How Different is Qualitative Health Research From Qualitative Research? Do We Have a Subdiscipline?

Janice M. Morse

Abstract
Here, I compare the content, characteristics of participants, and the methods used in qualitative health research with qualitative inquiry in general. Special problems that occur when conducting research in an institution, with the emotional content when participants are ill, in pain, or dying, will be discussed. What concerns for the investigator, for the researcher as a person, and methodological quandaries occur? The bottom line is: Do we have a subdiscipline? Is there a need for a special forum for those practicing qualitative health/illness research?

Keywords
discipline / subdiscipline; health; illness and disease; research, qualitative

There is no doubt that the subject of qualitative health research draws a particular group of people—that is, health professionals—because of the subject matter itself. But the question we will explore pertains to the qualitative aspect: Does the nature of health research force us to modify or change qualitative methods, or to somehow use them differently, because of the phenomena that we study? This is a question that we have struggled with implicitly or explicitly over the course of our careers, for if both our research topics (i.e., substantive area) and also our methods are delineated from other medical/health researchers, then we have a subdiscipline—one that warrants our own journals, texts, courses, positions, and perhaps even professional societies. If not, then we submit our articles to nonspecialized conferences and our methods are incorporated into generalized qualitative texts; we cannot justify specialized texts.

Adding to the consideration of this question is that it is not easy to be a qualitative researcher in these times of evidence and numbers; but it is doubly difficult to be a qualitative health researcher in a context that devalues both your method and the topics that you study. One argument is that qualitative inquiry is of no use because of inherently poor methods (it’s biased, not valid, not generalizable, cannot provide proof, and so forth), and another camp argues that because qualitative researchers do not study topics of importance (as the findings do not save money, save lives, nor improve treatments and practice), it is a waste of public monies to fund qualitative inquiry. Mike Agar once said that he was collecting a list of innovations that were produced from qualitative research; his favorite (perhaps because of Mike’s appreciation of irony) was the Hawthorne Effect (Landsberger, 1958). He asked if I would collect innovations developed from qualitative health research. I did present a keynote about the value of qualitative evidence—“Does Qualitative Research Save Lives?” (Morse, 2004)—but it is telling that the list of innovations is short. Actual clinical use is hard to recognize, and effectiveness not demonstrated. Unfortunately, these three points—innovation, usefulness, and effectiveness—are critical to the overall acceptability of qualitative health research when arguing for the recognition of qualitative health research as a legitimate science. The prevailing attitude is, if it is of no use, it is not needed. And, if we push this two steps further—if it is not useful clinically and if it is substandard methodologically—then why teach it? Given these positions, we do not have a subdiscipline, and we should all vanish into the sunset.

Oddly, despite the strong opposition to qualitative health research, it has not gone away, and is becoming...
stronger. When we consider health science research as a whole, the great majority of research is conducted by medicine as clinical drug trials, epidemiological research, and basic research (including the emphasis on genetic research). Although funding agencies do not keep records of funding by method per se, the major federal research funds from the National Institutes of Health, the National Institutes of Mental Health, and the Agency for Healthcare Research and Quality are spent on quantitative research. At the National Institute of Nursing Research, the majority of funding is also spent on quantitative research—mostly on quantitative experimental design and surveys, and on some basic physiological research. Very few qualitative studies are funded. And this pattern of primarily supporting quantitative research is repeated in social work, occupational therapy, physical therapy, and other health disciplines.

Here I will try to make the case that we do have a subdiscipline in qualitative health research—one that is methodologically different enough from the qualitative inquiry used in disciplines such as education that it is a subfield in its own right. I will argue that the context, those who participate in our research, and the nature of research questions asked are distinct. I will make the case that special skills and qualifications are necessary to conduct qualitative health research (as “insiders”). I will argue that qualitative health research does warrant its own journals and conferences, and that it should be taught as a separate subject in health science curricula.

Characteristics of QHR

In 2010, the boundaries between qualitative and quantitative research remain clear. We all agree that the research question dictates the method used, and qualitative and quantitative questions are distinct. If there is a grey area, the researcher will usually opt for quantitative research, because those are the methods that most researchers are familiar with and competent in. However, this dichotomy has resulted in different substantive areas being addressed by different methods, with most of the research addressing concrete quantitative questions of treatment efficacy, rather than “softer” qualitative questions pertaining to the patient’s experience of illness and of receiving care. This should be no surprise, and medicine has traditionally been concerned with the pathophysiological processes (which Abraham Verghese, 2008, p. 2749, refers to as the “iPatient”), with physicians focusing on lab values displayed in the monitor/chart rather than examining the patient.

From the medical perspective, qualitative inquiry’s attention to the patient’s experience is “off focus.” For instance, from the medical perspective, it is more important to develop adequate analgesics than to learn about the experience of chronic pain or how patients cope with such pain in their daily lives, or whether or not adequate analgesia is available. Even though qualitative inquiry could remove much trial and error from practice—such as contributing to the optimal way of “breaking bad news”—medicine continues to largely ignore questions that can best be answered using qualitative methods. It is my opinion that much of the qualitative realm is not desired knowledge in medicine: Physicians might find it more difficult to treat patients if they understood the patient’s perspective (for instance, how painful a procedure actually is), and it would be more difficult to provide care with such compassionate insight.

Who Conducts Health Research?

The vast majority of medical/health research is conducted by medical/health researchers (referred to as “insider researchers”); that is, physicians, medical scientists, nurses, social workers, physical and occupational therapists, dietitians, counselors, and so forth. They usually address applied research problems that come from the bedside, from care provider situations, although some concept/theory development work may be classified as basic research.

Researchers conducting health/medical research who do not have medical/health professional education and licensure we will refer to as “outsiders.” This includes medical/health research conducted by medical anthropologists or sociologists, health educators, or psychologists, or research conducted by qualitative researchers who were former patients or relatives who had a medical/health problem drawn to their attention by personal experience with the illness. To determine if special qualifications are necessary to conduct medical/health qualitative research, and therefore, whether or not we do have a subdiscipline, the discussion and comparison of insider vs. outsider research is relevant to this issue.

Insider/Outsider Investigators

When preparing a proposal, background information is not a know-nothing/know-it-all dichotomy. There is some information in the library, and there is usually some personal knowledge of the topic. Researchers who have some working knowledge of the topic are usually health professionals working with patients, and their knowledge and perspective come from this occupational closeness and care provider role. We will refer to them as insiders. A smaller number are researchers who themselves are (or were at some point) patients, or significant others of patients. These researchers we will refer to as outsiders, along with others who do not have a “medical” background or extensive contact with health care, but who are fascinated by medical/health topics.
Outsider Research

The earliest outsider research was conducted on topics that other people had bought to research attention; these others had access to participants, usually outside the hospital or institution. Examples are Parkes’s (1970) bereavement theory, or the work of Glaser and Strauss (1965; both of whom had a parent dying in hospital). If the outsider researcher needed access to patients, he or she usually underwent a period of orientation before beginning the research (for instance, Goffman, 1961, worked as an orderly at a psychiatric hospital in Philadelphia before researching total institutions), while others spent some time in negotiation, and served as an observer (Lock, 2002), used patients who were outside the institution, or, as Glaser and Strauss, used students who were nurses to collect data. Less commonly, patients who were also social science researchers wrote about their own experiences (e.g., Murphy, 1990).

Insiders, on the other hand, were usually physicians with social science degrees (e.g., Kleinman, 1980) from specialties with a lot of patient and family contact, such as family physicians, psychiatrists, and now, in increasing numbers, from oncology. There are larger numbers from nursing—originally the nurse-anthropologists and, since the mid-1990s, from nursing. Possibly there are two reasons for this increased attention—the clinically constant nurse–patient contact and the increased amount of social science theory in nursing programs.

Comparison of Insider/Outsider Research

There are advantages and disadvantages to being both an insider and an outsider for conducting qualitative health research. Insiders do not come to the topic with a “naïve” perspective, one that is valued in ethnography. Their familiarity with the environment and the patient is both an asset and a deterrent to good research. It is an asset because they know the rules and norms for interaction in the hospital. They know the rules for privacy and maintaining confidentiality; for instance, they know when they may interrupt and when not, and even where they may go or not go, such as not violating infection precautions. These researchers are used to the sights, sounds, and smells, so are less likely to be disturbed by what they see or hear.

But being an insider is also a deterrent to good research, because routines and practices are taken for granted, and certain care practices and behaviors are not questioned or examined with new eyes. Many insider caregivers carry assumptions that may appear in the research, and be taken for granted. One example would be the use of restraints not being questioned by health professionals, yet being considered cruel by outsiders. Therefore, “knowing the setting” makes it more difficult to see “what is going on.”

A comparison of pros and cons for insider vs. outsider research appears in Table 1.

But there is more than knowing what is going on; insiders also know how to act in the hospital setting. Outsiders may not recognize codes of conduct and regulations—about confidentiality and HIPAA (Health Insurance Portability and Accountability Act) regulations, for instance—and may not be knowledgeable about who to ask questions, know who is who, and who is in charge, and so forth. Of greater concern is that an outsider with some type of uniform and ID badge may be mistaken for “real staff,” or even drawn into helping or providing care—especially if it is an emergency, such as a patient coding.

Table 1. Pros and Cons of Insider vs. Outsider Institutional Research

<table>
<thead>
<tr>
<th>Insider Researcher</th>
<th>Outsider Researcher</th>
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<tbody>
<tr>
<td><strong>PROS</strong></td>
<td><strong>CONS</strong></td>
</tr>
<tr>
<td>Know and respect rules and regulations; privacy (e.g., HIPPA)</td>
<td>Ignorant of regulations, must take extensive course work</td>
</tr>
<tr>
<td>Knowledgeable about caregiver hierarchies—who’s who, who to talk to, who is in charge, when to interrupt</td>
<td>Long period of orientation to learn norms before commencing data collection</td>
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<tr>
<td>Understand care practices—e.g., isolation procedures; how to respond to questions from patients or relatives</td>
<td>May unwittingly violate protocol</td>
</tr>
<tr>
<td>Can “read” the patient’s condition, pace data collection accordingly, and intervene in an emergency</td>
<td>May find the critically ill frightening</td>
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<tr>
<td>More accustomed to seeing patient distress/distraught behaviors</td>
<td>May be haunted by sounds of distress; limited access to debriefing and support</td>
</tr>
<tr>
<td>More accustomed to seeing and smelling blood/bodily fluids, wounds, etc.</td>
<td>Sights and sounds may traumatize/paralyze, inhibit data collection</td>
</tr>
<tr>
<td>Provide adequate background/interpretative material</td>
<td>Sometimes unsophisticated/uniformed write up</td>
</tr>
<tr>
<td>Health researchers may not know social science theory</td>
<td>Social science researchers may not know health/medical literature</td>
</tr>
<tr>
<td><strong>CONS</strong></td>
<td><strong>PROS</strong></td>
</tr>
<tr>
<td>Not a naïve perspective</td>
<td>Naïve about the norms, the patients’ experiences (response, meaning of illness, somatic response, treatments, care)—may facilitate analysis</td>
</tr>
<tr>
<td>Familiarity dulls senses; do not see assumptions/taken-for-granted practices</td>
<td>May be astute in recognizing “new”; assess with new eyes</td>
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Outsiders may not recognize certain care practices; for instance, inadvertently violating isolation procedures, or responding to questions posed by visitors. Furthermore, a researcher without a nursing or medical background often cannot recognize the patient’s condition, signs of fatigue, and so forth, and pace their data-collection strategies accordingly. Researchers with a medical or nursing background are accustomed to the sights, smells, and sounds of hospitals. Seeing a distraught, bereaved relative, and a patient in agony, may be disturbing at any time, but it is not as disturbing to a seasoned caregiver as it is to an “outsider.” Nurses and physicians have seen and managed patients with open wounds or serious injuries, and are more accustomed to seeing and smelling blood, bodily fluids, and so forth. Researchers unaccustomed to the hospital may be so horrified at the sights and sounds that they may to be unable to move or to collect data, and may have to leave the room.

The last insider advantage of importance is that health researchers have the background to conduct appropriate interpretations of the data. They are familiar with the literature and are able to appropriately link their findings with others’ research. Conversely, outsiders as investigators are not as familiar with the medical/health literature, and sometimes present unsophisticated interpretation, particularly noticeable in the discussion section. Their analysis and discussion may use social science theory and literature, so that the product is different—not necessarily worse—and may focus in on topics that the medical/nursing researcher would not consider important. Of course, these differences may also occur as clashes between insider care providers; for instance, a nurse researcher investigating nonpharmaceutical interventions in the alleviation of pain, and an insider physician reviewing that study, who may not consider the topic “important.” From the physician’s perspective, the alleviation of pain is the role of analgesics. (I have been told that my interest in nonpharmaceutical modes of alleviating pain, and my mode of collecting data, by videotaping the person receiving emergency care while in agonizing pain, is “perverted.”)

However, conducting research from the outside is not all negative; there are some advantages. On the “pro list” is that the outsider is coming into the setting with a naïve perspective—an approach particularly valued by ethnographers. In the worst insider case, the care provider is working in the same setting where he or she hopes to collect data. The familiarity with the setting means that the researcher will not be able to see what is truly going on, whereas important assumptions will be evident to the outsider new to the setting. The insider researcher is also more likely to be drawn onto assisting staff just when he or she wants to collect data. A partial solution to this problem is for the insider researcher to change specialties, or to collect data in a setting different from the one in which he or she is working.

How serious is this insider/outside problem for the conduct of qualitative inquiry? In the past, I delayed hiring an outsider (who was an experienced qualitative researcher) as a research assistant for a project in the trauma room until the person had worked for 2 months as a volunteer in the emergency department to learn hospital norms. Another time, I was not allowed to audiotape in the trauma room, but was allowed to take in a stenographer. The stenographer felt faint, and I found myself caring for her rather than collecting data. Hospital staff expect certain standards of conduct from all those who are there in an official capacity, whether actually on staff or not. This standard cannot be guaranteed from outsiders without extensive training.

The Nature of QHR Topics

Qualitative health research largely focuses on the illness experience, including injury, chronicity, birth, and death and dying. Yet such articles, focusing on the definitions, meaning, and experiences of health and health attainment, are largely in the minority of health research overall. Of course, neither health nor illness are static conditions, and often the focus is on the trajectory of illness, on becoming ill or recuperating, on disability or health maintenance. For documenting such trajectories, qualitative inquiry is particularly important, as it is not tied to rigid calendar time frames.

Exactly what do qualitative health researchers study? Elsewhere (Morse, 2010), all articles published in QHR in 2009 used in content analysis produced the following categories:

1. The identification of health care needs
2. Identifying patterns of seeking health care
3. Describing the illness experience
4. Adjusting to illness/living with illness
5. Experiences and practices of professional care providers
6. Experiences and practices of lay caregivers
7. Experiences of both lay and professional care providers
8. Identification and analysis of support systems
9. Reflections on the illness experience

It would be very difficult to argue that such topics are not important. But it is the descriptive nature of the information that renders it difficult to implement. Researchers describe the problem in depth, but then stop short of recommending solutions or providing concrete intervention strategies.
The Characteristics of Participants

Our patients, as participants, require special knowledge and abilities to enable participation in our research. If our participants are in hospital, they are often very ill, and are discharged to their homes before they are well. Our participants may be unable to talk and express themselves, and therefore not able to be interviewed. They may even be unconscious, on a ventilator, aphasic, too young (an infant), on drugs, in pain, or too fatigued to be interviewed. They may be in a different reality, lack memory of pertinent events, or be confused, and unable to provide the information needed by the researcher. Such conditions require that the researcher be innovative or have special knowledge of the participants when collecting data. For instance, Lorencz (1991), when interviewing participants with schizophrenia, knew that her questions were competing with the voices that each participant was hearing in his or her head, and knew to wait, and that after some time—often minutes—the person would answer. But sometimes the participant’s condition means that a different method must be used altogether. If the participant is unable to speak, an observational method such as ethology must replace interview methods. Alternatively, the researcher could interview the patient’s significant other rather than the ill person directly, thus obtaining indirect data about the experience. If action is too rapid to be recorded as observed (such as during resuscitation, when several things are happening at once), the scene could be recorded on videotape for later analysis. Frequently, the participants are interviewed some time after the illness, and asked to reflect back and tell their stories, providing retrospective rather than ongoing data. Such techniques take the participant psychologically back to the event, and may produce very emotional data as the person recalls and reenacts the events. Of course, there are some ethical concerns, such as in Roberts’ (2002) study of second stage labor, in which interviews after the event triggered phantom labor pains in the postnatal women.

Overwhelming in qualitative health research is the patient’s emotional state, invariably one of suffering. The experience of illness leads participants to grapple with the experiences of lack of control, of losing one’s physical and mental abilities, enduring pain and treatments; the uncertainty of living and the possibility of dying result in distress. Witnessing such suffering impinges on the researcher, creating a state of shared suffering. Researchers who are also care providers are expert and accustomed at managing such emotions, and adept at assisting the distressed patient. However, those who are outsiders are less adept at responding to such emotion, and inexperienced at controlling their own responses, to the extent that transcriptionists have been reported to manifest symptoms of PTSD (posttraumatic stress disorder; Splevins, in press). Thus, it is important that principal investigators have some system of debriefing for research assistants and others who are new to qualitative inquiry. Haunting stories also haunt listeners.

Is the Modification of Methods Necessary?

Qualitative health research requires the modification of methods because of both the condition of the participants and the contextual features of the hospital. As noted in the previous section, the patients’ conditions may demand that a different method be used, that data be collected in small increments because of fatigue, or the interruption of data collection for treatments or physicians’ rounds, visitors, and so forth. The research has lowest priority; any and all assessments, treatments, and even visitors have priority over the researcher’s agenda for data collection in the patient’s day. Furthermore, the demands of the hospital often make data collection tricky, if not impossible. If the patient has a shared room, even finding a quiet and private place to interview the patient is sometimes a challenge. If the researcher is an outsider, negotiating for space to conduct the research may be difficult, and a place to write notes or store equipment difficult.

Is Qualitative Health Research a Subdiscipline?

I have tried to make the case that a background in a health profession is crucial for the conduct of qualitative health research:

- Health professionals are “street smart,” knowing the rules, regulations, and norms for working in a hospital.
- Health professionals, with some working knowledge of the patient population, can recognize appropriate research questions.
- Because of their knowledge of the signs of fatigue and experience with illness, health professionals can monitor their patient participants throughout data collection.
- From their completed projects, health professionals can more readily make realistic recommendations for practice.

In summary, the qualitative health researcher must be an excellent qualitative methodologist; plus have the ability to modify methods to fit contextual and participant limitations; plus be knowledgeable about hospital
codes of conduct (confidentiality and so forth); plus have an understanding of illness, the patient’s condition, staff roles, and relationships with the staff; plus the wisdom and ability to step back to evaluate/assess/balance the clinical situation from multiple different perspectives.

Therefore, qualitative health research is a subdiscipline, with different outputs than other qualitative researchers, and different skill sets that are required by these researchers. We have a subdiscipline that makes a unique contribution to both health care and qualitative research. In light of this, qualitative health researchers have different needs that must be met in qualitative health research courses, texts, conferences, and so forth. The special conditions for the collection and interpretation of data, and for recommendations, result in a “changed product” or outcome from qualitative health research conducted by insiders. Qualitative health research consists of modified methods, administered in special circumstances, with unique and tailored interventions. It is these features that provide qualitative health research the status of a subdiscipline, worthy of separate methodological texts, journals for reporting results to health professionals, courses and preparation, and even professional societies.

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