An open letter to BMJ editors on qualitative research

Trisha Greenhalgh on behalf of 77 signatories (see appendix for all names and affiliations)

Conflict of interest

We have read and understood the BMJ Group 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.

License

Contributorship

TG wrote the first draft of the letter, which was modified by ST, AK and LLingard and then circulated to all other authors, many of whom suggested further amendments. All authors have seen and approved the final manuscript.

Summary
In this open letter, 77 senior academics from 10 countries invite the BMJ's editors to reconsider their policy of rejecting qualitative research on the grounds of low priority. They challenge the BMJ to join other intellectual leaders in moving beyond a 'quantitative strong, qualitative weak' stance and develop a proactive, scholarly and pluralist approach to research that aligns with its stated mission.

Introduction
We are concerned that the BMJ appears 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" and/or "not of interest to our readers" (Figure 1).

In this open letter, we argue that the BMJ should develop and publish a formal policy on qualitative and mixed-method research, and that this should involve 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 BMJ'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 describes its mission as *"to lead the debate on health and to engage, inform, and stimulate all doctors and health care researchers 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 relationships between the health care system and the outside world, such as the socio-political context in which health care is regulated, funded, and provided, and the ways in which clinicians and regulators interact with industry.

Some of the BMJ's top papers in the past 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 BMJ'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 – which explored how primary care clinicians develop and use collective 'mindlines' instead of written guidelines;[2] what worries parents when their pre-school children are acutely ill;[3] and the nature of collusion in the doctor-patient relationship when death is imminent[4] have been cited by 572, 191 and 113

subsequent papers respectively (Google Scholar data). In contrast, the three nominated randomised trials have been cited by 316,[5] 74[6] and 40[7] subsequent papers.

We are not claiming that citation rates for these nominated papers are statistically representative. But they do illustrate 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 the field of clinical decision-making and patient care can be sufficiently understood through quantitative research alone. Take patient safety, for example, in which quantitative studies have addressed the question 'what is the effect size of an intervention to improve safety?' and qualitative ones have addressed equally important questions such as 'why did the observed effect occur?' and 'why, in some cases, did the predicted effect *not* occur?'.

The surgical safety checklist offers a revealing case in point. A controlled before and after study published in the *New England Journal of Medicine* demonstrated that in 3733 patients undergoing non-cardiac surgery, the introduction of a surgical safety checklist was associated with a statistically highly significant reduction in peri-operative 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 significantly 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 policymaker's perspective, qualitative studies of the professional, organisational and political context of nationally-driven checklist-based patient safety initiatives can help explain both successes[12] and failures.[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 BMJ'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 a 'Qualitative Notes' occasional series accompanying exemplars of relevant empirical studies in qualitative research. Through such a series, the BMJ's readership would gain in qualitative research literacy.

New challenges

The inclusion of qualitative research as a mainstream theme will undoubtedly surface 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 and/or online discussion.

A proposal

We believe it is time for a prospective study to address 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 per month for one year to a 'landmark' qualitative paper along with an accompanying 'Qualitative Notes' 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 in the BMJ's 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 (e.g. JAMA, NEJM) 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 here by ensuring that all types of research relevant to its mission are considered for publication, its reputation as an international academic journal will be strengthened. Some qualitative papers will be highly cited and this will contribute

directly to the BMJ'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, whilst initially predominantly focussed 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 >700 online publications by a considerable margin. These organisations have decided that 'quantitative *versus* qualitative' is yesterday's war. We encourage the BMJ to join them.

Figure 1: Excerpt from a BMJ rejection letter

Originally Tweeted by the McGill Qualitative Health Research Group (@MQHRG), September 30 2015

Subject: BMJ Manuscript Decision Research

Sep-2015

Dear xxxxxxxxxxxxx

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.

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