

1

Qualitative Methodology and Health Research

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Chapter summary

This chapter introduces the theoretical perspectives that have generated qualitative research both of and for health, and argues that an understanding of these is vital for both conducting good quality research and for researching in a multidisciplinary environment. Some broad orientations common to much qualitative research are then outlined, and the criticisms these can attract from other approaches are discussed. The contribution of qualitative research to areas such as public health, health promotion and health services research is identified as that of providing contextual, in-depth understanding of the perspectives of participants.

Introduction

'Health' and 'illness' have long been topics of interest for social science disciplines such as sociology, social anthropology and history.

- *Sociology* is the study of human society. It has traditionally focused on developed countries, with the sociology of health and illness addressing such issues as concepts of health and illness, inequalities in health, experiences of health and health care systems (Nettleton 2013).
- *Social anthropology*, the study of people in the context of culture and society, has traditionally studied cultures ‘other’ than that of the researcher. Medical anthropologists have focused on how a society’s beliefs and practices relating to health and illness (including healing systems and folk practices) are embedded in other aspects of its culture (Helman 2000).
- *History of medicine* has contributed to understanding the history of medicine and medical knowledge, understanding the role of health and illness in social history, and to policy studies in the health arena (James 1994).

Maintaining health and dealing with ill health are universal challenges, and there is now a large research literature within these disciplines on how these have been accomplished over time and across different human societies. Health professionals have a long history of integrating insights from social science research into their understanding of human health (see, for instance, Henderson 1935; Kleinman 1973; Helman 2000). More recently, the *methods* of social research have become an accepted part of health research in areas such as public health, primary care, health promotion and nursing. Although disciplines such as sociology, social anthropology and history have their own methodological traditions, what they have in common is perhaps a focus on human behaviour in context, whether social, cultural or historical. It is not therefore surprising that health care practitioners, managers and policy-makers have increasingly turned to the qualitative methods of social inquiry used within the social sciences to enhance understanding of health, health behaviour and health services, and to improve the management and provision of health services. As the problems of public health are increasingly those of human behaviour, rather than the development of new technical interventions, those trained primarily in health sciences, such as medicine or nursing, are turning to social research to help understand how to improve health and health care. This book is intended for both qualitative social scientists interested in applying their disciplines to health research, and for health professionals interested in using qualitative research approaches.

We focus on the particular contribution of qualitative research methods to health research. What we mean by ‘health research’ includes two broad strands of work. First are critical studies *of* health from various social science perspectives, which address questions such as: What are health and illness? How are they managed, and in whose interests? Second are studies *for* health, from within the disciplines of public health, health promotion or health services research, in which the contributions of social science are defined in terms of the health agenda. The distinction between these two sorts of investigation is perhaps a useful one for thinking about the aims of the study. (Is it basic research, aiming to expand our knowledge of society, or applied research, aiming to address an existing health care problem?) How the two kinds of investigation are written up may also differ, in order to meet the expectations of different intended audiences (see Chapter 12). However, the distinction does not imply different criteria for methodological rigour. Doing

applied research *for* health is not an excuse for inadequate research design, a superficial approach to data collection or under-theorized analysis. Producing useful findings involves, as a necessary condition, producing sound findings. Indeed, if the research has been funded to produce policy-relevant findings, there is perhaps even more reason for rigorous design and analysis. The principles of qualitative research are, therefore, exactly the same, whether the study is primarily academic (such as a PhD thesis in Anthropology) or more 'applied', such as a funded evaluation of a health care project. Similarly, the same principles of good design and conduct apply whether the research setting is a health service organization in a high-income country, or a rural village in a low-income country. Clearly the practicalities of carrying out the study will differ, but we hope to show how the same elements of research planning are involved. Whatever the setting, the researcher has to consider the local cultural and social context, and this is an essential part of adapting methodological techniques to a particular research project. Throughout this book we have used examples from a variety of settings, and we hope this range will illustrate the universal applicability of methodological principles.

What is qualitative research?

Health research, then, includes any study addressing understandings of human health, health behaviour or health services, whatever the disciplinary starting point. What is meant by 'qualitative' research is perhaps more contentious. Some have seen the division between 'quantitative' and 'qualitative' approaches as a false one, and it is perhaps impossible (and unhelpful) to characterize qualitative research in a way that is completely separate from quantitative research. Although qualitative research tends to use language data (written or oral), and quantitative research numerical data, for instance, this is not always the case. Many qualitative studies use simple frequency counts, whereas language data can be used in quantitative studies. Although qualitative research tends to have smaller sample sizes, it certainly does not follow that any study with a small sample is a qualitative study.

There are some methods of data collection that are particularly associated with qualitative research. These are discussed in the chapters in Part 2 of this book. However, these methods of data collection can also be used in quantitative studies, so it is not merely the way in which data are collected (such as through an interview, or by observation) that characterizes a study as qualitative. It might be more useful to characterize qualitative research not by the kind of data produced or the methods used to produce them, but by the overall aims of the study. The most basic way of characterizing qualitative studies is to describe their aims as seeking answers to questions about the 'what', 'how' or 'why' of a phenomenon, rather than questions about 'how many' or 'how much'. Box 1.1 shows some examples of qualitative research studies reported in social science and biomedical journals, together with their main methods of data collection and the stated aims of the study.

PRINCIPLES AND APPROACHES

Note that many of the studies in Box 1.1 have ‘examine’ or ‘explore’ as an aim. These are studies which were conducted to understand more about a phenomenon, rather than ‘measure’ it, and to investigate health, illness or health services from the perspective of the communities and individuals affected, or the professionals who provide health services for them. Understanding questions such as these as legitimate aims for research is the consequence of having a particular theoretical perspective on the role of knowledge, how we acquire it from research activities, and what ‘counts’ as valid knowledge about the world. Although theoretical assumptions in research articles are not often made explicit, they nonetheless frame the kinds of questions researchers decide to ask, how they go about answering them, and how debates about the soundness of their findings are conducted. Therefore, a consideration of the theoretical approaches and broad orientations that are typical of qualitative approaches is fundamental to understanding the contribution of qualitative research to the study of health.

Box 1.1 Some examples of qualitative health research questions

Title of paper	Methods of data collection	Aims
Using qualitative methods to understand the determinants of patients’ willingness to pay for cataract surgery: A study in Tanzania (Geneau et al. 2008)	Semi-structured interviews, informal discussions	‘to understand better cataract patients’ willingness to pay for surgery’
Cancer patients’ information needs and help-seeking behaviour (Leydon et al. 2000)	In-depth interviews	‘to explore why cancer patients do not want or seek information about their condition other than that supplied by physicians’
Virtually he@lthy: the impact of internet use on disease experience and the doctor-patient relationship (Broom 2005)	In-depth interviews	‘[to investigate] how access to information and online support affects men’s experiences of disease and [...] the doctor-patient relationship’
Leprosy among the Limba (Opala and Boillot 1996)	In-depth interviews	‘examines Limba concepts of leprosy within the wider context of Limba world view’
Parents’ perspectives on the MMR immunisation (Evans et al. 2001)	Focus group interviews	‘to investigate what influences parents’ decisions on whether to accept or refuse ... [measles, mumps and rubella] immunisation’

The role of theory

'Theory' is central to research, even the most applied research. By this we do not mean that researchers have to start with grand theoretical concerns, or that research should necessarily be testing or building theory. Some studies are designed to do this, but many other health research projects are properly designed to address empirical questions, without any explicit theoretical aims. In Box 1.1, for instance, the study of parents' perspectives on MMR immunization (Evans et al. 2001) is designed to examine how parents make decisions in this particular context, not to generate theory about decision-making in general, although of course it may do this as well. However, whether we are aware of it or not, theoretical assumptions about how the world works, and how health care, illness behaviour or doctor–patient interaction are organized, do frame the kinds of questions that are considered important or legitimate to ask and how we choose to answer them. There are several ways in which theory does this. First, there are what could be called large-scale, or macro theories about the social world and how it works.

Macro theory

'Macro' theoretical perspectives frame particular issues as 'puzzles' or questions requiring research because they entail particular assumptions about the way the world is, and how people behave within it. These might include questions such as: 'Is it inevitable that wealth is unequally distributed?', 'Is there a real world of physical objects that exist separate from and independent of our perceptions of them?' One well-known example of macro theory is the materialist approach, which is built on an assumption that the material sphere of life (such as economic relations) determines other aspects, such as culture. In this tradition, Karl Marx developed his theory of class relations to explain both the contemporary situation and to predict future social patterns. The basis of his theory was the inevitable conflict produced between those who *own* the means of generating wealth (the means of production) – that is, the ruling class – and those who have to *sell* their labour – that is, the working class. This is an economic theory of production using generalizable concepts.

It is, nevertheless, not the only way of explaining that particular set of social relations, and other economists, Adam Smith for example, observed the same phenomena (the effects of industrialization) and theorized that the division was not only inevitable, but also that it was uncontentious. Other social theorists (rather than economists) working at a similar period to Marx also produced explanations of these conditions but proposed that the social processes to which they gave rise were a matter of consensus between the different interest groups. Thus one of the major divisions in social theory has been between those who take a 'conflict' and those who take a 'consensus' perspective. Clearly this initial position about the way in which the social world works will lead to very different ideas about how to make sense of other social phenomena, and indeed whether they are even framed as puzzles or

problems at all. Thus, if you take a Marxist view of industrial relations, conflict between workers and bosses, for example in the form of strikes, would seem entirely expected – and harmonious periods of production would be puzzling and might suggest that a modification of the theory was needed. In contrast, a consensus theorist would feel that a period of dispute was an anomaly. Large-scale, or macro theory allows questions to be asked at the higher level of social organization. Examples would include questions about the relationship between social class and ill health, or indeed poverty and ill health, or about the effects of globalization, or if ‘globalization’ is a phenomenon that exists.

A larger set of presumptions or particular worldview will, then, frame any social inquiry. For the most part, however, these remain implicit. Few researchers state the assumptions they have about the social order, and why these have shaped their particular research question as a legitimate one, or as a puzzle that needs explaining. Nevertheless, we believe it is important to bear in mind that all researchers will have a particular worldview, or theoretical perspective, which both underpins and shapes their project and its findings.

Middle-range theory generates questions to ask

As well as shaping inquiry at the most abstract level, macro theory also generates what we could call ‘middle-range theories’ that link concepts together, and sometimes generate hypotheses to be tested, or interesting questions to address. Middle-range theories are the link between the general, abstract concepts of macro theory (social class, gender, globalization and so on) and the grounded, observable behaviour of people in everyday settings. Thus, in understanding specific social issues, such as ill health, the concepts of ‘health’ or ‘illness’ that are employed will generally be derived from a larger scale – if taken for granted – theory about the way the world works. These might lead to questions such as: ‘What is the relationship between employment and health?’ or, ‘Are women’s experiences of health care different from those of men?’

In Box 1.1, for instance, the aims of Alex Broom’s (2005) study of how men use the internet to access health information explicitly locates the data and discussion in two particular bodies of literature. First, Broom frames his research questions as ones that arise out of contemporary concerns about the impact of the proliferation of internet sources of information on the relationship patients have with their doctors, and concerns doctors have about the risks of access to ‘misleading’ information. To link this practical concern to more general issues about power, knowledge and control in medical care, Broom reviews literature on professional–patient relationships, and specifically on the potential for access to medical knowledge to be a threat to professional power. Second, given his participants are men, and the specific focus of the study is on prostate cancer, he also locates the data in terms of literature on masculinity and risk, which frames particular issues, such as men’s reluctance to seek information, as problems. Thus middle-range theoretical concepts are drawn on to generate research questions. How users of the internet use the information they find becomes an interesting question in the light of theories

about deprofessionalization which suggest that, for instance, the power of medicine is in decline because of the public's greater access to health knowledge, and theories of masculinity, which suggest that the internet may be a resource for men to seek information and manage risk.

Qualitative research contributes to middle-range theory

An example of how qualitative research contributes to middle-range theory comes from the study by Geneau et al. (2008) in Box 1.1, which aimed to understand how decisions were taken in Tanzania about patients' willingness to pay for surgery for cataracts. The authors begin their paper with a discussion about economic theory related to the concept of 'willingness to pay', much of which arises from utility theory, which assumes that people act to maximize the most 'rational' outcomes. Such a theory would predict that for sight-saving surgery with minimal risk, patients would have a high willingness to pay, in order to maximize a valued state (good eyesight). The qualitative research conducted for this study questions these theoretical assumptions, as the researchers found that, in practice, decisions about paying for health care in Tanzania were household, not individual decisions, and willingness to pay was related more to the resources a patient might reasonably expect to muster across the extended family than it was to their own individual assessments of utility.

So middle-range theory generates the particular questions we ask, and the findings of qualitative studies may add to the body of theory at this level. In the case of Geneau et al. (2008), the researchers suggest a significant limitation in the ability of utility theory to explain health care decisions in settings such as Tanzania.

Middle-range theory shapes how we approach questions

Middle-range theories are often rooted in particular disciplines, and we acquire our knowledge of them through training as nurses, doctors, sociologists, psychologists, economists and so on. If we take the study listed in Box 1.1 by Maggie Evans and colleagues (2001) on how parents make a decision to have their children immunized, there are a number of theoretical approaches that might have had relevance within different disciplines. Each would imply a rather different research question, with preferred ways of finding out the answer. To illustrate this, Box 1.2 suggests, in summary form, some 'middle-range theories' associated with particular disciplines or professional knowledge that might influence other studies on this topic.

The suggested questions in Box 1.2 are all potentially interesting and legitimate, but our professional and academic training means that we are likely to be more familiar with some of these bodies of theory than others. When we are considering a particular topic, we draw upon these explanations (of how professionals and clients relate, or how individuals make decisions) to shape specific questions that are interesting because they relate to a broader body of theory. Social science disciplines such as sociology and psychology tend to be more

explicit about these kinds of theory than biomedical sciences, but health professionals also have a set of more or less formal explanatory models they can draw on to make sense of topics as research questions. The advantages and challenges of working across disciplines, when we are often combining not just methods of data collection, but also these kinds of theoretical approaches, are discussed in Chapter 11.

Box 1.2 Researching parents’ decisions about childhood immunizations: possible theoretical starting points for research

Middle-range theory	Possible research questions	Main discipline
<i>The health belief model</i> (Becker 1974) suggests that the likelihood of an individual engaging in a particular behaviour results from their assessment of the costs and benefits of that action, and their perceived vulnerability to illness	What risks and benefits do parents associate with the immunization? How susceptible do they think children are to measles, mumps and rubella?	Psychology
Lack of ‘compliance’ with health advice reflects, in part, failures of health professional-client communication	Are parents more likely to ‘comply’ with immunizations if they have an opportunity to discuss their worries with a health professional?	General practice
There is a <i>lay epidemiology</i> (Rogers and Pilgrim 1995) of risks associated with immunizations that may be different from that of experts	What sources of knowledge do parents draw on to assess the risks of immunization? How do experts and non-professionals explain these risks?	Sociology

An example: Research on nurse–patient interaction

As an example of how middle-range theory informs both the framing of particular issues as research problems, and the ways in which we can understand them, consider the example of Rachel Jewkes and colleagues’ (1998) work on nurse–patient interactions in South Africa’s obstetric public health services. Jewkes et al. found evidence of widespread abuse of patients by nurses, including clinical neglect, scolding, humiliating, and even slapping women in labour. Although widely recognized as a ‘problem’ in South Africa, and commonly talked about by both patients and nurses they interviewed, it had not been recognized as a *policy* problem by professional organizations, nor had it been the object of research aimed at finding solutions. That the researchers could frame what is presumably

an everyday feature of normal life as a research question ('Why do nurses abuse patients?') relies first of all on a body of nursing theory that constructs the nurse's role as one of caring, nurturing and compassion. Without a normative theory of how things 'should' be (that is, nurses should be caring, not abusive), the behaviour they documented could not be constructed as a problem to be understood. Second, although participants' accounts focused on the personal characteristics of individual nurses as the cause of the problem, the researchers could draw on a number of theoretical perspectives to make sense of the problem in a way that suggested particular solutions. These included accounts of the ethnic and class basis of the South African social structure, which makes the nurses' social position precarious; in this kind of social context, abusing patients may be one route for symbolically stressing the social distance between themselves and their patients.

Epistemological approaches: Theories of knowledge

A third level of theory which researchers have to consider relates to theories of knowledge, or ideas about how we come to *know* the world, and have faith in the truth, or **validity**, of that knowledge. The theory of knowledge belongs to a branch of philosophy called **epistemology**. As research is essentially about producing knowledge about the world that we can claim as valid, some attention to epistemology is vital. Different epistemological traditions imply different ways of 'knowing' the world, and rather different accounts of the status of that knowledge. Most societies, for instance, include healers from a number of traditions who base their work on very different epistemologies; that is, different understandings of what leads to health or illness, different understandings of how the body works, and different understandings of how the healer can diagnose a problem. An illustration comes from a series called 'Second Opinion', that ran in the *Observer* newspaper, which used this contrast in a weekly article from two practitioners, one a general practitioner with a biomedical training, the other an Ayurvedic practitioner. Box 1.3 illustrates how the different epistemological assumptions of the two approaches lead to very different advice for potential clients.

Box 1.3 How to deal with rheumatoid arthritis: different epistemological approaches

	Biomedically trained general practitioner	Ayurvedic practitioner
Cause	'the body produces antibodies to its own immunoglobulins'	'aggravated vata (air element) combined with an increase in ama or toxins in the body'

(Continued)

(Continued)

	Biomedically trained general practitioner	Ayurvedic practitioner
Advice	'rehabilitation programme of exercise, physiotherapy and patient education designed to improve muscle strength, encourage mobility and prevent depression'	'Panchakarma, a detoxification and rejuvenation treatment ... oil massage with maharaya oil ... a vata balancing diet with rice, vegetables and lentils'
Prognosis	'... there is no cure ... and a high incidence of serious side effects from drugs'	'good results ... [from] an anti-arthritic formula [of] anti-inflammatory herbs'

(Source: adapted from *Observer Magazine*, 30th June 2002)

There are clear implications for health research in these contrasting understandings of 'health' and what it is. If, for example, these two practitioners wanted to research the efficacy of their remedies, they would be asking slightly different questions. The biomedically-trained general practitioner may be more interested in how the drugs reduce symptoms framed by a biomedical understanding of the 'disease' of arthritis, whereas the Ayurvedic practitioner might be interested in how well remedies detoxify the body. Understanding how different disciplinary traditions generate different legitimate research questions and different ways of convincingly answering them is key to working in multidisciplinary settings. However, it is not always as easy to identify the different frameworks used by researchers as it is to identify the kinds of differences outlined in the box between different healing traditions, because they are rarely explicitly discussed, or set out as an obvious contrast. *Many debates about the value of research findings are rooted in epistemological differences between researchers in terms of what kind of knowledge they believe research should produce, or what counts as adequate evidence for conclusions to be drawn.* For this reason, it is worth outlining some of the main epistemological starting points of research, to help unpack the assumptions on which research knowledge is built. These will help you understand the kinds of knowledge produced by qualitative research, and the particular contribution they make. Many of the epistemological assumptions of qualitative research arise from a critique of positivism; that is, an approach to knowledge rooted in what early social scientists saw as the methods of the natural sciences.

Positivism and realism

Over the last few hundred years the natural sciences, and many of the more quantitative social sciences, have developed a broad view of science and knowledge that has been described as 'positivism'. A positivist philosophy is one that

first assumes that there is a stable reality 'out there' – that phenomena (such as diseases, bacteria, villages, health) exist whether we are looking at them or not, and that they exist in exactly the same way whether we understand them or not. Thus, human understanding may be flawed (in, for instance, believing malaria to be caused by 'bad air'), but there is a potential 'right' explanation. There is also an implicit notion of progress in positivist accounts which suggests that, as knowledge gradually increases, we progress towards a better understanding of health and disease. As a basic epistemological tenet, positivism generates approaches to research which are **realist**: ones which assume, as a starting point, that there is a stable and knowable reality, separate from our human understandings of that reality.

The implications of this starting point for research methods are threefold. First, there is a stress on *empiricism*, or studying only observable phenomena. At the beginning of the 'scientific revolution', this was an innovation, in terms of replacing the philosophical speculations of pre-Enlightenment scientists with a science grounded in the experimental method and on observations of the natural world. The second implication is known as the *unity of method*, the idea that eventually, when mature, all sciences will share the same methods of inquiry. At this point of maturity, the proper object of scientific inquiry is the establishment of relationships of cause and effect and the generation of laws about the natural world. That many of the social sciences focus on other questions is, in this view, evidence of their immaturity. Because we understand, as yet, little about human behaviour, we have not got to the point where we can look for relationships between cause and effect. A third element of a positivist approach is the emphasis on *value-free* inquiry. Science is held to be separate from society, and as objective, rational and neutral. In this view, knowledge derived from proper scientific inquiry is not bound up with emotional, subjective or political viewpoints, and is 'true' for all times and places.

This model of scientific inquiry has come under considerable criticism, from both those who see it as an idealized model of how scientific progress happens and those who see it as an inappropriate model for research, particularly social research. In the qualitative social sciences, research is often rooted in rather different epistemological traditions, which depart from one or more tenets of positivism, and often reject a simplistic form of realism.

Interpretative approaches

Some have seen a positivist view as an unachievable and inappropriate goal for research into human behaviour. Human beings differ in some essential respects from the objects of natural science inquiry. Unlike atoms (or plants or planets), human beings make sense of their place in the world, have views about researchers who are studying them, and behave in ways that are not determined in law-like ways. They are complex, unpredictable, and reflect on their behaviour. Therefore, the methods and aims of the natural sciences are unlikely to be useful for studying people and social behaviour: instead of *explaining* people and society, research should aim to *understand* human behaviour. This is the starting point of

the *interpretative approach*. In this view, the most interesting questions are not about the ‘reality’ of the world, but about people’s interpretations of it. Thus, if we were interested in how people took medication for their asthma, we might be more interested not in any objective reality of the severity of symptoms, but rather in patients’ interpretations of their symptoms, since these may tell us more about how they use medication. This interpretative tradition characterizes much qualitative work in health research, which focuses on the meaning of phenomena (such as symptoms, health behaviours) for people. Case Study 1.1 illustrates an example of research in this tradition, and many other case studies throughout this book draw on interpretative approaches.

CASE STUDY 1.1

Using qualitative research to explore patient understandings of asthma

Source: Adams, S., Pill, R. and Jones, A. (1997) ‘Medication, chronic illness and identity: The perspectives of people with asthma’, *Social Science and Medicine*, 45: 189–201.

Asthma is a common condition, and from the perspective of health professionals, there is a problem in that many patients don’t take medication as prescribed: the medication intended to prevent symptoms (the ‘preventer’) may not be taken at all, and the medication intended to relieve symptoms (the ‘reliever’) is often over-used. Adams and colleagues note that such apparently irrational behaviour is understandable if we look at the patients’ perspectives – how they understand symptoms and medications, and how these are managed within everyday lives. The study used in-depth interviews with a sample of patients on preventative asthma medication. After analysing patients’ accounts, the researchers identified three broad groups in their sample.

First were the ‘deniers’. These patients, about half of the sample, denied that they had asthma, although they had been identified from general practice records as people diagnosed with asthma and prescribed preventative medication. However, these patients did not see themselves as asthmatic, but saw their problems as ‘chest trouble’ or bronchitis. They also claimed that symptoms did not interfere with everyday life, despite at times using quite complex or drastic strategies to manage symptoms, such as complete avoidance of going outdoors. This group also hid their medication use to a large extent, reporting only using inhalers out of sight of others, and had negative views of asthmatics – an identity they did not accept for themselves. Most did not use preventative medications at all – partly because of worry that they would become dependent on drugs that have to be taken daily, but also because taking medication regularly, whether there are symptoms or not, relies on accepting an asthmatic identity, which these ‘deniers’ did not. Given that they didn’t see themselves as having asthma, they did not attend special clinics for asthma patients.

A smaller group within the sample accepted both the diagnosis and their doctors’ advice completely, using medications as prescribed and taking pride in doing so. For this group, the route to ‘normal life’ was gaining adequate control over symptoms through

medication. Their definitions of asthma coincided with those of medical professionals. For them, 'asthmatic' was not a stigmatized identity, and they used inhalers in public.

The final group was identified as the 'pragmatists'. This group did use preventative medication, usually not as prescribed, however, but only when their asthma was particularly bad. They also had a pragmatic approach to disclosing asthma diagnosis; for instance, in telling family but not employers in case it prejudiced their employment prospects. This group accepted they had asthma, but usually perceived it as mild, or as an acute rather than chronic illness.

Looking at medication use from the point of view of patients enabled the researchers to see how health behaviour was tied tightly to people's beliefs about asthma and what kind of chest problems they had, as well as social circumstances and the threat of an asthmatic identity to other social identities. For service providers and health promoters, this kind of information is very useful. First it suggests that providing designated asthma clinics may not appeal to the majority of sufferers, since they don't identify themselves as having asthma. Second, professionals can see that what appears to be irrational use of medication, and the result of ignorance, is actually deeply embedded in complex social identities that have to be managed. For patients, health, defined in medical terms, may not be the top priority all the time, and the meaning of symptoms for professionals may be rather different from the meaning of symptoms for patients.

Reflective questions

You might like to reflect on a setting with which you are familiar. Are there seemingly 'irrational' choices made by some of the 'actors' in your chosen scenario (be it work, leisure or study)? Think how you might apply some of the research techniques discussed above to tease out why these seemingly irrational choices are made. For example, people continue to eat 'unhealthy' food even though they are well aware of its negative aspects. What do you think might be the reasons? What might you do differently as a policy-maker hoping to address these negative outcomes?

Feedback

One approach would be to get the perspectives of the 'actor' whose behaviour puzzles you by simply asking them in an open-ended way and then listening carefully to what they say. In the example of 'unhealthy foods' it might be that social norms and expectations (food as celebration) or eating as emotionally satisfying (a discourse of pleasure) outweigh any perceived health impact. Policy-makers might: a) consider how best to take these other perspectives into account; or b) consider whether the health benefits or risks do in fact outweigh the other reasons. This latter would be an example of how taking a 'critical approach' can lead to very different aims and outcomes.

Phenomenology

Many interpretative traditions are rooted in the philosophical approaches of **phenomenology**, and the writings of the philosopher Edmund Husserl (1970) and sociologist Alfred Schutz (1964, 1970) (see also Holstein and Gubrium 1998). Husserl, writing in the first decade of the twentieth century, posited that the distinction made

by natural science between subject and object was false as everything was subject to the act of perception. He argued that objects in the world were not passively understood, but were actively constituted through consciousness and subjective experience. To understand the 'essence' of phenomena, one had to understand how the 'life-world' was directly experienced. The **methodology** he described for doing this was called 'reduction', by which he meant a process of attempting to 'bracket off' the conceptualizations, prejudices and theories by which we come to understand phenomena and attempt to get to their universal and essential nature, which is experienced directly. Schutz is associated with bringing these philosophical ideas into sociology, and his approach focused on the ways in which the 'life-world' (the everyday world which we experience and take for granted) was actively constituted by 'members' (social actors within that world). In terms of epistemological position, this is clearly a departure from positivist social science, as the 'life-world' is not merely there, passively experienced, but is created through talk, interaction and behaviour. Following Husserl, Schutz's methodological stance is also one of 'bracketing' (or setting aside) taken-for-granted assumptions about the world (whether they are from 'common sense' or grand theory) and attending closely to how members themselves orientate to phenomena. This is not the same as attempting to be 'objective', in the positivist sense, but rather an attempt to open up to how the life-world is experienced. In this approach, then, phenomena are real because they are treated as real; whether they 'really' exist, objectively speaking, is irrelevant, as the 'essence' of objects can only be understood through studying subjective perceptions of those objects.

Therefore, a phenomenological researcher interested in studying medical dominance on a hospital ward might be interested in questions such as 'What is the lived experience of medical dominance?' and might focus on how dominance is created, at an everyday level, through the talk and interaction of members such as doctors and nurses, with the focus of enquiry being how 'dominance' as a phenomenon is actually constituted through what people say and do, through the stock of common-sense understandings that members draw upon in their day-to-day lives. Social life on the ward would be seen as a 'taken-for-granted' accomplishment, one that happens because in general we all assume that others routinely share our understandings and perceptions of phenomena. Unless there is some obvious breach in this sense of shared understanding, we are often oblivious to the 'taken-for-granted' nature of the life-world.

Phenomenological approaches have been particularly popular in qualitative research in nursing. The appeal lies in part in the focus on subjectivity, and perhaps also on the possibilities of identifying the 'essences' of what can be diffuse concepts used in nursing practice, such as 'caring' or 'comfort'. As illustrations, these aims are taken from three published qualitative nursing studies that overtly situate themselves as phenomenological research to:

- 'describe the lived experiences of men and women who suffer from psoriasis' (Watson and Bruin 2007);
- 'explore the meaning of comfort care for hospice nurses' (Evans and Hallett 2007); and
- 'investigate the meaning of living with cancer in old age' (Thomé et al. 2004).

The focus of each of these studies was on experiences and meanings, and attempting to identify what was unique about those meanings. Thomé et al. (2004) suggest that in investigating the experience of living with cancer in old age, their aim was to identify: 'What makes this lived experience what it is?' and 'What is unique about this?' In practice, many published studies claiming to have used a phenomenological approach use the term rather loosely, simply to describe studies which have focused on the experiences or subjective realities of the study participants.

Social constructionism

The interpretive and phenomenological approaches overlap considerably, in that they focus explicitly on either interpretations or experiences of the world as it is subjectively understood, rather than attempting to explain the objective reality of the world. A second criticism of positivist assumptions that has informed much qualitative work is a more extreme questioning of the view that there is one stable, pre-existing reality 'out there' waiting to be discovered. The *social constructionist* (sometimes called 'constructivist') approach instead assumes that reality is socially constructed. How we divide up the world in order to comprehend it (for instance, how we see the systems of the body, or how we classify diseases) is the result of historical, social and political processes, rather than an inevitable result of our greater understanding of the 'reality' of the body, or disease. The proper object of research from this perspective is thus how phenomena are constructed: 'What are the processes by which diseases become classified in particular ways?', 'Who has the power to produce legitimate classifications?' and 'What are the implications of such classifications?' There is a strong tradition of constructionism in the qualitative social sciences in health, which has had a vital role in questioning common-sense assumptions about the categories we use routinely, as if they were 'natural' categories, rather than social ones.

The **constructionist approach**, although an influential one in qualitative research, has not been without its critics. Mike Bury (1986), for instance, takes issue with the **relativism** implied by an extreme constructionist position, claiming it poses a logical difficulty. If phenomena such as disease categories are merely 'social constructions', he argues, rather than categories of the natural world, how are we to derive knowledge of them, other than through similarly constituted social categories? There is no rational basis to make a claim for producing valid knowledge of socially constructed phenomena, as there is no sense in which the researcher can 'stand outside' the constructions that he or she is analysing. Bury warns that an extreme agnosticism about the natural world can mean that 'reality is portrayed as a contingent and haphazard affair' (Bury 1986: 155). In the arena of health and illness, where research deals with phenomena such as distress, pain and death, such an extreme view, he suggests, is untenable and unhelpful.

The 'constructionist' approach could, then, be seen as the opposite end of a continuum to the positivist one in terms of assumptions about the nature of reality, with positivism assuming that reality is entirely separate from human perception, and

stable, and constructionists assuming that reality is an outcome of human processes, and impossible to separate from the processes from which it is constituted. Where an individual researcher stands on this continuum is largely a matter of their a priori assumptions about the nature of reality. It is impossible to ‘test’ the extent to which phenomena exist independent of our attempts to study them. There is no right approach to research, but these perspectives do generate rather different possible questions about a research topic. To follow on from the example of asthma in Case Study 1.1, for instance, rather than asking ‘How do people cope with asthma?’ or ‘How do patients interpret symptoms?’, a social constructionist research study might start with questions such as ‘How and why did “asthma” emerge as a category of disease?’ (see Gabbay 1982 for one perspective on this) or ‘How do some people come to be defined as “asthma patients”?’ Even if questions like these are not core to the research, they can be very useful for sensitizing researchers to be critical of the categories they do use. They would suggest, for instance, that we treat statistics about asthma rates with a critical eye. If rates of asthma diagnosis are rising, this might represent a growing number of cases of asthma, but it also might represent the different ways in which the category ‘asthma’ is being constructed by the patients, health professionals, researchers and record-keepers who create those statistics through social processes.

Interpretative and phenomenological approaches, then, start with a different aim from positivist ones – that of understanding, rather than explaining, reality. Constructionist approaches go further, in taking issue with the very concept of a pre-existing reality.

Critical approaches

A final set of criticisms of positivism has questioned the third tenet of positivism: that scientific inquiry should properly be ‘value-free’. These criticisms are of two sorts:

1. First, is the argument that the notion of science being ‘value-free’ is an *idealistic* view: ‘scientific research’ is in itself a social process, carried out by humans within specific social contexts, so it cannot be separate from or outside our social world (that is, research *can’t* be value-free).
2. Second, there is an argument that ‘value-free’ enquiry is a morally indefensible position. There are some perspectives, for example some feminist and participatory approaches, which explicitly assume research should have a political goal as well as a purely knowledge-generating one. In these models, science should not stand outside society, but should acknowledge that it is inextricably bound up with the social order, and be striving to improve that social order (that is, research *shouldn’t* be value-free).

A rejection of the ‘value-free’ aims of research is central to the *critical tradition* in social research, which Lee Harvey described as having the following elements:

[The critical tradition] regards the positivistic scientific method as unsatisfactory because it deals only with surface appearances. Instead, critical social research methodology cuts through surface appearance. It does so by locating social phenomena in

their specific historical context ... within a prevailing social structure. Critical social research analyses this structure ... and its ideological manifestations and processes. ... Critical social research includes an overt political struggle against oppressive social structures. (Harvey 1990: 19–20)

For Harvey, the distinguishing element of critical methodology is that epistemology and critique are intertwined: there can be no pure knowledge, and the task of methodology is to unpack the status of knowledge, and the processes by which it comes to be accepted. This perspective covers a number of traditions in the social sciences. Many of them are 'realist' in the sense that the starting point is that there is a 'reality' of the social world that can be uncovered through research – but that this reality requires more than simply atheoretical empirical work to identify. Also required is a careful analysis of the specific social, political and historical contexts of the phenomena of interest. Given that the particular sets of conditions that are prioritized in this analysis will depend on the (macro) theoretical perspective of the researcher, critical approaches include a number of potential starting points. A brief overview of some feminist approaches, often rooted in critical traditions, illustrates this. Feminist approaches have had a significant impact on the development of qualitative methodology in terms of positing rather different goals from the traditional ones of value-free inquiry.

Feminist approaches

The advent of 'second wave' feminist activism in the late 1960s has been mirrored by the development of feminist theory and research both within and outside the academy. This was notable in that it highlighted the relationship between knowledge and power, not just that knowledge enables empowerment but that the legitimation of knowledge claims is tied to social structures of domination. To this end, feminist theorists demonstrated that what counted as 'knowledge' reflected a masculine worldview – for example, reflecting only male experiences or concerns. Underlying this perspective is a notion of *difference*, whether it was to claim that men and women are *essentially* different (i.e., that, to some extent, biology is destiny) or that men and women occupy different *social* positions and therefore have very different worldviews and experiences. This caused the claims of natural science to objectivity to be called into question. If knowledge supposedly mirrors an independently existing world, how do we account for the different subjectivities of women and men? This led to the development of the feminist 'standpoint theorists'. These included Sandra Harding (1986), who argued that all knowledge is produced by social subjects, and knowledge that is being produced predominantly by men about a world that is predicated on male experiences and views cannot be held to be objective. What this therefore implies is the need for an explicitly feminist science.

However, one of the earliest tensions within feminist theorizing arose from this. Feminism as a social movement is (in common with other social movements such as the black, gay, peace or ecological movements) an emancipatory project. It has its roots in Enlightenment ideals of justice and freedom; that is, a commitment

to social change. Nonetheless, it also shares with the theories that underpin these other social movements a critique of these ideals. Notions of 'justice' and 'freedom' imply an absolute, objective existence independent of any power relations, but this becomes untenable in the face of the critique of 'objectivity' and the commitment to making the subjectivity of knowledge claims explicit. A further debate in feminist theorizing was over the principle of essentialism or relativism. This called into question the very existence of the categories 'male' and 'female'. Feminist theorists, such as those of the French psychoanalytical school (see, for example, Irigaray 1985; Wittig 1992), attempted to examine the processes by which subjects came to have a gendered consciousness. Others, from more sociological traditions, such as Judith Butler (1990) and Donna Haraway (1991), have addressed the concept of gender as a social construction as part of the 'postmodern' turn in social theory.

In research terms it is clear that the particular feminist epistemological framework adopted, whether standpoint or constructionist, will determine both the research question and the subsequent research design.

Participatory research

This brief review of positivism and the alternatives that have informed qualitative methodologies illustrates some of the range of epistemological starting points of qualitative enquiry. These different perspectives shape the kinds of questions the researcher is likely to ask about their topic of interest, as well as the methods they will employ. They also, as we have seen, imply some rather different approaches to the overall aims of research, with the critical traditions in particular often having an explicit political aim as well as one of generating knowledge. This section takes this final critique of positivism noted above – that research *shouldn't* be value-free – in outlining some of the participatory approaches that are used in health research. Participatory approaches are often rooted not just in an epistemological critique of positivism, but also in an ethical critique of the relationships generated by traditional scientific practice. From this perspective, one consequence of striving for an objective and neutral scientific method, as positivist researchers do, is a consolidation of knowledge within a small elite, and an unhealthy separation of scientists from the wider society. Following on from this, researchers from participatory traditions see research as ideally a cooperative enterprise, involving working with communities as co-investigators. For some, this has liberationist aims, and the purpose of research should be to engage in dialogue with oppressed people in order to further emancipation or critical awareness.

This liberationist philosophy often cites the work of Paulo Freire, the radical Brazilian educator who believed that education should be empowering and liberating, rather than a process of teaching passive subjects to accept their place in the world. These ideas have been taken up by health workers and researchers in a number of settings (see, for example, Wallerstein and Bernstein 1988), with the starting point being a dialogue with the community, such that knowledge (whether the product of education or research) is the outcome of a process of sharing, reflection, and experience, rather than a process of experts either inserting

or extracting information. Wallerstein and Bernstein describe how this approach informed an alcohol and substance abuse prevention programme in New Mexico, and discuss the implications of a participatory approach for their evaluation of the programme. This worked with school students, involving them in visits to an emergency room and in interviewing people in jail about the role of substance abuse in their lives. The young people were included as co-learners, rather than passive subjects of health education, and were encouraged to develop solutions to community problems through peer support and a three stage process of listening, dialogue and action. In terms of evaluation, the researchers used an experimental design (with the random allocation of students to the programme) to measure changes in such outcomes as students' risk perceptions and reported behaviour. The researchers note that this rather positivist research design (with its assumptions that an intervention will have a measurable, objective effect on an outcome) sits uneasily with the participatory need to be responsive to the needs of communities engaged in the project, as some were unwilling to participate in an experimental evaluation.

Peter Reason (1998) has identified three strands in participatory inquiry, which he labels cooperative inquiry, participatory **action research** and action inquiry. *Cooperative inquiry* assumes first that all actors are self-determining – in any research project, all involved are both researchers and subjects, cooperating by reflexively drawing upon their own experiences. *Participatory action research* is explicit about the relationship between knowledge and power, seeing the role of the researcher as liberating communities through research activities that shift the balance of knowledge. The aims are thus to produce understanding that is useful for the group that is being worked with, and to empower those people, rather than to do research 'on' them. *Action inquiry* is primarily orientated towards change, but involves a conscious approach to action, in which an organization or community develops a collaborative and reflexive awareness. The three approaches, he argues, share an epistemological focus on experiential knowledge and an orientation towards change (in both understanding and social reality). They differ in the relative emphasis they place on psychological or small group processes relative to macro-structural factors.

Although the emancipatory aims of participatory approaches are perhaps more associated with research in developing country settings (see, for instance, Case Study 2.2, which used participatory methods as part of an evaluation of a sexual health programme in The Gambia), the collaborative and action-orientated elements of these approaches have influenced health care researchers in developed country settings as well. Julianne Meyer, for instance, writing on the challenges of using action research methods in nursing research in the UK (Meyer 1993, 1997) argued that, despite challenges (such as the difficulty in integrating these methods with current frameworks of research funding), the role of action research was likely to be greater in the future, with a growing focus on interdisciplinary knowledge production and an emphasis on more 'porous' research structures that are less constrained by elitist university research and more open to partnerships with practitioners. This has to a large extent happened in both the UK and many other settings (Guta et al. 2013), with an increasing focus on patient and public involvement

in research, and initiatives to include representatives of the public on funding committees and project-steering groups. Indeed many funders of health research now expect some level of involvement from the ‘users’ of research. However, to date, these initiatives have arguably been largely consultative rather than truly collaborative. Participatory and action research is discussed further as a type of research design in Chapter 2.

The orientations of qualitative research

There are, then, some very different theoretical, epistemological and political starting points in qualitative research, although many of them share a rejection of one or more of the elements of a positivist tradition in social science. These starting points will influence the kinds of research question that researchers address, and how they go about generating knowledge. Clearly, what counts as a ‘proper’ research question, and what counts as valid knowledge, will depend on macro-theoretical assumptions about the world, middle-range theories that are often rooted in specific disciplines, and epistemological assumptions. This might suggest that to talk of ‘qualitative research’ in general is impossible, given the plurality of perspectives researchers bring to bear on health. However, there are some broad orientations to methodology that are shared by many researchers, although not of course by all, or at all times. They are: a commitment to naturalism; **reflexivity**; a focus on understanding; and a flexible approach to research strategy.

Naturalism

‘Naturalism’ refers to a preference for studying phenomena in their ‘natural’ environment. We know that behaviour, including health behaviour, is contextual. It is, for instance, a common experience that we take more ‘risks’ with our health when on holiday than at home. Similarly, we are likely to behave differently while being studied than when not. This was a key finding of the famous Hawthorne studies, in which researchers found that human behaviour (in this case, productivity in a factory) altered as a result of taking part in the study, rather than because of any of the specific interventions being tested. Rather than continuing with experimental methods, the Hawthorne researchers turned to ethnographic methods such as interviewing and observation to understand worker behaviour (see Schwartzman 1993 for a discussion). Studying health behaviour in a ‘natural’ environment allows us to study how, for instance, people manage medication regimes in the busy context of their everyday lives, rather than as part of a drug trial. Talking to people in depth, allowing them to tell their own story, provides us with access to their worldview rather than that of the researcher. Ethnographic methods (see Chapter 6) are perhaps the most ‘naturalistic’ in that they attempt to generate in-depth knowledge about a setting (whether it is a small village or a hospital ward) over time, in order to understand how and why people believe and behave

as they do. The aim is for the researcher to become part of the setting for long enough to minimize their impact.

For some social scientists, it is this 'naturalism' that defines a distinct qualitative methodological approach, and separates it from the methods of inquiry used in the natural sciences. Norman Denzin (1971), for instance, uses the term 'naturalistic behaviourism' to describe an empirical approach to studying the social world, with its own logic. For Denzin, social research should be closely tied to the everyday, routine lives of the people researched, aiming to understand their perspective and then 'reproduce in a rich and detailed fashion the experiences, thoughts and languages' of those studied. What distinguishes this enterprise from common-sense accounts of the same world is that the researcher 'attempts to impose order on the social world'. Naturalistic research is not merely the production of detailed, empathetic accounts of social worlds such as those of a hospital clinic or small village, but the theoretical analysis of them.

An orientation towards naturalism means that the qualitative researcher is more likely to be interested in everyday, or 'real life', contexts than in ideal situations (such as the laboratory setting of a drug trial), and is also more likely to explicitly reflect on how the research setting has in itself had an impact on behaviour. However, 'naturalism' is of course an idealistic notion, as there is in practice no 'untainted' research field observable by the researcher. Any act of observation will impact on the field, however 'invisible' the researcher becomes, and the researcher needs a reflexive approach that takes into account their interrelationship with the field studied. The second orientation of qualitative research, that of reflexivity, is an essential adjunct to a focus on naturalism.

Reflexivity

In essence, the principle of reflexivity is that researchers should subject their own research practice to the same critical analysis that they deploy when studying their topic. This extends to all aspects of the research process, and it is essential in qualitative research. In many quantitative traditions, the assumptions of positivism imply a striving for 'objectivity', in which the researcher attempts to minimize the kinds of political values, subjective impressions and partial accounts that might 'bias' their findings. In qualitative traditions, as we have seen, it is accepted that these values are inevitably part of the research process. It is impossible to have a field for study that is untainted by values, and impossible for the researcher to stand outside those values and subjectivities. Both research and researchers are part of the world, and there is no privileged place we can occupy from which to study that world objectively. However, this does not imply an extreme relativism, which would hold that any account is as good as any other and that research studies are merely another subjective story about a topic with no greater claim to legitimacy than any other. Reflexivity is one of the ways qualitative researchers have of taking subjectivity seriously, without abandoning all claims to producing useful accounts of the world.

First, reflexivity involves reflecting critically on the research itself. Why is it possible to ask this research question, now? Reflecting on why particular questions are legitimate, and why they can attract funding, or interest in the findings, enables the research to be situated within a social and political field. The reflexive researcher considers the broader political and social context of their research, in order to help to unpack any assumptions they have brought to the research, and to identify the ways in which this context might shape what they find. To illustrate, one of the studies listed in Box 1.1 was Leydon et al.'s (2000) study of the information needs of cancer patients. This study was reported in the *British Medical Journal*, which publishes short articles of interest to medical professionals, and does not generally give much space to theoretical concerns. However, Leydon et al. suggest in their introduction to this paper some of the reasons why they are able to ask 'why cancer patients do not want information' as a research question. They review the growing literature and health policy that addresses communication and information needs, and note the growing focus on ensuring that patients are as well informed as possible about their illness. That the researchers could ask this research question derives in part from this current assumption in Western health care that patients want, and ought, to know as much as they can about their own illnesses. There is a body of middle-range theory that addresses communication in health care settings and the needs of patients for information, and this generates a set of possible research questions around patients' needs for information and how these needs are met. This illustrates the kind of reflexivity that accounts for the research itself, in this case in terms of current health policy concerns, and ensures that the researchers do not uncritically work with taken-for-granted assumptions (such as greater information being universally a 'good thing').

The second level of reflexivity needed in qualitative research is more personal, and involves a consideration of the role of the researcher him or herself in generating and analysing their data. Who you are and where you are as a researcher (your gender, your social status relative to those interviewed, your institutional base) will inevitably shape the kind of data generated. Again, this is not to assume that those data are merely subjective impressions that would have been different if generated by a different researcher, but to attempt to account explicitly for the fact that data are 'produced' rather than merely 'collected'. The example in Case Study 4.1, on the differences between the data generated in studies with male and female interviewers, is an example of this in that the researchers used the differences actively in their analysis to identify something about the presentation of gender in interviews. This is not the same as addressing 'bias', which would assume that there was one account that could be 'true' if only we could collect it untainted by gender, but rather of assuming that all accounts are inevitably shaped by gender, and that reflexive practice attempts to account for this explicitly. In Chapter 4 we discuss further the implications of the ways in which social and cultural factors shape the kinds of data produced in a study.

A focus on meaning and understanding

Following on from the interpretative tradition in the social sciences, much qualitative research focuses on understanding the world from the point of view of the

participants in the study. The starting assumption is often perhaps a generous one: that most people, most of the time, are rational and sensible in their choices if we can understand the constraints they are under, what their priorities are, and what they are trying to achieve. As the American sociologist Erving Goffman (1961), who studied behaviour in psychiatric hospitals, put it:

any group of persons ... develop a life of their own that becomes meaningful, reasonable and normal once you get close to it ... a good way to learn about any of these worlds is to submit oneself in the company of the members to the daily round of petty contingencies to which they are subject. (1961: ix-x)

Thus, the best qualitative research starts by asking not what people get wrong, or don't know, or why they behave irrationally, but instead seeks to identify what they *do* know, how they maintain their health, and what the underlying rationality of their behaviour is. In the example in Case Study 1.1, for instance, apparently irrational behaviour (not taking medication as prescribed for a potentially disabling disease) becomes understandable if we see it from the point of view of those diagnosed with asthma. This is equally true of research with health workers. Doctors who refuse to implement evidence-based guidelines, or nurses who don't wash their hands between caring for different patients, are unlikely to be acting merely ignorantly or 'irrationally', and the aim of a qualitative study on their behaviour should be to focus on what they are achieving, and how, rather than what they are not doing, and why. Qualitative research attempts to understand the world (or the part of it we are interested in) from the perspective of the participant, not the researcher. So the most productive question may not necessarily be 'Why don't doctors implement evidence-based guidelines?' but 'How do doctors use evidence? How do the assumptions of evidence-based guidelines resonate, or not, with their assumptions about evidence, practice and health care? What kind of evidence is used in their work? How are guidelines in general integrated into the day-to-day work doctors have to accomplish?'

The benefits of this orientation towards understanding for health research are clear. Public health and health promotion, for instance, are often concerned with changing behaviour. Without an empathetic understanding of why people behave as they do, we are unlikely to identify the possibilities for change.

Flexible research strategies

In carrying out a large-scale survey or an epidemiological study, it is usual to plan most of the research in detail before beginning, including the sample size, the precise data to be collected, and the statistical tests likely to be used in analysis. Although qualitative studies also need careful planning, it is more common to have a flexible research strategy, which can be adapted as early data are produced and analysed. As a model it may be helpful to divide up the research process into stages such as literature review, research design, data collection, analysis and writing up, but in practice these stages are much more likely to overlap in qualitative work, and will inform each other. Early data analysis may suggest, for instance, a

more refined (or even completely different) research question that will influence later sampling, and may send you back to look for more literature. As we shall see in Chapter 12, the process of writing up is an essential part of the analysis in most qualitative work.

The degree of flexibility required depends on the demands of the study and the perspective of the researcher. In some studies, flexibility may mean simply adding to the intended sample in order to add more depth to one finding. In others, the research design is developed as the study continues, utilizing a number of different methods and approaches as the researcher unearths new clues to the answers they are seeking. One metaphor that is sometimes used to describe the qualitative researcher in this approach is the French term 'bricoleur' (Lévi-Strauss 1966) or professional 'do-it-yourself' person. This is a kind of skilled Jack or Jill of all trades, who can utilize, adapt and devise methods of inquiry and bodies of literature as the need arises throughout a project (Denzin and Lincoln 1998). This approach has great appeal in health research, where so many aspects of everyday life impinge on the topic of interest, and we are often required to shift perspectives throughout a project, or utilize unexpected opportunities for data collection. It may, however, be difficult to pursue in funded research, with most sponsors wanting clear protocols at the outset of a study.

Added to naturalism, reflexivity, interpretation and flexibility, Bryman suggested two other characteristics of qualitative approaches: description and process (Bryman 1988: 63–6). By 'description' he meant a tendency towards detailed (or 'thick') description, rather than a focus on explanation. Detailed description allows the broader context of social behaviours to be delineated. Following from the emphasis on context in qualitative research, Bryman argued, is an emphasis on process. This, he believes, is both a consequence of an orientation towards wanting (historical) context and a reflection of an underlying belief that participants perceive the world as an unfolding sequence of changes, so research should capture this. Qualitative studies therefore emphasize the processes underpinning social activity through detailed descriptions of the participants' behaviours, beliefs, and the contexts within which they occur.

Together with the epistemological traditions outlined above, these orientations towards naturalism, reflexivity, understanding and flexibility imply some other common assumptions that qualitative researchers work with. The recognition of the contextual nature of knowledge and behaviour, and an emphasis on understanding, implies an acceptance of different worldviews. In studying the organization of a rural clinic, we should not be surprised if the accounts given by patients and nurses are very different. It is not that one group is misinformed or mistaken, but that each provides an account that is rooted in different worlds. The task of the researcher is not to adjudicate between competing accounts, or to undermine the 'truth' of one, but to understand, from the perspective of those participants, how the world is the way they describe it. This is not an easy task, particularly when researching topics that are close to the researcher's own professional experience.

A second implication is that qualitative research is properly sceptical of received wisdom; that is, common-sense accounts and assumptions, whether these are from

academics or participants in the field. Treating an account of clinic organization from a nurse as a valid account, given his or her perspective, is not the same as treating this as the 'truth' about clinic organization. The researcher is not merely a reporter, taking down stories from the field to report back. They must also analyse those accounts, and link the empirical findings with a theoretical understanding of health care organizations, of nursing work, or of professional–client encounters. Equally, the 'common sense' of health care knowledge must be questioned. Qualitative research properly questions the categories it is presented with, rejecting the normative assumptions built into many research studies. Thus, in studying the introduction of 'patient-centred care' to a ward, we should be careful not to assume that 'patient-centred care' is inevitably a good thing, or that it means the same thing to different actors. In studying the 'barriers to evidence-based practice', it is important to remember that these are only likely to be 'barriers' from the perspective of advocates of evidence-based practice.

Criticisms and limitations of qualitative research

We have suggested a range of approaches to qualitative work, and some orientations many traditions share. Despite a growing interest in multidisciplinary research in health care (see Chapter 11) and an acceptance of the value of qualitative methods for addressing questions of understanding and process, these orientations do not always sit easily with the more positivist assumptions of other health research disciplines, such as **epidemiology**. It is also not always clear to policy-makers, managers or clinicians whether qualitative research can provide anything useful. We discuss further in Chapter 11 some of the opportunities and challenges of working across disciplines in health research, but by way of summarizing some of the discussion in this chapter, we review here some of the common criticisms users have of the limitations of qualitative methodologies, and point to where in this book these issues are covered in more depth.

Qualitative research is not 'scientific'

Murphy and Dingwall (2003) argue that a number of myths have grown up around qualitative research, arising in part from debates between sceptics, who reject qualitative methodologies for being unscientific and anecdotal, and romantics, who have rejected the entire attempt to be scientific. Setting out a realist programme for qualitative research, which they hold to be essential if health policy and practice is to gain from the outputs of qualitative research, they take issue with these myths, as well as what they call 'the romantic turn' in qualitative methodology. The first myth is that qualitative methods are more *inductive* than quantitative methods, meaning that they use a logic of 'theory generation' rather than 'theory testing'. Inductive approaches are those that start from the data, and search from those data for regularities and patterns that suggest general laws. Deductive logic, on the other hand, starts with a theory, from which hypotheses

are derived, and then tested against a body of data gathered to test that hypothesis. In practice, of course, all research uses elements of both logics, and it is perhaps impossible to be purely inductive or deductive. We cannot analyse our data with a completely blank slate, as there are always theories and assumptions made that shape the ways in which we read it. Similarly, theories and hypotheses do not come ready formed, and there are inductive processes at work which mean that researchers select particular theories to test, and have ‘hunches’ about how to test them. The potential polarization – which identifies quantitative methods as deductive and qualitative methods as inductive – is unhelpful, note Murphy and Dingwall, because it contributes to the separation of disciplines in health research, and the view that they are incompatible, whereas there is much potential for creative interplay between qualitative and quantitative methods. The essence of the realist programme they advocate is that qualitative methods can be ‘scientific’: that we can, and should, be disciplined and rigorous in the collection and analysis of data, and be thorough in subjecting our own assumptions to the same critical scrutiny as those of others. This echoes the positivist tradition of neutrality. The point is not so much to attempt to stand outside values (as we accept we cannot do that) but to approach research with a genuine striving for critical distance. This is not only an ethical stance, but also a pragmatic one. If researchers are overtly partisan they have perhaps undermined the grounds from which they can claim to produce credible, rigorous accounts that have any status beyond merely ‘one more account’.

Methodologically, though, this does create some tensions with the more critical approaches, such as action research. To be researching explicitly ‘for’ one group, or to decide, a priori, to privilege one set of accounts, is difficult to reconcile with an even-handed, reflexive critique of the researcher’s own assumptions. This tension is discussed further in Chapter 3 as an issue of research ethics and values.

To engage in a debate about whether qualitative methodologies can be ‘scientific’ obviously relies on coming to a definition of science. If we take a narrow positivist view, then we have seen that most qualitative traditions do depart from this. However, if we take the logic of a scientific approach, as Murphy and Dingwall do, then we can argue that qualitative methods take subjectivity seriously, but do produce more than merely ‘subjective’ impressions. There are a number of strategies for maximizing the rigour and credibility of qualitative findings, which are discussed further in the chapters on analysis and writing, but reviewed briefly here.

Does qualitative research produce only subjective accounts?

Most qualitative traditions, as we have seen, take subjectivity seriously, given that it is subjective experiences which are seen as the important ones in thinking about health care (in interpretive approaches), or those that constitute the ‘essence’ of phenomena (in phenomenological approaches). However, qualitative research does

not merely report these subjective experiences, but analyses them, and aims to produce accounts that have some value beyond reproducing anecdotes, or colourful examples. There are a number of strategies that perhaps differentiate research from other activities that seek to describe social life (such as novels or journalism). These include:

- *An attention to evidence.* Although any account of a social field (be it a hospital ward, or an asthma patient's experience) can never be complete, or the only one possible, qualitative research aims to provide evidence for descriptions and interpretation.
- *A critical approach to subjective accounts.* The subjective accounts generated through research are not simply taken as 'truth' about the world, but as situated, contextual accounts. The researcher's task is not to reproduce those accounts as if they offer a privileged representation of social reality, but to ask: why, and how, do people here come to think, behave and talk as they do? The aim is for an analysis that attempts to produce an understanding that may not be available to those we are researching, as we are often asking about taken-for-granted aspects of reality.
- *A critical approach to analytic accounts.* This principle of critically addressing the taken-for-granted and implicit rules of the social world applies to the research itself. Qualitative research should properly be conducted by constantly testing the assumptions built into the research question, and the emerging assumptions about interpretation. This involves a reflexive attitude, as suggested above, and also close attention to disconfirming evidence.
- *Careful and rigorous analysis.* The analysis of data should be done in a way that defends against cherry-picking evidence that confirms the researcher's assumptions, and ensures that the researcher does not see merely what they were hoping to see. Some methods for strengthening the reliability and validity of qualitative analysis are discussed in Chapters 8 and 9.

Although we have suggested, then, that qualitative methodologies often depart from positivist assumptions, it is clear that the logic of social enquiry is, in practice, very similar across different epistemological traditions, even if the style and assumptions about social reality are rather different. Specifically, doing good quality research involves both empiricism (even if the nature of that 'evidence' is rather different to that in the more quantitative sciences) and neutrality (research cannot escape values, but researchers should subject those values to reflexive scrutiny so they do not determine research outcomes).

Does qualitative research contribute anything useful for understanding health and health services?

Finally, there is a question that, even if qualitative researchers do not ask it themselves, may be asked of them by others: What are the results of a qualitative study likely to contribute to policy or practice? The examples throughout this book illustrate some of the contributions that qualitative research findings have made to professional practices in areas such as public health, health promotion, health service planning and policy, and they suggest a number of pragmatic answers to this challenge.

CASE STUDY 1.2

Evaluating an intervention to improve TB care in South Africa

Sources:

Lewin, S., Daniels, K., Dick, J., Zwarenstein, M. and van der Walt, H. (2002) *A qualitative evaluation of the Kopana TB training intervention*. Internal Report, Health Systems Research Unit, Medical Research Council of South Africa.

Lewin, S. and Green, J (2009) 'Ritual and the organisation of care in primary care clinics in Cape Town, South Africa', *Social Science & Medicine*, 68: 1464–71.

Cape Town, South Africa, has high rates of tuberculosis (TB) and clinics face problems in persuading patients to complete the long course of therapy needed to cure it and bring the epidemic under control. Previous research suggested that one barrier to patient compliance could be poor support from staff, who have a 'task orientation', rather than patient orientation, focus to their work. The Kopana project aimed to deliver a participative, experiential training intervention to clinic staff that would lead to improved communication with patients through patient-centred care and an orientation towards quality improvement. An experimental design, in which clinics were randomly allocated to either receive or not receive the Kopana training package, was used to evaluate the intervention. This used quantitative measures, including TB treatment completion rates, to look at the effectiveness of the intervention, and a qualitative evaluation to look at the process. The aims of the qualitative evaluation were to explore how the intervention was developed and implemented, and what impacts it had on staff, clinic organization and patients.

Simon Lewin and colleagues used ethnographic approaches to study the process of training and its impact on clinic organization. This included observations of TB clinic routines and the Kopana training sessions, interviews with staff, and analysis of transcripts of the training sessions. The findings from this ethnographic study first helped identify why Kopana did not have the anticipated outcomes; that is, it did not reduce TB cure rates significantly in the intervention clinics. A key reason was that in many clinics what the researchers call the 'integrity of the intervention' was difficult to maintain. For various logistical and organizational reasons, it was impossible to deliver the training package (which involved six facilitated sessions with clinic staff leading up to them identifying changes in practice, plus a follow-up session) in line with intention. This is perhaps typical of training interventions: although they may work well with enthusiastic advocates in initial projects, when rolled out as realistic interventions in randomly chosen settings, they are resisted and adapted by recipients in unpredictable ways.

Other findings from the qualitative evaluation were that 'task orientation' was deeply entrenched as a pattern of provision in this setting, and was hard to shift through the process of Kopana training; that a lack of middle management involvement may inhibit change; and that extensive health system restructuring at the same time as the intervention had created uncertainty among clinic staff and a high rate of turnover of experienced nurses. Qualitative interviews enabled the researchers to look in detail at staff concerns. In some clinics, staff fears about local gangsters causing trouble in the waiting rooms, or worries about catching TB themselves, meant that an intervention designed to increase patient-centred care raised concerns about reducing the amount of

control they had over patients. In others, deep-seated interpersonal conflicts between staff members or inadequate management limited the impact of any intervention that relied on building on team-working. Nurses did not necessarily identify themselves as part of a clinic team, so an intervention addressing 'the team' did not resonate with their perspectives.

Ethnographic insights included analysis of the implications of ritualised care in the clinics, which had symbolic functions: changing practice would need to engage with these functions as well as the more instrumental aspects of care. One example was the lack of any ritual that marked the end of the long period of TB treatment: there was no symbolic way in which the 'sick' patient was reintegrated into the healthy social body.

The qualitative study therefore helped unpack the results of the quantitative evaluation, in explaining why the intended outcomes had not occurred. It also suggested some issues to consider in future attempts to change the delivery of care for TB patients in primary level clinics. The ethnographic study also produced findings of wider significance, given the paucity of data on the organization of care in settings such as this one. Detailed accounts of how clinic organization is achieved from the perspective of staff involved, and why apparently irrational organization structures (such as 'task orientation') persist, are useful for building future interventions that take account of the motivations and behaviour of staff, rather than making assumptions about why nurses act in the way they do.

Reflective questions

Consider your own work setting, or somewhere you are familiar with, such as a school or a health clinic. Are there systems in place there that you feel could be improved if only the experiences of workers or users had been taken into account? List the ways in which these views might be made known (e.g. through a questionnaire survey, a suggestion box, one-to-one interviews, participant observation/ethnography). What might be the advantages and disadvantages of each?

Feedback

The relative advantages and disadvantages might relate to: whether the responses are confidential and allow for elements such as tension between staff to be acknowledged; whether the views of the users/practitioner are expressed about the situation as a whole, rather than simply about the issue in question, showing how it is experienced in the overall context rather than as an isolated and perhaps abstract 'issue'. Disadvantages of all methods may be that expectations are raised about issues or difficulties being resolved when this is beyond the power or remit of the research team.

First, there is the argument that qualitative methods 'reach the parts other methods can't reach'. Thus, Green and Britten (1998) argue that qualitative research has a potential role in contributing to the 'evidence base' of medicine because it can answer questions that experimental methods cannot address, such as the meaning of medication for patients, the social processes by which 'evidence' is utilized, or the interactional processes at work in the health care consultation. This 'deficit model' suggests that the specific contribution of qualitative methods to public health lies

in their ability to answer important questions that cannot be answered from a quantitative perspective. Case Study 1.2, an example of how qualitative methods are used in an evaluation, illustrates this. Here, qualitative methods are needed to answer questions about process and the meaning of interventions for those providing and receiving them: they answer questions that cannot be addressed by the quantitative evaluation.

A second potential response is to appeal to the epistemological positions outlined above. Questions in qualitative work are largely about *understanding* different perspectives, or examining how reality is constructed, rather than explaining one 'reality'. Qualitative designs thus provide 'better' answers to questions located in less positivist epistemologies. Nick Black (1994), for instance, cites a study of doctors' views of audit. Although most surveys suggested that doctors were in favour of audit, observation showed that little was carried out. A qualitative study identified a raft of reasons why doctors were uncertain or even unsupportive of audit, few of which had been raised in surveys. Designs that maximize access to these different perspectives are more likely to generate useful information for policy-making than those that merely ask for respondents' views in an unsophisticated way. Qualitative methodologies, then, can be presented as generating 'better' data on beliefs and behaviour.

Third, for individual professionals, qualitative findings are often useful for 'sensitizing' them to patients' views. In Case Study 1.1, for instance, several possible orientations towards asthma medication are described. It is less important to quantify what proportion of the population would share these views than to sensitize professionals to these as possible viewpoints. The 'usefulness' of this study lies in part in its potential to alert practitioners to possible patient perspectives, and how they affect health behaviour. At the policy level, qualitative studies have the potential to provide evidence for population needs, the development of appropriate policy, and evidence for how to implement policy with health care staff.

To return to the examples of qualitative health research studies given in Box 1.1, looking at the conclusions of the studies listed illustrates what their contributions to policy or practice might be:

- The study of willingness to pay for cataract surgery identified a realistic amount that families could pay for surgery, and found that 'willingness to pay ... concerns not only the elderly patients but also their relatives', an important finding for those conducting surveys on similar topics in these settings (Geneau et al. 2008).
- Understanding why cancer patients may not want information at particular times helps inform a national cancer information strategy that is based on understanding patients' needs, rather than common-sense assumptions about patients' needs (Leydon et al. 2000).
- Interviewing those seeking health information on the internet for prostate cancer demonstrated a range of effects on men's ability to manage their disease. For some, online forums provide support, and empower men in their interactions with professionals. However, doctors were often defensive about such use. This study suggests that doctors could more usefully guide and support use of internet sources, rather than dismiss them (Broom 2005).
- An ethnographic study of Limba views about leprosy was used to evaluate the effectiveness of a leprosy control programme and to aid communication between health professionals and their patients, as both groups had misunderstandings about the beliefs of the other (Opala and Boillot 1996).

- The study of parents' views about the MMR vaccine found that parents felt more information from health professionals, shared in an open manner, would have helped their decisions, and concluded 'only by fully appreciating the concerns of parents will health professionals be able to ... restore their confidence in the MMR' (Evans et al. 2001).

Conclusion

Qualitative health research in general, then, aims to answer 'what', 'how' or 'why' questions about social aspects of health, illness and health care. Although the contribution of qualitative research to our understanding of such activities as health behaviour and health provision is now broadly welcomed, qualitative researchers do still face some scepticism from those rooted in other research traditions. We have suggested this arises in part from differences in epistemological assumptions, with the preference for non-positivist approaches in qualitative methodology. We have also suggested the range of approaches covered by qualitative methodology, including interpretative, constructionist and critical traditions. While these approaches generate different research questions, there are perhaps some shared perspectives, including preferences for naturalistic studies, reflexivity, a focus on meaning, and flexible research strategies.

Key points

- Research questions arise from particular theoretical frameworks.
- Most qualitative research rejects a positivist epistemology, and instead adopts interpretative, constructionist or critical methodological approaches.
- Common orientations in qualitative methodology include: naturalism, reflexivity, a focus on meaning and understanding, and flexible research strategies.

Exercise

Look at the abstracts of qualitative health research papers in a social science or biomedical journal. Identify the theoretical assumptions made by the authors. These may be explicit, but are often not, so you will have to infer them from how the abstract is written. What other theoretical frameworks could have been used to address the topic?

Further resources

Murphy, E., Dingwall, R., Greatbatch, D., Parker, S. and Watson, P. (1998) 'Qualitative research methods in health technology assessment: a review of the literature', *Health Technology Assessment*, 2(16): 1–276. (Available from: <http://www.hta.ac.uk/fullmono/mon216.pdf>). Chapter 1 of this review has an excellent discussion of the foundations of qualitative research perspectives, the philosophical underpinnings of the main traditions in qualitative research, and a brief history of two disciplines, medical sociology and social anthropology. This is a useful resource for an orientation to qualitative approaches.

Read examples of published qualitative research in your area of interest to get an overview of the possibilities. Many journals are now moving to 'open access', which means you can download

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full manuscripts if you do not have access to library subscriptions. Journals that publish qualitative health research include: *Sociology of Health and Illness* (http://www.blackwellpublishing.com/shil_enhanced/), *Social Science and Medicine* (<http://www.journals.elsevier.com/social-science-and-medicine/>), *Critical Public Health* (<http://www.tandfonline.com/loi/ccph20>), *Qualitative Health Research* (<http://qhr.sagepub.com>) and *Qualitative Research* (<http://www.sagepub.com/journal.aspx?pid=280>).

The journal *Forum: Qualitative Social Research (FQS)* (which has articles in English, German and Spanish) at <http://www.qualitative-research.net/index.php/fqs/index>, is a good source of articles on methodology, and is completely open access.

'Online QDA' is a collection of learning resources (including videos, tutorials and text sources) for those doing qualitative analysis. See the pages on methodologies for useful short descriptions and examples of some of the commonly used qualitative methodologies you may come across: <http://onlineqda.hud.ac.uk/methodologies.php>.

**Companion website materials available here:
www.sagepub.co.uk/green_thorogood3e**