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ANALYSIS

An open letter to *The BMJ* editors on qualitative research

Seventy six senior academics from 11 countries invite *The BMJ*'s editors to reconsider their policy of rejecting qualitative research on the grounds of low priority. They challenge the journal to develop a proactive, scholarly, and pluralist approach to research that aligns with its stated mission

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We are concerned that *The BMJ* seems to have developed a policy of rejecting qualitative research on the grounds that such studies are "low priority," "unlikely to be highly cited," "lacking practical value," or "not of interest to our readers" (box). Here, we argue that *The BMJ* should develop and publish a formal policy on qualitative and mixed method research and that this should include appropriate and explicit criteria for judging the relevance of submissions. We acknowledge that (as with all methods) some qualitative research is poor quality, badly written, inaccessible, or irrelevant to the journal's readership. We also acknowledge that many of *The BMJ*'s readers (not to mention its reviewers and editors) may not have been formally trained to read, conduct, or evaluate qualitative studies. We see these caveats as opportunities not threats.

The BMJ's mission is method agnostic

The BMJ says its mission is to lead the debate on health and to engage, inform, and stimulate all doctors, researchers, and other health professionals in ways that enable them to make better decisions and improve outcomes for patients.

Some clinical and policy questions are best answered by the results of randomised controlled trials or other quantitative approaches, but other decisions and outcomes are more usefully informed by qualitative studies. Qualitative studies help us understand why promising clinical interventions do not always work in the real world, how patients experience care, and how practitioners think. They also explore and explain the complex relations between the healthcare system and the outside world, such as the sociopolitical context in which healthcare is regulated, funded, and provided, and the ways in which clinicians and regulators interact with industry.

Some of *The BMJ*'s top papers have been qualitative

The BMJ recently celebrated 20 years of online presence by asking experts to name the most influential paper published in that period.[1] The 20 nominated papers included 11 commentaries or editorials (highlighting the journal's important role in publishing papers that contextualise and interpret research), three randomised controlled trials, three qualitative studies, two surveys, and one methodological paper.

The three qualitative papers explored how primary care clinicians develop and use collective "mindlines" instead of written guidelines[2]; what worries parents when their preschool children are acutely ill[3]; and the nature of collusion in the doctor-patient relationship when death is imminent.[4] They have been cited by 572, 197, and 114 subsequent papers respectively (Google Scholar data). In contrast, the three nominated randomised trials have been cited by 321,[5] 78,[6] and 38[7] subsequent papers.

We are not claiming that citation rates for these nominated papers are statistically representative. But they do show that good qualitative research with a clear and important clinical message can be highly cited, is popular with readers, and enriches *The BMJ*'s overall contribution to the knowledge base.

Different study designs provide complementary perspectives

Few research topics in clinical decision making and patient care can be sufficiently understood through quantitative research alone. Take patient safety, for example, in which quantitative studies have examined the effect size of interventions to improve safety and qualitative ones have examined equally important

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Excerpt from rejection letter tweeted by McGill Qualitative Health Research Group (@MQHRG), 30 September 2015

Thank you for sending us your paper. We read it with interest but I am sorry to say that qualitative studies are an extremely low priority for *The BMJ*. Our research shows that they are not as widely accessed, downloaded, or cited as other research.

We receive over 8000 submissions a year and accept less than 4%. We do therefore have to make hard decisions on just how interesting an article will be to our general clinical readers, how much it adds, and how much practical value it will be.

questions such as why the observed effect occurred and, in some cases, why the predicted effect did not occur.

The surgical safety checklist is a revealing case in point. A controlled before and after study published in the *New England Journal of Medicine* showed that in 3733 patients having non-cardiac surgery, the introduction of a surgical safety checklist was associated with a highly significant reduction in perioperative mortality (from 1.5% to 0.8%) and complication rate (from 11% to 7%).[8]

But attempts to replicate these impressive improvements have sometimes failed dramatically.[9 10] Eighteen qualitative studies, summarised in a recent qualitative systematic review, help explain why.[11] The operating theatre is a complex social space with established hierarchies and routines. Far from being a simple "technical" procedure, the checklist demands new forms of cooperation and communication between surgeons, anaesthetists, and nurses. Depending on a host of contextual factors, safety checks may substantially disrupt team routines and be resented rather than welcomed. When (and to the extent that) the checklist is treated as a tick-box exercise, it will fail to generate benefits and may even lead to harms.

From the policy maker's perspective, qualitative studies of the professional, organisational, and political context of nationally driven checklist based patient safety initiatives can help explain both successes and failures.[12 13]

The BMJ has a long tradition of educating its readers about less familiar research methods

Statistics is a closed book to many jobbing clinicians. "Bite sized" methodological commentaries, often linked to exemplar papers published in the research section of *The BMJ*, have enabled its readers to grasp important concepts such as why continuous variables should not be dichotomised[14] or why some apparent improvements are explained by regression to the mean.[15] Through the journal's Statistics Notes and Economics Notes series (of which over 100 have been published in the past 20 years), the quantitative research literacy of its clinician readership has significantly improved.

The BMJ has not yet introduced a comparable ongoing educational approach for qualitative research. It is 20 years since Pope and Mays edited the original *BMJ* Education and Debate series on qualitative methods, which covered interviews, focus groups, ethnography, case study, and criteria for assessing quality and establishing rigour.[16-24] Their 2000 paper on how to analyse qualitative data remains *The BMJ*'s 12th most highly cited paper ever (Web of Science data).[24] In 2008, *The BMJ* published a further series updating and extending the range of qualitative research methodologies and emphasising the importance of theory in interpreting evidence.[25-29]

An opportunity exists to supplement these popular series on qualitative theory and method with an occasional series of "qualitative notes" accompanying exemplars of empirical studies in qualitative research. Through such a series, the journal's readership would gain in qualitative research literacy.

New challenges

The inclusion of qualitative research as a mainstream theme will undoubtedly raise new methodological, philosophical, and ethical questions. For example, the laudable principle of data archiving and sharing is supported by some but not all qualitative funding bodies (see, for example, the Qualidata archive, part of the UK Data Service https://discover.ukdataservice.ac.uk/?q=qualidata). A requirement to share data may generate tricky challenges in the trade-off between transparency and informant confidentiality, especially in the digital age when anonymisation of interview data may not be possible.[30 31]

We offer no simple solutions to such complex issues, but suggest that (as with comparable questions in quantitative research) *The BMJ* could provide a forum for methodological commentaries or online discussion.

A proposal

We believe it is time for a prospective study to assess whether *The BMJ* can come to value and be proud of qualitative research as part of its mission to lead the debate on health, inform clinical decision making, and improve outcomes for patients. We challenge *The BMJ* to allocate one slot a month for one year to a "landmark" qualitative paper along with an accompanying methodological commentary from an international expert. We offer to assist *The BMJ* to appoint an appropriate team of reviewers, guest editors, and commentators. We can also advise on training to build capacity and confidence of editorial staff to distinguish good from poor qualitative research and identify which of the many submissions it receives holds promise as "qualitative paper of the month."

Conclusion

As pointed out by its editors in response to an earlier draft of this letter, *The BMJ* is by no means an outlier in its current policy on qualitative research. Many leading US journals (including *JAMA* and the *New England Journal of Medicine*) also consider such research low priority. We believe all such journals would benefit from revisiting their policies.

The BMJ, with its history of supporting qualitative research, is in a unique position to lead the field by ensuring that all types of research relevant to its mission are considered for publication; we believe its reputation as an international academic journal will be strengthened if it does so. Some qualitative papers will be highly cited and contribute directly to the journal's impact factor. With others, the reputational benefit will be indirect and result from introducing the new ways of thinking that are essential to scientific progress.

Both the International Cochrane Collaboration and the UK Health Technology Assessment Programme, though initially predominantly focused on the quantitative, were persuaded to include qualitative and mixed methods research where appropriate.[32 33] The Health Technology Assessment Programme's monograph on qualitative methods[33] subsequently became the most downloaded of its more than 700 online publications by a considerable margin. These organisations have

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decided that "quantitative versus qualitative" is yesterday's war. We encourage *The BMJ* to join them.

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Competing interests: We have read and understood BMJ policy on declaration of interests and declare that two of us have received consultancy income from qualitative research and some of us have received royalties for books or book chapters on qualitative research. Our only other conflict of interest is that we value the contribution of qualitative research to medicine.

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1 Payne D. Twenty top papers to mark The BMJ's two digital decades. 2015. *BMJ* 2015;351:h3660.
2 Gabbay J, le May A. Evidence based guidelines or collectively constructed "mindlines?" Ethnographic study of knowledge management in primary care. *BMJ* 2004;329:1013.
3 Kai J. What worries parents when their preschool children are acutely ill, and why: a qualitative study. *BMJ* 1996;313:983-6.
4 Hak T, Koëter G, van der Wal G. Collusion in doctor-patient communication about imminent death: an ethnographic study. *BMJ* 2000;321:1376-81.
5 Baqui AH, Black RE, El Arifeen S, et al. Effect of zinc supplementation started during diarrhoea on morbidity and mortality in Bangladeshi children: community randomised trial. *BMJ* 2002;325:1059.
6 Kaczorowski J, Chambers LW, Dolovich L, et al. Improving cardiovascular health at population level: 39 community cluster randomised trial of Cardiovascular Health Awareness Program (CHAP). *BMJ* 2011;342:d4442.
7 Seehusen DA, Johnson DR, Earwood JS, et al. Improving women's experience during speculum examinations at routine gynaecological visits: randomised clinical trial. *BMJ* 2006;333:171.
8 Haynes AB, Weiser TG, Berry WR, et al. A surgical safety checklist to reduce morbidity and mortality in a global population. *N Engl J Med* 2009;360:491-9.
9 Urbach DR, Govindarajan A, Saskin R, et al. Introduction of surgical safety checklists in Ontario, Canada. *N Engl J Med* 2014;370:1029-38.
10 Reames BN, Krell RW, Campbell DA, et al. A checklist-based intervention to improve surgical outcomes in Michigan: evaluation of the keystone surgery program. *JAMA Surg* 2015;150:208-15.
11 Bergs J, Lambrechts F, Simons P, et al. Barriers and facilitators related to the implementation of surgical safety checklists: a systematic review of the qualitative evidence. *BMJ Qual Saf* 2015 Jul 21. doi:bmjqs-2015-004021.
12 Dixon-Woods M, Bosk CL, Aveling EL, et al. Explaining Michigan: developing an ex post theory of a quality improvement program. *Milbank Q* 2011;89:167-205.
13 Dixon-Woods M, Leslie M, Tarrant C, et al. Explaining matching Michigan: an ethnographic study of a patient safety program. *Implement Sci* 2013;8:70.
14 Altman DG, Royston P. The cost of dichotomising continuous variables. *BMJ* 2006;332:1080.
15 Bland JM, Altman DG. Statistics notes: some examples of regression towards the mean. *BMJ* 1994;309:780.
16 Pope C, Mays N. Qualitative research: reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *BMJ* 1995;311:42-5.
17 Mays N, Pope C. Qualitative research: rigour and qualitative research. *BMJ* 1995;311:109-12.
18 Mays N, Pope C. Qualitative research: Observational methods in health care settings. *BMJ* 1995;311:182.
19 Britten N. Qualitative interviews in medical research. *BMJ* 1995;311:251.
20 Keen J, Packwood T. Case study evaluation. *BMJ* 1995;311:444.
21 Bland JM, Altman DG. Statistics notes: calculating correlation coefficients with repeated observations. Part 1—correlation within subjects. *BMJ* 1995;310:446.
22 Mays N, Pope C. Qualitative research in health care: assessing quality in qualitative research. *BMJ* 2000;320:50.
23 Kitzinger J. Qualitative research. Introducing focus groups. *BMJ* 1995;311:299.
24 Pope C, Ziebland S, Mays N. Qualitative research in health care: analysing qualitative data. *BMJ* 2000;320:114.
25 Reeves S, Albert M, Kuper A, et al. Why use theories in qualitative research? *BMJ* 2008;337:a949.
26 Hodges BD, Kuper A, Reeves S. Discourse analysis. *BMJ* 2008;337:a879.
27 Reeves S, Kuper A, Hodges BD. Qualitative research methodologies: ethnography. *BMJ* 2008;337:a1020.
28 Kuper A, Reeves S, Levinson W. An introduction to reading and appraising qualitative research. *BMJ* 2008;337:a288.
29 Kuper A, Lingard L, Levinson W. Critically appraising qualitative research. *BMJ* 2008;337:a1035.
30 Saunders B, Kitzinger J, Kitzinger C. Participant anonymity in the internet age: from theory to practice. *Qual Res Psychol* 2015;12:125-37.
31 Saunders B, Kitzinger J, Kitzinger C. Anonymising interview data: challenges and compromise in practice. *Qual Res* 2014:1468794114550439.
32 Noyes J. Never mind the qualitative feel the depth! The evolving role of qualitative research in Cochrane intervention reviews. *J Res Nurs* 2010:1744987110381696.
33 Murphy E, Dingwall R, Greatbatch D, et al. Qualitative research methods in health technology assessment: a review of the literature. *Health Technol Assess (Winchester, England)* 1998;2:iii.

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