In this paper I will show the profound influence the evidence-based practice movement has on the use of qualitative research findings in health care, and in nursing in particular. I will argue that it has become difficult if not impossible to base practice on qualitative research within this way of thinking knowledge. Hence the qualitative research community needs to develop methods that will make a way for qualitative research into the evidence-based practice context. One method is meta-synthesis. Within nursing this method is just evolving, and there are many problems. I will like to focus on one of these problems, the question of quality in qualitative research, focusing on what could be possible in that area and finally I will make recommendations on how to move forward.

**Evidence-based practice in health care and nursing**

Evidence-based practice and the ideology behind is a very real reality in health care today. At the First Congress of Qualitative Inquiry Janice Morse (2005) held the opening plenary address on evidence-based health care and what it means, especially for nursing. Some of her finer, but very serious, points were:

- The politics of evidence is an impediment to health care research and constrains qualitative inquiry.
- The evidence-based movement impedes how, when and to whom qualitative inquiry is taught, contracted, funded, conducted, published, read and implemented.

Morse cites Larner:

“*The political economy of evidence...is not a question of evidence or no evidence, but who controls the definition of evidence and which kind is acceptable to whom*” (Morse 2005:395).

Working in the clinical world I agree with her.

These days in the era of evidence-based practice methodological conservatism has defined what counts as research in denying the influences of poststructuralism, postmodernist theory, race, advances in qualitative methods and rigorous criticisms of positivist research on two accounts:

1. Its arrogant claim to be the only, best and most rigorous of research methods and
2. Its insistence on criteria for inquiry that have been systematically rejected by philosophers as impossible to achieve (Lincoln & Cannella 2004).

The problems with evidence-based practice

The concept of evidence-based practice is attributed to the British epidemiologist Archie Cochrane who in 1972 wrote a book about effectiveness and efficiency in health care. In this he recommended standards for medical research. This placed the randomized controlled trials as “the gold standard” for medical research (the cure part), but has also led to the evidence hierarchy, the standard for quality of all evidence, we know today. This hierarchy was promoted by the Evidence-Based Medicine Working Group from McMaster University in Canada and taken by David Sackett to the Oxford Centre for Evidence-Based Medicine, and now has great influence in Europe. The hierarchy places mere opinions at the lowest level, which is one thing. The problem is that qualitative research is almost equated with mere opinion. This is also a political standpoint which has grown out of the neoconservative discourse that asserts that qualitative research is non-scientific (Denzin & Lincoln 2005). But it is also to the best of my opinion a sign of ignorance.

Evidence-based practice is most often defined as: Best research practice combined with clinical expertise and patient preferences. This actually implies that there are several forms of evidence in evidence-based practice, and this kind of practice is difficult to disagree with. But the evidence is understood as research evidence produced from a specific research position. Another criticism is that the patients’ preferences and values in treatment decisions have yet to be discernibly included in the evidence-based process.

But what about nursing, why is it a problem for nursing? Throughout history nursing has been heavily influenced by medicine and thereby its research paradigm. This was just beginning to change, and then came evidence-based practice. Within the nursing community there are two poles: Those who see nursing as a biological/physiological discipline, and those who see nursing as a humanistic discipline. I for one belong to the latter, thinking that nursing has to do with helping patients live with having or having suffered an illness. This can encompass living with a body that doesn’t function or work as it used to, and everything that comes with it in terms of changed lifestyles, changed social roles, and everything that has to do with the perspective of the patient. The scientific knowledge base for this kind of nursing is grounded in the qualitative paradigm.

However, it is difficult to utilize this kind of knowledge in a health care reality where the concept and the ideology of evidence-based practice are prevailing.

But there is no way around it:

- Society - the politicians which basically means you and me - demands evidence and research utilization.
- Nurses need “their” evidence to be available.
The patients require the knowledge developed from research.

So we have to live with it, but we must - for many reasons - challenge it!

**Qualitative research in health care and nursing**

My primary concern with the evidence-based practice movement is the patients, and my question is if the increased focus on evidence-based health care actually is a threat to the patient’s autonomy and at the same time reduces their choices. Those, who define and decide health care will increasingly tend to want only what is clinically effective and cost-effective by restricting the patients’ choices. In practice this means that not-documented treatment equalizes not-effective treatment and that is a big mistake. Most of health care is not documented, and there are many treatments which are useful and meaningful even though they are not documented e.g. many surgical procedures which are very much based on personal experience, learning curves and common sense and therefore not supported by randomised controlled trials. This means that the patients are at risk and in real danger if we only are to use treatment that is documented!

Using an evidence hierarchy that defines randomized controlled trials as the golden standard devalues or even excludes qualitative research (Sandelowski 2004:1369). This is a huge problem, because as a consequence it excludes the patients’ perspectives from evidence-based practice.

“**Qualitative health research encompasses a diverse collection of approaches to inquiry intended to generate knowledge actually grounded in human experience**” (Sandelowski 2004).

“**It [qualitative research] contains information on the subtleties and complexities of human responses to disease and its treatment that is essential to the construction of developmental and culturally sensitive instruments to appraise health conditions and appropriate interventions to improve them**” (Sandelowski & Barroso 2006).

Therefore it is important to discuss how to render visible and include the experience, the knowledge and the preferences that is linked to the patient perspective in evidence-based practice. Qualitative research offers a variety of methods for identifying what really matters to patients. The use of such methods could lead to a better understanding of how to improve health care seen from the patients’ perspective.

In that sense I think we are obliged to help making qualitative health research a part of evidence-based practice at all levels and by all levels I mean from policy makers, researchers, teachers and clinicians.

But if qualitative research is to be a part of evidence-based (nursing) practice – and I believe it should – we need to work out methods that will fit into the system, but not into the thinking!
The problems with qualitative research?

Qualitative research does have legitimacy problems. It provides insight and understanding, but:

- Is it useful to policy planners?
- Is it relevant to the health care agenda?
- Does it reduce mortality, morbidity or costs?
- Does it resolve “real-world” problems?

The obvious answer to these questions is YES, but it needs to be visible and evident for others than qualitative researchers.

There are an increasing number of qualitative research studies in the health sciences, but they have largely remained isolated works (Finfgeld 2003). The abundance of one time studies on the same phenomenon, limits progress in building a body of knowledge for addressing significant problems in nursing practice (Sherwood 1999). At the same time there is a relative absence of efforts to integrate the findings from qualitative research (Sandelowski & Barroso 2006). In this way qualitative research findings continue to have little impact on clinical practice.

So we need to find ways to get qualitative health research findings out of the doldrums and into health care.

Qualitative meta-synthesis as part of evidence-based (nursing)practice

Nowadays research utilization is very much in focus, you can actually speak of “a utility discourse” driven by the evidence-based practice movement. But the explosion of health-related information by itself warrants the need for methods of synthesizing the enormous amounts of research.

Evidence-based practice has led to many things. Of great influence is the Cochrane Collaboration and with that meta-analyses. Meta-analysis in the context of evidence-based medicine is defined as:

“...a systematic review of the literature that uses quantitative methods to summarise the results” (Kristiansen & Mooney 2004).

But the methods of meta-analysis are not transferable to qualitative research for a number of pragmatic and epistemological reasons e.g. criteria for quality are different and statistical methods are inapplicable. It is here qualitative meta-synthesis comes in as one relevant and useful tool, but we need to develop the methodologies.
What is qualitative meta-synthesis?

Meta-synthesis is an umbrella term referring to “the synthesis of findings across multiple qualitative research reports to create a new interpretation” (Finfgeld 2003:895).

According to Finfgeld (2003) several nurse researchers engaged in doing meta-synthesis define meta-synthesis as:

- The bringing together and breaking down of findings
- Examining them
- Discovering the essential features and
- In some way combining the phenomena into a transformed whole

The goal of meta-synthesis is to go beyond both narrative and systematic literature reviews. It involves “some degree of conceptual innovation” (Britten et al. 2002). Qualitative meta-synthesis involves re-interpretation of findings based on published findings – unlike secondary analysis, that is based on primary data.

Meta-synthesis is a complete study that involves rigorously examining and interpreting the findings of a number of qualitative research studies using qualitative methods. A synthesis should grab the essence of a phenomenon and that way presenting a “fuller knowing” than the individual studies could. A synthesis is a translation of studies into one another, which encouraged the researcher to understand and transfer ideas, concepts and metaphors across different studies (Britten et al. 2002). In a meta-synthesis studies can relate to one another in three different ways:

1. They may be directly comparable as reciprocal translations
2. They may stand in opposition to one another as refutational translations
3. Taken together they may represent a line of argument

Meta-synthesis differs from simple accumulative logic. The uniqueness and holism is retained, providing understanding or interpretive accounts of the phenomenon of interest. Scholars in this field of research agree that meta-synthesis is “...fundamentally different from the original parts, capable of substantiating a more convincing argument about major theoretical elements within the phenomenon of interest and positioned to advance the science in that particular substantive field more forcefully” (Thorne et al. 2004).

Meta-synthesis also has the potential to improve clinical outcome, enhance research and shape health care policy. Meta-synthesis will enhance generalizations of qualitative research in terms of naturalistic and idiographic generalizations (Sandelowski et al 1997), but we need to understand qualitative generalizations better. Probably we also need to use another word like transferability to denote a different meaning, but that is another question.

Meta-syntheses have been made on topics like:

- Living with HIV
- Caring within nursing education
- Postpartum depression
• Courage and long-term health concerns
• Wellness-illness
• Adapting to and managing diabetes

The problems with qualitative meta-synthesis

Synthesizing qualitative research findings is a new task for the qualitative research community and there are no standard methods for conducting syntheses of qualitative research. One method seems more developed than others and that is the work of Noblit & Hare on meta-ethnography from the eighties. In nursing, Sandelowski and her colleagues in North Carolina have been very active from the mid-nineties developing the different aspects of methodology. Another group is Paterson and colleagues from Canada, who have developed a method for meta-study. And there are others.

In qualitative research meta-synthesis is being used to integrate qualitative health research findings as an interpretive analysis that goes beyond aggregating. The methodology of qualitative meta-synthesis is still in the early stages of development and diverse opinions exist concerning the right way to conduct the many forms of inquiry referred to as qualitative research (Sandelowski & Barroso 2003). Even though researchers involved in this activity differ in their views of what qualitative meta-synthesis is as a method and how it should be conducted, they agree that it represents an advancement in making qualitative research findings more useful and in moving them to the center of evidence-based practice (Sandelowski 2004).

So this has become the focus of my research. But why? Isn’t it already an established research method? Well, few nurse researchers are engaged in developing methods for synthesizing qualitative research findings, and there are many unsolved problems. Therefore it is necessary that researchers at all levels work with this challenge, but I must stress that I am just at the beginning of my project. So, I have many questions and few answers!

Many questions both philosophical and methodological need to be answered. Just to mention a few:

• Is it possible to synthesize research with different perspectives and what do we mean by synthesizing?
• Are human experiences comparable and thus suitable for synthesizing?
• How do we understand generalization?
• What is considered quality in qualitative research?

I would like to focus on the last one.

Standards for qualitative quality

In the absence of any attempt to develop standards, there is a danger that qualitative research evidence will be misunderstood and judged inferior by those whose field of vision is firmly fixed on a hierarchy of evidence that makes randomized controlled trials the gold standard.
There are several other related reasons why the development of criteria or standards for the evaluation of qualitative research has become more urgent in recent times:

- If health care assessment and evaluation is to extend beyond the preoccupation with effectiveness we need to develop criteria to judge the quality of other forms of research.
- If we want systematic reviews or meta-synthesis standards for good quality are necessary.
- Health care research is so abundant and therefore health care professionals need to be able to discriminate between good and bad research.

The problems with qualitative quality

The search for quality criteria is not a new preoccupation, but there seems to be different ways of viewing this:

1. There is nothing unique about qualitative research, and hence traditional definitions of reliability, validity, objectivity and generalizability apply to qualitative as well as quantitative research.
2. There can be no criteria for judging qualitative research outcomes, because it is not possible to specify criteria for good qualitative work.

Well, we have seen the result of the first approach with the evidence hierarchy where qualitative research is seen as inferior to quantitative research. The second approach is nihilistic and precludes any distinction based on systematic or other criteria (Popay et al 1998).

The problem of quality, of trustworthiness, of authenticity of findings will not go away (Miles & Huberman 1994). The fact is that some accounts are better than others. As Miles & Huberman once stated: “

Qualitative studies take place in a real social world and can have real consequences in people’s lives... there is a reasonable view of what happened in any particular situation, and those who render accounts of it can do so well or poorly and should not consider their work unjudgable (Miles & Huberman 1994:277).

Most of the methodology literature agrees that it is necessary to have criteria for quality (Olsen 2002), so shared standards are worth striving for!

What is good qualitative quality?

Generally speaking, quality refers to the transparency of the whole research process; credibility pertains to the validation of findings and results. These issues are also associated with the reliability of methods and validity of data (Seale et al. 2004).

Some immediate criteria may be equally applicable to the evaluation of any research product regardless of the methods. These minimalist criteria include (Popay et al. 1998):
• Sufficient explanation of the background
• A succinct statement of the research question
• A full description of the methods used
• A clear presentation and discussion of the main findings with some statement of their relevance to policy or practice

But, judgment about whether what is presented is good or bad requires criteria that are more “tailored” to particularities of the work in question. Several scholars (Denzin & Lincoln, Hammersley, Seale) have provided the basis for a third approach to developing standards for assessing evidence from qualitative research. This approach accepts that some criteria are equally applicable regardless of method, but it also acknowledges differences of which there are two fundamentally important ones (Popay et al. 1998):

• The type of knowledge that different methods can generate (i.e. the epistemological difference) and
• The type of reality or object to which different methods are relevant (i.e. the ontological difference)

Three criteria can be identified as the foundation of good qualitative health research (Popay et al 1998):

1. Interpretation of subjective meaning
2. Description of social context
3. Attention to lay knowledge

**What are criteria for good qualitative quality?**

When you look at various criteria that have been brought forward there are many words and concepts. Qualitative terminology is an issue in itself, and it is even a greater problem, when you have to translate the words and concept into a different language other than English, as I do, coming from Denmark. But how many different criteria are there basically?

Several nurse scholars (Sherwood 1999; Barroso & Powell-Cope 2000) – and I must say that most of my inspiration comes from nursing scholars engaged in doing meta-synthesis - base their critique form on Burn’s (1989) standards for qualitative research. She proposes five standards by which qualitative studies can be evaluated. Within these standards two have sub-elements:

1. Descriptive vividness
2. Methodological congruence
   2.1. Rigor in documentation
   2.2. Procedural rigor
   2.3. Ethical rigor
   2.4. Auditability
3. Analytical preciseness
4. Theoretical connectedness
5. Heuristic relevance
5.1. Intuitive recognition
5.2. Relationship to existing body of knowledge
5.3. Applicability

These standards seem to consider most of the significant issues in appraising the methodological implications of qualitative research.

Another approach or set of criteria comes from Miles & Huberman (1994). They position themselves in the “critical realist” tradition and discuss five main, but somewhat overlapping issues:

1. Confirmability/Objectivity
2. Dependability/Reliability/Auditability
3. Credibility/Internal validity/Authenticity
4. Transferability/External validity/Fittingness
5. Utilization/Application/Action orientation

In this way they pair traditional terms with those proposed by Guba & Lincoln as more viable for assessing the trustworthiness and authenticity of naturalistic research (in Miles & Huberman 1994).

Several other criteria have been brought forward, but do they add something new? What needs to be done is figure out the qualitative terminology and what’s really behind the words or the concepts. That is an important part of my project.

Seale (2004) talks about an “inner” and “outer” dialogue the social researcher must conduct. This parallels external and internal validity. The outer dialogue concerns the external relations of a research project – its relevance to practical and political projects, its consequences, uses and overall purpose. The inner dialogue concerns its internal logic e.g. the adequacy of links between claims and evidence. Lack of this means the result is “inadequately saturated”.

He refers to three broad questions that are central to assessing the quality:

1. How important or relevant is the topic to a specific community?
2. Are the claims made plausible given our existing knowledge about the subject?
3. Is the credibility of the claims supported by sufficient evidence?

Conclusion

The ideology behind the evidence-based practice movement and with that the evidence hierarchy has made it very difficult if not impossible to make qualitative research findings part of evidence-based practice. But qualitative research has problems of its own. A central part of evidence-based practice is the synthesizing of research findings, but within qualitative research the methodology for synthesizing research findings is not very well developed.
Therefore we need to develop methods for synthesizing qualitative research findings, but many questions both philosophical and methodological needs to be solved. One central problem is what constitutes good quality?

Evaluation of qualitative research takes many forms depending on whom you rely on or read. Some define general criteria that can be used regardless of method. Others find it necessary to make a clear distinction. What could be done here and what I will recommend is:

1. Synthesizing the various, but recognized approaches translating the quantitative “holy trinity of reliability, validity and generalizability” (Kvale 1997) into a whole. This will provide a specific set of criteria with compatible philosophical orientation (Thorne 1997).
2. Combining this with a set of general criteria that can be used to evaluate the methodological stringency.

Together this will provide a useful basis for evaluating qualitative quality. But as Smith & Hodkinson (2005) point out in the latest edition of THE HANDBOOK (2005) criteria must be thought of not as abstract standards but rather as socially constructed lists of characteristics. Such a list is open-ended, in part unarticulated, and always subject to constant interpretation and reinterpretation. It will be contested, overlap with others, and quite possibly partly contradict others. Finally we must all remember:

“…that politics and power are part of the complex process by which we sort out the good from the bad and the indifferent” (Smith & Hodkinson 2005:923).

The evidence-based movement is a “good” and somewhat frightening proof of this!

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