualitative methodologies has arisen. Used in this sense, the term "applied" signifies that some elements of conventional methods are being taken up for knowledge development in the applied and practice disciplines such as nursing.[7] Among the newly emerging applied qualitative approaches, my team has explicitly developed a methodology that is built-in alignment with a nursing approach to knowledge generation. Named "Interpretive Description," this method calls for framing our questions, not in the service of advancing theorizing but instead in such a manner that they orient us to the knowledge needs of the discipline.[8] For example, instead of asking a phenomenologically oriented question such as "What is the lived experience of cancer?" which assumes an essential and unifying experience, we might ask "What can be learned from accounts of the experiences of cancer patients that might inform our capacity to care?"

This shift in focus allows us to seek both commonalities and diversities, to envision from the outset of our study the nursing audience to which our findings will need to resonate with credibility, and to design the processes of our data collection and analysis in such a manner as to align with a nursing perspective on what constitutes a reasonable clinical knowledge claim. Just as nurses use theorizing where it serves their purpose, but do not mistake their purpose in the world as "being" theorists, this kind of research steers nursing not only to describe the phenomena of their practice but also to interpret what they are describing. Knowing that nurses have a strong need to ask the "so what?" question, the nurse using Interpretive Description methodology will critically reflect on the process and product of inquiry throughout the study so that the disciplinary cautions and concerns have been built into the analytic process and are reflected in the study report. Thus, the findings of this kind of research begin to address the nature of the knowledge nurses need, not only to apply current large-scale evidence to their practice but also to know when departures and variations are justifiable and indeed essential, and to build up their capacity to articulate

a strong disciplinary rationale for nursing's clinical priority directions.[9]

To illustrate, I refer to the field of communication research in cancer care. That cancer patients care about and are affected by their communications with health-care providers is well established, and thousands of studies have attempted to add to our capacity to ensure effective communication. However, most are quantitative, breaking the exceedingly complex phenomenon of communication into measurable elements. While they may have produced some useful insights in relation to such tension points as treatment decision-making and bad news consultations, many provide relatively little by the way of useful recommendations, and the vast majority conclude with the claim that more clinicians ought to receive communication training. At the same time, evidence that communication training solves the problem is very sparse, despite numerous studies to demonstrate that. Instead, based on qualitative studies of communication from the perspective of patients and their families, we can begin to see that many of the communication difficulties they encounter have to do with the "occasional misses" that any clinician can make given the complexity of the challenge and with systematic misconceptions of what patients want based on generalizations associated with prior research findings.[10] However, the most devastating of communication problems tend to arise as a result of a small subset of clinicians who, for reasons of attitude, knowledge or will, persist in communicating with patients in a manner that is unhelpful, counterproductive, or even toxic. These "persistent offenders" tend not to be influenced by any level of investment in communication training, and instead, require a more systematic "team based" approach in which the patient's right to a safe communication environment trumps the individual clinician's prerogative to deliver care unassisted. Thus, by targeting our qualitative investigations at the heart of the problem from a patient perspective, by listening to patterns within patient accounts across context and time, and by understanding the clinical audience into which we hope our findings can make a difference, we can design studies that provide nurses the ammunition they need to act as patient advocates and ensure that the communication patients encounter is helpful rather than harmful. In this instance, a nursing perspective shifts the orientation to problem-solving rather than documentation of the phenomenon of concern and allows for new solutions to emerge.

As we emancipate qualitative research methodology from the conventions of the social sciences in which it originated,[11] nurses can creatively focus their thinking on the most complex and messy of challenges in the practice environment – those aspects in which a nursing angle of vision is conducive to seeing things holistically, dynamically, and in as comprehensive a manner as possible. When we allow a nursing perspective to take its rightful place in qualitative study design and conduct, we open up an intellectual curiosity and freedom that allows us to expose the forms of knowledge that nurses need to "see" to practice well. Thus our qualitative findings do not need to be considered "evidence" in their own right to make a meaningful contribution to the evidence-based practice environment. With advances in applied qualitative methods allowing us to more creatively inject a nursing perspective into our inquiries, we shine a powerful new light on the marvellous intellectual perspective nursing has to offer to healthcare.

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Conflicts of interest

There are no conflicts of interest.

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