Does Health Research Warrant the Modification of Qualitative Methods?

Now, this is an interesting question: Does the nature of the illness, and the hospital context in which qualitative health research is conducted, force us to adapt our qualitative methods to access the data we need? Can we send our students to courses taught by faculty from education or sociology—faculty with no knowledge of the clinical context or what it is like to conduct research with the ill—and have these students learn to do qualitative research to a level where they could function as qualitative health researchers? Is it adequate to know about illness and hospitals in a superficial sense—perhaps by being a patient ourselves rather than a health professional—to conduct qualitative research about illness, or must one actually be a clinician, a physician or a nurse, to function within the hospital, identify a meaningful question, or collect adequate data? In other words, I am asking, Are qualitative health research methods a subspecialty of qualitative inquiry?

First, issues of privacy and access aside, I am not convinced that anyone can simply barge into a hospital, regardless of research preparation, and be able to conduct qualitative research about illness, or must one actually be a clinician, a physician or a nurse, to function within the hospital, identify a meaningful question, or collect adequate data? In other words, I am asking, Are qualitative health research methods a subspecialty of qualitative inquiry?

Adapting Qualitative Methods for Health Research

The following adaptations are often made by qualitative health researchers:

1. Changing methodological approach. Data collection that takes place when the participant is sick or ill may require special skills and adjustment. Sick patients may not, for instance, be able to be interviewed because they are mute. For example, even if they are cognitively...
aware, intubated patients are not able to speak. They may communicate by other means, using a pen and paper or a spelling board, or by signaling, but such means of communication may give poor data for qualitative research purposes. Researchers may choose to observe rather than to interview or to use videotaped data, thus changing their approach to the research altogether.

When patients are fatigued, very ill, or dying, interviews are necessarily shorter. The researcher must observe the patient carefully so that the interview can be ended before the patient becomes overly exhausted, and the researcher should be available for when the patient is ready to resume the interview. Sometimes data collection will be competing with complex treatments, visits from family and friends, and doctors’ rounds.

Data collection is sometimes a compromise: The researcher recognizes that he or she could possibly get better data, but such data may compromise patients’ privacy or interfere with treatments. Researchers sometimes recognize that it is necessary to work with poor data when the alternative is not doing the study at all.

Sometimes, the compromised data provides a more significant data source than the methods first planned in a study. Patients are rarely able to describe such things as the effect of caregiver touch, yet microanalytic description, using videotapes, enables the examination of transient nurse touches and fleeting facial expressions and responses of patients. In my own studies conducted in the trauma room, I was shooting blind with the camera attached to the wall. I have hours of tapes showing caregivers’ backs, with no patient in sight, but with the dialogue still audible. The best data are often only what one can best get.

2. Adapting or modifying the preferred method. Conducting research with the ill has resulted in the modification of qualitative methods so that new or different methods emerge. Consider focused ethnography: The assumption in ethnography is that culture is learned and transmitted, yet, for instance, diabetics in the community have relatively limited contact with one other. They learn to be a diabetic indirectly through the conditions of their illness, contact with caregivers, and health information materials. While orthodox ethnographic methods do not fit the study of diabetics in the community, adaptation of these methods as focused ethnography has developed. Some researchers have even dropped the participant observation component of ethnography, relying solely on interviews and documents. The method is still ethnography, but modified.

3. Adapting the timing of the data collection. In this case qualitative researchers interested in illness often interview their participants after the event—often many years later. Researchers know that participants do not forget the details of events that impact seriously on one’s life and are able to recall in minute detail the necessary events. For example, researchers have elicited the experience of being on a respirator by asking these patients to tell their story after they have been weaned from the respirator. Sometimes these details are more valid than data collection at the time of the event, for the person is able to put the event into perspective and is not as overwhelmed as he or she may have been at the time. Data collection may therefore be improved when conducted after the fact. Furthermore, if the researcher is interested in the trajectory of the illness, data must be collected after the fact, with the benefit of participant hindsight.

4. Using the observations of others. Many times when a person is too ill to be interviewed or too overwhelmed to be a good participant, the researcher must interview others—family members or friends—and use their accounts of the event or observations of what it was like for them or the ill person.

5. Recognizing the phenomenon in its entirety: Qualitative researchers learn to be patients; their knowledge of illnesses often enables the collection of good data. For instance, in her study with psychiatric (schizophrenic) patients Beverly Lorencz noted that, after asking a question, if she waited, an answer would eventually come. These disturbed patients first talked to their “other voices,” and Lorencz knew that she had to wait her turn. Alterations in reality are part of these patients’ reality and must be included in the data, no matter how bizarre.

6. Finding a place to do research: This last condition may seem odd, but in hospitals there is often no place to conduct interviews. The patient’s room may be shared and therefore not private. If the patient is in a single room, even if the researcher has placed a sign on the door “interview in progress,” anyone may come in, interrupting any time. Finally, if the participant is critically ill or injured, it goes without saying that care and
treatments have priority over data collection activities, and data collection may be interrupted at any time.

What Is the Bottom Line?

I do think that the methods inherent in qualitative health research are different enough and require enough skill to be considered a subspecialty of qualitative inquiry. Our methods are developing rapidly to meet the requirements extending from our questions, our participants, and the context in which we conduct our research. Our specialized courses, conferences, texts, and journals are critical to the development of our methods. Our products—the results of qualitative health research—are important and make an essential and unique contribution to health care.

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