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Qualitative Health Research in the Era of Evidence-Based Practice

Maria H. F. Grypdonck

Evidence-based health care (EBHC) sets the tone in health care and health care research nowadays. Qualitative health researchers have to position themselves in a world that is dominated by it. The popularity of EBHC is not due to the rationality of its tenets. In this article, the author addresses major problems in EBHC. Qualitative research is important for providing the understanding that is necessary to apply findings from quantitative research properly and safely. Basic studies about the human experience in illness and regarding human behavior and meaning in general remain of great value, even in the era of EBHC. Qualitative research also plays an important role in developing scholarship.

Keywords: *evidence-based practice; qualitative research; randomized controlled trials*

Evidence-based health care, or EBHC, is presently a major theme not only in medicine and health sciences but also in the social sciences (Davidson et al., 2003; Swinkels, Albarran, Means, Mitchell, & Stewart, 2002). It has even reached law (Bird, 2004). What is the evidence? This question is raised a million times a day all over the world.

Reasonable practitioners are concerned about the evidence and have a program to replace, in their personal practice and that of their profession, opinion-based actions by evidence-based actions—at least, that is the dichotomy that EBHC constructs (see, for example, Hampton, 2002, 2003; Harden, Grant, Buckley, & Hart, 2000; Heffner, 1998; Herzog, 2003; King, 2005; Lyles, 2004). Qualitative researchers feel the hot breath of the EBHC movement on their neck (see for example, Annells, 2005; Aoun & Kristjanson, 2005a, 2005b; Johnson & Waterfield, 2004; Morse, 2005; Sandelowski, 2004). They feel compelled to defend the place of qualitative research on the health scene and thus in EBHC. Indeed, if that place cannot be established or clarified, there seems to be no future for qualitative research in health care, so pervasive has the EBHC ideology become.

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The major tenet of EBHC is that practices need to be evidence based (Evidence-Based Medicine Working Group, 1992), which means, in the EBHC movement, that they need to be based on scientific research studies of the randomized control clinical trial type (RCT; Sehon & Stanley, 2003). Sackett, Rosenberg, Gray, and Richardson (1996) define evidence-based medicine as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research” (p. 71).

Rational practitioners base their decisions regarding individual patients on the available evidence. When a research study has shown that a treatment that was thought to have a beneficial effect does not have that effect—in the RCT study conducted to investigate its merit, there was no significant difference between the group receiving that treatment and the group not receiving the treatment or receiving a control treatment—opinion should be replaced by evidence (Evidence-Based Medicine Working Group, 1992). The use of the treatment is no longer deemed rational and so is not warranted. Prescribing drugs that have been shown not to have an effect cannot be considered good practice.

Of great importance, then, is what counts as evidence. Although “any systematic observation of the apparent relation between events” can be considered evidence (Evidence-Based Medicine Working Group, 2002, p. 72), there is a firm—be it not always consistent (Evans, 2003)—hierarchy (Akobeng, 2005; Hamilton, 2005). Evidence of the higher order always supersedes that of the lower order, as the order is “evolutionary,” based on the containment of the risk of bias (Akobeng, 2005). Indeed, some systematic reviews include only RCTs (see, for example, Guevara, Wolf, Grum, & Clark, 2003; Tang et al., 1998). There are also more open approaches in which it is recognized that other types of research can be considered, albeit with caution (Rychetnik, Hawe, Waters, Barratt, & Frommer, 2004). At the very low end of the hierarchy, to be taken into account when evidence is lacking, we find qualitative research, consensus, and opinion. Qualitative research is sometimes distinguished from the other two, sometimes not. Almost invariably, qualitative research is regarded as the lowest level of research, its being of a provisional nature to be used initially pending better, “real” ways of producing evidence (Leys, 2003).

Qualitative researchers feel they should be assigned a higher place in this hierarchy and have their evidence received with more respect. Thus, in their opinion, they must pay particular attention to the trustworthiness of their findings. If findings of qualitative research are to be taken into account, if they are to be taken seriously, one will have to make sure not only that they are trustworthy but also that their trustworthiness can be assessed and expressed in criteria that quantitative researchers understand and use (Pope & Mays, 2004). Objectivity and replicability are of great importance. Metasynthesis is conceived of and developed as a parallel to meta-analysis (Paterson, Thorne, Canam, & Jillings, 2001). Criteria of objectivity are copied from the quantitative methodologies; coding and analysis have to be checked by a second rater and interrater reliability established by the usual means, that is, the means that quantitative researchers use, to establish and prove objectivity (Pope & Mays, 2004).

Obviously, qualitative researchers or researchers who consider qualitative research valuable cannot ignore the developments related to EBHC. However,

there is a snake in the grass. There is a danger that the ideology of EBHC and quantitative research will affect qualitative research in its roots, which may endanger the quality of qualitative research. And we should not let this happen.

In this article, I will first address some issues in EBHC to demystify EBHC and reduce it to its true proportions.

DEMYSTIFYING EBHC

EBHC can be and has been characterized as a movement (Alam & Talha, 2005; Davidson & Spring, 2005; Goldenberg, 2006). It is a very powerful and successful movement. There has been, however, no research to explain the success of the movement, but is it certainly not due to the internal logic of its tenets.

Why does EBHC get so much attention?

It is highly remarkable that a position that has been so severely criticized and is so severely undermined (for an overview, see Weisz, 2005) remains so influential. The success of EBHC in part can be due to its being poorly defined. Proponents often cite the definition of Sackett, Straus, and Richardson (2000) and given above. This definition almost precludes opposition—who could be against using best available evidence?—but it is, as a definition, inadequate: It does not indicate the specificity of EBHC; EBHC prescribes much more than is rendered in that definition (Sehon & Stanley, 2003).

In the propaganda, the benefits of EBHC are put forward in very well-worded phrases (Couto, 1998; Sehon & Stanley, 2003). That is not enough, however, to explain its success. Other, equally honorable movements have worded their assumed benefits equally attractively but have not been so successful. EBHC promises the practitioner certainty, and for professionals who have to face difficult and risky decisions, sometimes implying life and death, it may be very reassuring that there is light at the end of this particular tunnel. Acting according to the evidence frees the professional from doubt about the proper course. No more afterthoughts, no more unanswerable questions whether the patient would not have been saved from death if another treatment had been administered. Evidence dictates, and he who follows the evidence is not to be blamed and certainly not to be prosecuted. Health care is becoming a much less tricky business, with much less subjectivity and many fewer reasons for confusion, it seems. It becomes a much more rational business, with many fewer discussions that cannot be settled. The evidence will settle them (Van Heijst, 2005).

Apart from risk, the objectification of suffering might also be an important factor in the success of EBHC. In the late 1960s, Menzies (1970) described task allocation in nursing as a defense against anxiety. In the same way as task allocation can create a distance between the patient with his suffering and the nurse who needs to deal with it, EBHC can create a distance between the patient with his or her suffering and the practitioner who needs to make decisions about it. The very fact that a problem can be generalized and also that the question to be answered is which treatment has proven to be most valuable, converts the personal problem into a general one.

EBHC is very attractive to managers, as it renders many issues objective and makes care more predictable and controllable. When two physicians are disputing about the care to be provided, the manager can ask for evidence to resolve the issue objectively. A practitioner claiming resources can also be asked for his or her evidence. Discussions about standards can be very easily resolved, and anyone who does not adhere to evidence-based guidelines can be called on the carpet.

Another reason why EBHC seems to be attractive is the power that it appears to give the practitioner over disease and suffering. Indeed, EBHC can be deemed to be one of the expressions of an exaggerated belief in progress. It promises control over disease, the elimination of false therapies, and their replacement by real ones. Doctors and nurses who are confronted with the limitations of their actions can find consolation in the belief that their impotence is but temporary. They can expect that a time will come when this particular problem, too, will be able to be resolved.

Is EBHC Rational?

EBHC is an ideology (Miettinen, 1998) but one that violates its own ideology. Indeed, one of the basic tenets, very fundamental to EBHC, is that only what has been scientifically proven in RCTs is credible, and it is a matter of faith that only what has been proven in such research is safe to be used in health care to improve health (Sackett, Straus, et al., 2000). Evidence-based medicine is for believers, as they themselves state (Evidence-Based Medicine Working Group, 1992). However, there are no RCTs to substantiate the contribution of EBM (evidence-based medicine) to public health, as the proponents of EBHC have to admit (Haynes, 2002; Sackett, Straus, et al., 2000). There has been no RCT that proves the superiority of EBHC, and it is even inconceivable that such a trial could ever be carried out (Sackett, Straus, et al., 2000). EBHC adepts will be in the belief state forever. It is not a transient stage, not one that could be expected to be redressed in the near or far future. Claiming that opinion should give way to evidence, while not being able to provide evidence for such a statement, is itself neither logical nor rational (Couto, 1998).

How Informative Are RCTs?

In EBHC, what counts as evidence are the results of RCTs, which are at its very core. They are the heart of the matter. They certainly are the method of choice when the question pertains to the effectiveness of medications. When complex health care problems or complex interventions are involved, things are quite different. RCTs tell us that for a certain group in a certain, often specific situation, a specific way of carrying out an intervention to treat a problem has resulted in the measured outcome: The experimental group's results are or are not superior to those of the control group. The RCT establishes a causal relationship, the doctrine teaches (Rychetnik et al., 2004). But a causal relationship between what? If a patient group receives one drug and another group receives another, and all other things are equal, one can assume the difference in drugs to be responsible for the difference in outcomes. However, when complex interventions are administered

in complex situations, what precisely is responsible for the effect (Victora, Habicht, & Bryce, 2004)? There is no way to know. Is it the intervention itself or, perhaps, the circumstances under which it is administered? Indeed, with drugs it is fairly easy, although often more difficult than assumed, to keep the circumstances controlled and equal. With complex interventions, it is far from easy and often not even possible (Van Meijel, Gamel, Swieten-Duijfjes, & Grypdonck, 2004). Often different health professionals have to administer the experimental and the control intervention. Not only are they not blinded but also much of the context of the intervention may contribute to, or even be responsible for, the effect. While great care is taken to avoid contamination and selection bias, often very little attention is given to the representativity of the stimulus, including the person administering the experimental treatment (see, for example, Kamps et al., 2003). How do we know, Brunswik, a very well-known experimental perception psychologist and coauthor of the famous *Encyclopedia of Unified Science*, wrote in 1955, that an effect is due to differences in cues we offer the experimental subjects and not to the length of the nose of the person administering the cues? An RCT in which a complex intervention is tested also provides no information about what parts or elements of the intervention contribute to the effect. That the intervention as a whole has positive results does not mean that the intervention does not contain elements or parts that would better be left undone (Van Meijel et al., 2004).

Another problem with the information RCTs provide about a complex intervention is that of the base line. It is common to compare the experimental intervention to "treatment as usual." In the case of pharmaceutical interventions, this "treatment as usual" may consist of a specific drug given in a specific dose under similar circumstances, as is given the experimental drug. In psychosocial or educational interventions, however, "care as usual" is usually highly heterogeneous. When investigating the effect of self-efficacy interventions for adolescents, the control group may be recruited in a clinic offering hardly any psychological support to its patients or the experiment may be conducted in a clinic where nurses take great pains to maintain good relationships with their clients, to listen to them, and to try to resolve the problems they have with their therapeutic regimen (Grypdonck et al., 2003). It is obvious that the chances of finding significant differences are not equal in the two cases. What should the practitioner conclude if he or she finds significant differences in the first study that are not confirmed in a second one? Does the second study weaken the evidence of the first one, as EBM methodology implies?

Many RCTs do not report intervention checks. The investigator does not systematically assess whether or not the experimental treatment was carried out as designed. Of course, when analyzing the significance of studies and, even more so, when analyzing them in a meta-analysis, it is of the greatest importance that this has been done. The frequent absence of any mention of adherence to the experimental treatment in published studies shows that it is not used as a criterion for publication. The best way to destroy the reputation of your enemy who has developed an interesting intervention and demonstrated its success is to do an experiment with the same intervention and apply it sloppily to a large sample. Your negative findings will overrule his or her positive ones when meta-analyses are conducted, and it is very likely that the journal in which you publish the results will not ask how well you carried out the intervention.

Amazing is the almost complete absence in EBHC of attention to the cross-cultural differences that may prohibit generalization of findings. In a systematic review of effects of the teaching of patients about adherence in asthma treatment, Chinese articles were translated to add them to the North American, Spanish, Finish, Dutch, and South African ones (Guevara et al., 2003). Apart from cultural factors, the issue of whether results from experiments may be generalized to real life is important, as Argyris had already pointed out in 1975. In the field of adherence to treatment regimens, the warning of Argyris should be taken very seriously. Persons in a control group may be compliant because they are controlled or, as we have often seen in our studies, because they do not want to cause problems for the student who needs the study results for his or her degree.

Should Evidence Always Prevail?

Is it reasonable to give precedence to interventions that have been tested and proven to be beneficial over those that have not been submitted to test? It may seem so, and the EBHC ideology defends it, but often it will not be the case. Imagine the following situation. For one or another disease, a new drug has become available. The drug requires quite a bit of patient knowledge to take it appropriately comparable to what is required for treating children for asthma. A nurse responsible for the care of the patients develops a method of instruction based on observation and interviews with her clients. She observes them performing the administration, analyzes the mistakes they make, develops slides to show right and wrong methods, uses strategies to enhance their self-efficacy, as Bandura's (1997) theory suggests, and lets them formulate if-then intentions, which in other situations have proven to increase desired health behavior. After the instruction, the nurse observes a high rate of compliance in her patients, and they tell her that the explanation was very clear and that they feel confident that they could do it properly. When they demonstrate their technique in a follow-up consultation, most of them—the nurse registered 90%—do, indeed, perform as desired. The nurse applies for funds to test the intervention in an RCT but the Lung-Disease Fund replies that this year, her particular disease is not a research priority. In the meantime, the drug company has carried out an RCT, published in a high-impact journal. In the experimental study, carried out according to the rules of the game, a fairly basic method of instructing the clients is tested. When the experimental group, receiving this instruction, is compared to the control group, not receiving any instruction, the experimental group performs better. The difference is significant: Thirty percent of the subjects take their medications in the appropriate way as compared to 12% in the control group. Should the higher level evidence take precedence here, and should the nurse leave her intervention aside and use the one that has been proven to work in only 30% of the patients because there is stronger evidence that it works?

What Is Worthwhile?

RCTs can clarify relationships between interventions and outcomes. The questions for RCTs that are appropriate are those about means to ends (Glasziou, Vandembroucke, & Chalmers, 2004; Petticrew & Roberts, 2003). If we want to

achieve a certain behavior or a certain state, what means do we have at our disposal and for which one do we have evidence as to their effects?

To infer from the relationship between the intervention and the outcomes that the use of the intervention should be preferred supposes that there is agreement about what the best solution to the problem would be. Again, in simple medical issues that might be the case. In more complex issues, however, obtaining consensus will certainly not be easy. In a qualitative study about what quality of life would consist of for elderly psychiatric patients who have been moved from a psychiatric hospital to more independent but assisted living arrangements, Pols (2004) observed a divergence in opinion between the psychiatric nurses and the ADL assistants. The psychiatric nurses have a rehabilitation ideology. Their aim is to restore the capacity for independent living, even for those people who have been in a psychiatric hospital for a very long time and have now been placed in homes for the elderly. One of these capabilities is being able to make coffee for oneself. Each home unit has its own coffee machine, and the aim is that as many elderly as possible be capable of making their own coffee and do so. The ADL assistants, without psychiatric training, do not have such a philosophy. Their aim is that their clients feel good, are content, are relaxed, enjoy themselves if possible, and are not lonesome. One of the residents makes coffee in the morning. She really likes it. She invites her fellow residents to drink coffee in the common room. The ADL assistants think this is a good idea. They consider it of value that the residents enjoy coffee together and that the lady can do this for them. But the psychiatric nurses do not share this viewpoint. Indeed, if they let the lady make the coffee, the other residents will never learn to do it for themselves. To the psychiatric nurses, it matters, even though they know that the residents will never leave the nursing home where they are now residing. As long as the difficult questions—what really matters, what really contributes to good life, what is worth aiming for, or what outcomes one should try to achieve—are not answered, information from RCTs can only partially inform decision making.

It is very striking that in general, in RCT testing interventions, very little attention is given to side effects or unintended consequences. They are, however, of concern in any case where one intervenes purposefully to change a situation.

Averages and the Vulnerable

RCTs establish relationships between treatments and effects. They make it clear whether it is reasonable to assume that a certain intervention produces a specific result. The relationship is tested, of course, at a group level. If the experimental group does better than the control group, it certainly does not mean that every member of the experimental group benefited from the intervention, and, conversely, if the intervention does not show to have an effect, it does not mean that no one at all benefited from the intervention. This is why, as Miettinen (1998, 2004) pointed out, RCTs allow prognoses, not predictions. This is very straightforward, and it would not be of value to call attention to it were it not for the consequences that this state of affairs has for disadvantaged groups, consequences that should be of even greater concern when evidence is used in policy making.

Indeed, if evidence is used to decide about how reasonable it is to use or to pay for a specific intervention for a certain group of clients, people with more

severe problems, the highly vulnerable, may be denied interventions that would be really beneficial to them because, on average, these interventions do not make a difference (Feinstein & Horwitz, 1997). In a study on preparing patients for a CT scan, our research group found that oral instruction of patients did not increase the benefit of the written communication we had provided to the patients (Feyaerts, 1997; Van Slycken, 1998). We came to the conclusion that giving the folder suffices. This will, of course not be the case for patients with a very low degree of literacy. If the results of the RCT, however, are taken as the standard, patients will no longer receive the verbal instructions. If more important issues are involved than the one in the example, and if health care policy makers decide on the basis of evidence from RCTs which treatments should be covered by health care funding or health insurance, the more vulnerable will suffer. As the marginal and the highly vulnerable are, by definition, poorly represented in random samples from general populations, the issue should be of great concern.

The Exception Confirms the Rule

In any case, the practitioner should question whether it is appropriate to follow the evidence. RCTs create expectations that are reasonable but may or may not be fulfilled. That is the reason why the practitioner should make decisions based on the evidence and his or her clinical judgment (Sackett, Rosenberg, et al., 1996). The practitioner should judge whether the findings from the RCT are generalizable to the client involved. Strauss and Sackett (1999) consider this to be the case if the client does not differ from those included in the RCT. How this judgment should be made without a good understanding of the processes involved in producing the results is not at all clear. Which differences should be judged relevant and which not? Moreover, even if similar clients have been included in the trial, it does not at all mean that the beneficial results apply to that particular subgroup of clients (Feinstein & Horwitz, 1997). In the study cited above about preparing patients for a medical examination, people who are illiterate can be assumed to have been included in the study. Persons with a reading disability make up about 10% of the population, and since they were not excluded and the sample consisted of 300 subjects, they almost certainly made up part of the sample. Does that mean that we can assume that the results are equally applicable to them, as Strauss and Sackett—most remarkably—seem to imply? Of course not.

That every patient can be an exception to the rule underlines the importance of taking each individual patient's experiences into account. The patients' experiences should be distinguished from the patients' preferences, the latter often being referred to in the EBM discourse, the former rather seldom. The patient's previous experiences may indicate the extent to which the general findings of research studies apply to him or her. They may contradict, for explainable or unexplainable reasons, the evidence.

RCTs are certainly of great value for finding out whether a specific treatment or intervention in general has the supposed effects, and practitioners need to take the findings of RCTs into account when making decisions in health care. However, much more is needed for the advancement of health care than such studies, for they can provide only a small part of the guidance that research can offer health care practice. The EBHC movement has made RCTs into acroliths: They may seem

impressive and potent, but they mean nothing if not complemented by other types of knowledge, among which, certainly, is the knowledge generated by qualitative research.

THE CONTRIBUTION OF QUALITATIVE RESEARCH TO THE APPROPRIATENESS OF HEALTH CARE

Qualitative research can contribute substantially and in different ways to the appropriateness of care. *Appropriateness* is a broader category than *evidence based*. Care can be considered appropriate when the chances are maximized that the care will contribute to the well-being of the person who needs it at reasonable cost for society.

Qualitative research can contribute by providing explanations for that which quantitative research expresses in relations between variables, in cause-effect relations. Where quantitative research, such as RCTs, can demonstrate that, indeed, a teaching intervention leads to better control of behavior, qualitative research can provide an explanation and understanding of why it does. It can bring to light the sometimes complex processes that underlie the positive results or account for why they remain absent. Reasoning in the other direction, qualitative research can provide an understanding of processes such as adherence to, or self-management of, a therapeutic regimen, and thus provide the foundation for developing interventions that address the factors that are at play in these situations (Morse, Penrod, & Hupcey, 2000; Van Meijel et al., 2004). In an ongoing qualitative study that I am conducting with Sigrid Vervoort about adherence among AIDS patients, we noted how processes of cognitive dissonance are at play when patients, despite their personal conviction that they should, do not manage to adhere to the directions they receive about their medications. Confronted with the realization that their lack of adherence creates situations that endanger their life and with the impossibility of their complying with the prescriptions, they begin to believe that the rules do not need to be followed quite so strictly and end up believing that they have been told that it does not matter so much if they do not observe the rules so strictly. This, of course, resolves the tension that noncompliance generates. The understanding of this process enables interventions to be designed that take these processes into account. It also demonstrates why one should proceed very thoughtfully when patients are convinced that they are compliant but, in fact, are not and why it is of no use to stress the dangers of deviations from the therapeutic regimen if one does not at the same time help them to improve their behavior by removing some of the barriers to adherence. It also warns us that we should be very careful with quantitative measurements of adherence based on self-report.

The understanding of why interventions lead to the desired results is also of utmost importance for the intelligent application of the findings of RCTs. As we have already pointed out, practitioners should ask themselves in every particular case whether it is wise to follow the guidance from RCTs based on averages. The better the understanding of the practitioner of what is involved in a particular situation, the better he or she can judge the likelihood that a deviation from the norm is or may be indicated. Qualitative understanding, and especially qualitative theory construction, can contribute much to the awareness of the practitioner of the

factors that may be important in a situation that require adaptation of the routine procedure. Findings from qualitative research can enable one to contextualize or recontextualize the RCT findings.

Qualitative research is also important for judging the desirability of the outcomes that an intervention seeks to produce and for finding clues to desirable and undesirable side effects. People's accounts of what the intervention means to them, what they got from it, what they found annoying or disturbing, and especially participant observation of what actually takes place can inform the researcher and thereafter the practitioner of what the intervention brings about in a much broader and more understandable way than can the measurements of quantitative research and *a fortiori* of RCTs (Vandenbroucke, 2004).

The most important contribution of qualitative research to the appropriateness of care lies in its ability to bring the perspective of the person with the illness to the fore. Indeed, health care has gained enormously since it has become fashionable to do, read, and take into account research about the perspectives of the persons with an illness. Especially in the case of people with a chronic illness, this research has contributed very much to our understanding of what it means to have a chronic illness and of how people try to cope with it. People with a chronic illness repeatedly point out that one cannot understand what it means when one does not suffer a chronic illness oneself, and, leaving aside whether this says more about the enormity of the experience or about the reactions that people with a chronic illness encounter, I think they are right. Qualitative research certainly helps one to bridge the gap between the experience of the people with a chronic illness and the images "healthy" people, including professionals, have of what it means to live a life of which a chronic illness is an unavoidable part. Based on the reactions of people with a chronic illness to our efforts to understand their lives, I consider our attempts at understanding reasonably effective. Such research does, indeed, make a difference.

One of the examples in which the influence of qualitative research is visible is the shift from disease management to self-management of one's life with a chronic illness (Barlow, Wright, Sheasby, Turner, & Hainsworth, 2002; Coates & Boore, 1995; Kogan & Betrus, 1984; Newman, Steed, & Mulligan, 2004). In nursing, probably more or earlier than in other disciplines, the concept of compliance and its successor adherence have been replaced by self-management. Self-management, more than adherence, underlines the role of the patient in the decisions and the execution of the therapy. The disease and the therapeutic regimen require a series of decisions that have to be executed properly in order to control the disease. Qualitative research, however, has clearly brought to light that the decisions concern not only the therapeutic regimen or how it should be incorporated in daily life but also the attempts of people with a chronic illness to try to find a balance between the demands of the disease and the demands of life (Grypdonck, 1999, 2005a). They deliberately choose to violate the prescriptions of the therapeutic regimen in order to safeguard that which they feel is important for them and their family. Self-management is concerned with maintaining that balance. It is, therefore, appropriate to speak about adequate and inadequate self-management (Grypdonck, 2005b). Self-management can be considered adequate when it leads to the goals the patient considers important in life. Self-management is inadequate when the balance is lost sight of or when the person with a chronic illness does not manage to keep the balance as he or she would like it. The role of the nurse and

other health care workers, then, is to help the patient lift life above disease (Grypdonck, 1999). In lifting life above disease, the person with a chronic illness manages to control the disease and does what is necessary for it but in such a way that the disease does not occupy a central place in his or her life. Qualitative research about living with chronic illness shows us that this is, indeed, what patients do. It makes clear that they do not simply follow orders, even if they have been decided upon together with the physician. Persons with a chronic illness devise their own personal versions of their therapeutic regimen and choose to take risks. They do so in order to obtain what is of greater value to them or to give in to what they cannot resist, hoping the consequences will not be too detrimental or accepting the suffering when they turn out to be serious. Supporting persons with a chronic illness in the management of their lives with a disease requires that the professionals be aware of these processes.

In the care of people with a chronic illness, the view that the primary concern should be to safeguard their lives is much more complete than the one that is rooted in the quantitative and medical approach to chronic illness and is apparent in the concept of disease management. Although disease management can be considered a major improvement over the fragmented medical care of people with chronic illness that often is the case in many countries (Epstein & Sherwood, 1996; Sidorov & Schlosberg, 2005), it still gives the disease the central place and still makes it the point of departure.

Understanding what it means to be ill, to live with an illness, to be subject to physical limitations, to see one's intellectual capacities gradually diminish or to be healed again, to rise from death after a bone marrow transplant, leaving one's sick life behind, to meet people who take care of you in a way that makes you feel really understood and really cared for, understanding all this all is a major asset of practitioners who use findings from qualitative research in their daily work. They will be aware, however, as our respondents often point out, that this understanding cannot be but partial. An important threat to the usefulness of qualitative research for practice is the tendency to use it for prediction. Knowledge from qualitative research should not function as a prejudice (Grypdonck, 1997). In each encounter, the practitioner should be aware that for qualitative research, as well as for quantitative research, one who relies solely on scientific findings will often err and do the wrong thing.

Understanding and, especially, integrating the understanding that different studies provide are dependent on adequate general schemas about human experience and human behavior. The practitioner needs such schemas that can serve as the background against which observation pertaining to a particular client can be placed and interpreted. The schemas should not define the interpretation of what is observed but what is observed should be interpreted in dialogue with them. For the practitioner as well as for the researcher, the openness to the possibility that things might be different from what one expects needs to be maintained at all times.

The importance of these global schemes for practice means that one should not consider relevance for practice too narrowly. Qualitative research should and does provide information that can directly help in making decisions. Helping in the interpretation of the situation of the client is at least as important. Certainly and especially in health care, we have to be careful with research money and be aware that the use of research funds to study one topic precludes its use for

another. Research priorities, therefore, must be carefully considered. It is, however, a far-to-narrow a view that the direct applicability of the findings in practice should determine the utility of a research study. If qualitative research wants to play the role in EBHC it is capable of playing, much room has to be made for what I would call "basic research," research that helps us understand very basic processes in illness and human experience, and creating meaning in general. Such research should not at all yield way to more narrowly conceived applied studies, for instance, about specific diseases or specific threats or situations. Indeed, not only will the proper study of the specific topics benefit greatly from broader and more fundamental studies about humankind, but also practitioners will find the broader schemes and ideas of great importance in dealing with their patients.

Last but not least, I want to point out the great benefit of conducting qualitative research in developing clinical expertise. Indeed, as Rolfe (1999) has pointed out, contrary to what Sackett, Rosenberg, et al. (1996) pretend or maintain, clinical expertise is the integration of scientific findings, reflected experience and observations, and knowledge synthesized through the years and continuously adapted to new information and experiences. Elsewhere (Grypdonck, 2001), I have described the development of scholarship, and the same certainly applies for clinical expertise, as taking place by walking through life as if it were a continuous qualitative study: Every piece of information, wherever it comes from, is compared to the pieces one already has, interpreted, and accorded a provisional status.

CONCLUSION

Although EBHC manifests many gaps in its doctrine and cannot be considered a rational response to the needs of society, the growth of knowledge, and the need to make knowledge used in practice, it is doubtless here to stay (Weisz, 2005). Qualitative researchers have to take it into account. Positively, EBHC has certainly contributed to a greater awareness of the need to establish the trustworthiness of the research and to legitimize it. Negatively, it leads to flirting with the quantitative researchers who decide about publication in high-ranking journals and so can undermine the true nature of qualitative research. Qualitative research has much to contribute to the appropriateness of care, so qualitative researchers must be assertive in affirming the value of their work.

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