Editorial

The Emergence of Qualitative Methods in Health Services Research

This Special Supplement Issue of *Health Services Research* draws attention to the growing role played by qualitative methods in health services research. This is consistent with developments in the social and policy sciences at large, reflecting the need for a more in-depth understanding of naturalistic settings, the importance of understanding context, and the complexity of implementing social change. Recent health care examples include the turmoil and ambiguity created by managed care, the challenge of applying evidence-based medicine to everyday clinical practice, and the accelerated pace of change occurring within the health care sector at large. After briefly commenting on these forces, I want to highlight the intended audiences for this volume, discuss some major impediments to qualitative research, and offer a few suggestions for their removal.

In the case of managed care, most "information" to date has come from two sources: (1) quantitatively oriented studies of the impact of managed care and (2) accounts in newspapers or other media. The quantitative studies generally conclude that managed care has no *net* positive or negative impact on quality or outcomes of care, and that the rate of growth of costs has been lowered, at least temporarily. In contrast, newspapers and the electronic media have generated a large number of individual "horror stories" depicting the harmful consequences of managed care to patients and their families. Little "in-between" research has been published that might help explain *what* forms of managed care implemented in *various ways* might influence provider behavior *under certain conditions or circumstances* in ways that might improve *or* harm quality of care. This is often referred to as the "black box of managed care" (c.f. Conrad, Wickizer, Maynard, et al. 1996). What is missing are qualitative investigations of the various forms of managed care, the influence of managed care on provider and patient behavior alike, and the resulting consequences. The current "debate" would be much better informed if the results of more qualitative research were available.

A second major reason for the growing interest in qualitative methods lies in the challenge of implementing the findings of evidence-based medicine in everyday clinical practice (Simpson, Osborne, and Eisenberg

1999). Qualitative research methods can play a major role in developing a science of "evidence-based implementation." This is aptly recognized in a British Medical Journal editorial entitled, "Why Do Qualitative Research? It Should Begin to Close the Gap Between the Sciences of Discovery and Implementation" (Jones 1995).

Third, the rapid pace of change occurring within the health care sector (e.g., mergers and consolidations of hospitals, health plans, and physician practices; new developments in pharmaceuticals, biotech, and information technologies) make it increasingly difficult to use existing data sets to address the issues at hand. Data and findings that might have been true in the early '90s or even a few years ago have often been overtaken by recent events. Ongoing qualitative (as well as quantitative) examination of these rapidly occurring changes offers a fruitful approach for shedding light on these emerging forces. The Robert Wood Johnson Foundation's Community Tracking Study, funded through the Center for the Study of Health System Change, serves as one example (Kemper 1996).

AUDIENCES

This Special Supplement should be of interest to all health services researchers, policymakers, and users. The primary beneficiaries may well be those who view themselves exclusively or primarily as "quantitative" researchers and/or those who have viewed "qualitative" research with skepticism. The fact is that the complex problems facing health systems throughout the world require multiple methods and approaches for their solutions. We need to remind ourselves that, regardless of our primary disciplinary and methodological training, the nature of the problem, issue, or question we're addressing should dictate our choice of methods to use, and not vice versa.

Readers, of course, will select those articles of greatest personal interest. But, as a guide for doing so, everyone should read or at least scan the excellent overview provided by Rundall, Devers, and Sofaer (1999). Although it is tempting to underscore several of their points, I want to use the remaining limited space to discuss briefly *five major impediments* that I see to the greater use of qualitative methods in health services research, and to suggest means for their removal.

IMPEDIMENTS

The five impediments may be grouped under the three general headings of (1) funding, (2) training, and (3) journal review and dissemination. Under

funding, the two primary impediments relate to funding agency priorities and the review process. Many funding agencies, particularly governmental, tend to favor proposals that can yield results within a relatively short 12 to 18–month time period using existing data. This eliminates the possibility that the question or issue might be best addressed through the use of qualitative methods or a combination of qualitative and quantitative approaches, some of which may require original data that take time to collect.

What is needed is a balanced portfolio of projects that appropriately recognize the relevance of qualitative methods of various forms (ethnographic studies, longitudinal comparative case studies, observational techniques, etc.) along with the contributions that can be made from an analysis of existing data sets and newly collected data. Qualitative research is particularly appropriate when relatively little is known about a given phenomenon. As suggested earlier, we may have jumped too quickly to large-scale quantitative analyses in our attempts to assess the effects of managed care without first adequately understanding what constitutes "managed care." It is suggested that funding agencies systematically evaluate the amount of knowledge available about a given area before placing parameters on either the length of study that will be considered for review or the specific forms of data or data collections that might be favored.

A second set of barriers relates to the review process. There is a need to use more trained, experienced reviewers of qualitative work. Study sections, in part, may be hampered in this regard because of the relative lack of supply of such individuals with an appropriate knowledge of health services issues. This can result in good qualitative research not being funded and/or poor qualitative research that is being funded. One suggestion is to use well-trained, experienced qualitative researchers regardless of their field. These individuals can then be paired with other reviewers who have the necessary health services content expertise to ensure that a balanced review occurs. At the same time, renewed effort should be made to identify and train health services researchers with qualitative methods expertise.

The review process would also be improved if every proposal were examined to see if it would be strengthened by incorporating a qualitative component. Any number of well-designed randomized trials and quasi-experiments fail to make an impact beyond the study setting because of the difficulty of duplicating the characteristics of the study setting. Incorporating some qualitative components into such study designs would help to place the research in context and assist in the implementation of findings in other settings.

Related to this point is the suggestion that study sections provide more

careful or, perhaps, expanded oversight of the composition of investigators needed to address the issues posed in a given proposal. In my experience, this oversight has usually been limited to suggesting that the proposal would benefit from more statistical consultation or from adding an investigator or consultant with specific expertise in a relevant clinical area. But if greater attention is given to the potential advantages of incorporating some qualitative work, then the need to broaden the investigator team along other lines becomes evident. For example, clinical proposals are sometimes put forward to examine the effect of a particular treatment intervention or a new therapy with the expectation that the results of the research will then automatically influence clinical practice. These proposals would benefit from a more informed understanding of the ways in which changes within organizations and changes in provider behavior are brought about. Social scientists with expertise in these areas and in some of the qualitative methodologies appropriate to examining these issues would need to be added to the team.

Two aspects of training programs in health services research also serve as impediments to the use of qualitative methods. First, it is impossible for health services doctoral students to complete their degree without having at least one, if not several courses in multivariate data analysis, but almost no one receives even a basic course in qualitative methods! The suggestion here is very simple. Regardless of the disciplinary focus of the doctoral student—anthropology, decision sciences, economics, epidemiology, medicine, organization theory, political science, sociology, and so on—*everyone* should take at least a basic qualitative methods analysis course. This course, at a minimum, would cover the epistemological foundation for the most common qualitative methods in use, the pros and cons of each method, the reliability and validity issues associated with each method, and examples of each method in health services research application. This Special Supplement issue can serve as "source material" for such a course.

A second training program issue concerns the dissertation. Most doctoral programs encourage the use of existing secondary data sets in order to reduce the time needed to complete the dissertation. Students frequently use data sets assembled by their dissertation advisor. However, this discourages individuals from attacking problems that may be best addressed through field work and related qualitative methodologies even though such research may take longer to complete. If we are candid, the bias among faculty may involve more than consideration of time issues. Several years ago, I overheard a colleague tell a doctoral student that "not only will your field work approach take a lot longer, but you will be less sure what you will have afterwards."

The latter, of course, reflects an uninformed understanding of qualitative research—a problem that is directly addressed by this Special Supplement.

There is risk, to be sure, in advising doctoral students to undertake a qualitative dissertation. I am reminded of a true story, relayed by a colleague, who was recounting a major earthquake in Papua, New Guinea in the 1980s. He received a phone call in the middle of the night from his graduate anthropology student who had been working in the region for over a year. Between sobs reflecting intense grief, the doctoral student finally blurted out: "Professor, my entire Pygmy tribe was wiped out overnight. There goes my dissertation! What do I do now?" I am not sure whether we should think of health systems, hospitals, health plans, and physician group practices as tribes, but given the rapid changes occurring in health care today, some of them won't be around in 18 months. The lesson is not to discourage relevant qualitative field work, but rather to choose one's sites carefully. Of course, we can also learn from "postmortems."

The final impediment relates to criteria that journals use to review manuscripts. It is frequently alleged and commonly perceived that most health services research journals either are not interested in publishing qualitative work or do not have adequate reviewer expertise to evaluate such work appropriately. This results in what qualitative researchers perceive as discrimination against their work. At *HSR*, we actively encourage qualitative work (see our April 1997 editorial), but, to date, we have received few submissions. We do not have special criteria for reviewing qualitative manuscripts, believing that the usual criteria applied to any manuscript (importance of topic, appropriate study design, reliability and validity of measures, analytic rigor, clear discussion of the implications of the results, etc.) apply to qualitative work as well as quantitative work. We make efforts to ensure that reviewers with appropriate expertise and experience in qualitative methods review the qualitative papers.

Whether qualitative manuscripts require different criteria than quantitative manuscripts can be argued. More relevant may be a recognition that the standard criteria need to be spelled out in further detail when qualitative work is reviewed. To this end, we suggest the following "expansions" for explicit review of qualitative manuscripts submitted to *Health Services Research*:

1. *Importance and interest of the topic or question under investigation.* Because qualitative researchers are often breaking new ground in an area about which little is known and little data are available, it is important that authors provide a full description of the importance of the topic and its interest to potential stakeholders—policymakers, providers,

consumers of care, and others. That is, Why are the qualitative methods proposed the best way to yield new knowledge about the important issue being addressed?

2. *Appropriateness and description of the specific qualitative strategy(ies) used given the topic.* Qualitative methods range widely, involving the use of focus groups, interviews, observation, ethnographic accounts, audiotaped conversations, comparative case studies, and related methods. Do the methods used fit the topic addressed? Do they yield the most accurate, valid, reliable information? For example, if one is addressing issues of "what happened," then ethnographic methods, field notes, interview materials, and documents may all be relevant. If one is asking "why," then approaches that get at "the meaning of things" are appropriate drawing on phenomenology, interviews, and related materials. If the major interest is answering the questions of "how," then grounded-theory approaches are most relevant. These include interviews over time, participant observation, and related methods. Issues of retrospective accounts versus prospective accounts, cross-sectional versus longitudinal studies, and so on also need to be addressed. In brief, authors need to indicate clearly what was done, why it was done, and how it was done. Otherwise, "we have a smile without a cat" (Downs 1983).
3. *Sampling strategy.* Although in quantitative research authors' sampling strategy is usually laid out clearly, this is sometimes not the case with qualitative research. Authors of qualitative papers need to be clear in describing the purpose or rationale for the sampling strategy of their cases or units of observation, particularly as these may have changed over time (see Devers 1999; Yin 1999).
4. *Analytic rigor.* This addresses the reliability and validity of the findings obtained. How much confidence should be placed in them? It involves issues of adequacy, appropriateness, use of audit trails, verification with secondary informants and data where possible (i.e., triangulation), and using multiple raters who are familiar with the topic and context as appropriate (Morse 1994; Devers 1999; Patton 1999; Yin 1999). Have the authors sought evidence of alternative observations that might have contradicted or modified the present findings? Many of the articles in this volume speak to these issues. It is important to note that common shared standards for evaluating qualitative work do exist consistent with the criteria discussed in this

editorial (Devers 1999; Patton 1999; Yin 1999). We repeat *HSR*'s interest in publishing manuscripts that meet these criteria. We also invite manuscripts that address methodological issues in qualitative research or offer creative approaches for combining qualitative and quantitative methods.

CONCLUSION

Concerted action will be needed by all—funding agencies, reviewers, investigators, educators, and editors—to remove these barriers to the conduct and dissemination of well-done qualitative research. But although debate about the relative pros and cons of quantitative and qualitative approaches can be helpful, health services research needs to move beyond these debates to produce, capture, and put into use valid knowledge, however generated, to improve the financing, organization, delivery, and outcomes of care. Increasingly, this may involve the creative combination of quantitative and qualitative methods. The Agency for Health Care Policy and Research has encouraged this in recent requests for proposals. It is hoped that this Special Supplement issue, based on the conference organized and co-sponsored by the Agency for Health Care Policy and Research and the Robert Wood Johnson Foundation, will make a further contribution toward this end.

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Editor

SPECIAL NOTE

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