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DOING QUALITATIVE RESEARCH

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BENJAMIN F. CRABTREE
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for Primary Care
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11 A Qualitative Study of Family Practice Physician Health Promotion Activities

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Introduction

In prevention research, qualitative approaches often are viewed as a vehicle to generate hypotheses and to identify problems for later positivistic research (Willms et al., 1990). Alternatively, qualitative methods are employed after a basic science study has been conducted; at this latter stage they are used to identify appropriate strategies for disseminating the results of basic science research in the clinic or community (e.g., the results of a randomized, controlled clinical trial). Countering this "handmaiden" role in primary prevention research, we believe that qualitative methods are also relevant in their own right. They are a useful method for interpreting the response

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of persons and communities to critical events (e.g., the response of physicians, as a subculture, to allegations of extra-billing), and identifying the social-cultural meanings of these "events-that-happen" by casting problems, purposes, and intentions in a new light. In short, qualitative studies enable investigators to examine and explain problems and events *from the perspective of the actor*—his or her experiences, understandings, and interpretations of events and "events-that-happen." The nondirective methods of participant observation, semistructured interviews, and focus groups are commonly used means of uncovering these understandings. We describe these three methodologies, as well as the preliminary results of our recent study of the health promotion activities of a group of family practice physicians.

Background

From a primary care perspective, physicians' offices are an obvious setting for initiating, negotiating, and maintaining health promotion advice. The family practice physician who treats entire families and establishes a history of care with related family members is in an advantaged position to authoritatively negotiate competing notions of risk, explanations of disease etiology, and life-style strategies for disease prevention. Stated differently, the family practice physician is situated professionally to mediate scientific (biomedical explanations), professional (clinical/biomedical capabilities and contingencies), and popular (individual/social-cultural expectations) realities (Kleinman, 1980; Kleinman, Eisenberg, & Good, 1978; Stein, 1985) for the patient and his or her support group.

Relatively little, however, is known about the strategies or methods employed by physicians in delivering motivational messages to their patients. What we do know is that physicians involved in health promotion activities differ considerably in their effectiveness as advice givers (Ewart, Wood, & Li, 1982). The reasons for these differences are many: the issue of whether a physician personally exemplifies a healthy life-style; differences between the physician and patient in the perception, assessment, and explanation of clinically presented problems (Kleinman, 1980); a professionally ineffective relationship established between physician and patient, predicated on either interpersonal or social-cultural differences (Kleinman,

1980; Willms, Kottke, Solberg, & Brekee, 1986). We do know, for example, that physicians utilize subjective, as well as objective, assessments in the clinical encounter (Hahn, 1985; Stein, 1985).

In the present study, we sought to learn from exemplary family physicians—those who were especially motivated and involved in health promotion work in their practices—how it is that they are effective as health promoters. Specifically we attempted to generate a description of the strategies, models, and approaches employed by this group of family practice physicians as they engaged in health promotion interventions—in particular, smoking cessation counseling. In addition to characterizing and typifying their work and experience as health promoters, we attempted to identify modifiable barriers in family practice medicine that currently impede the effective dissemination of health promotion advice.

Design and Methods

Twelve family practice physicians from the Kitchener-Waterloo area of southern Ontario, Canada, were recruited to participate in the study. The research involved (a) *interviews with physicians* to learn their views and experiences of health promotion work in family practice; (b) *interviews with patients* to elicit their perspectives on the physician-patient clinical encounter; (c) *physician focus group interviews* in which we brought the physicians together in small groups to refine critically these views; and (d) an *ethnographic participant observation* substudy of 4 of the 12 physicians who agreed to have one of the researchers spend approximately 4 half-days in each of the clinics, observing the full range of clinical strategies used by the physicians in their day-to-day practice (see Figure 11.1).

The triangulation of research methods and data entry points (physician interviews, focus groups with physicians, patient interviews, and participant observation of physician-patient encounters) is helpful in qualitative research to confirm the reliability and validity of the interpretations (Jick, 1979). Where convergence exists in understandings between these different methods, the data are viewed as being the most reliable; differing viewpoints, while valid on an individual basis, contribute to the refinement of problems identified, hypotheses generated, and explication of social-cultural meanings.

Phase I	12 Physician Interviews —semistructured interviews in physicians' offices —2 consecutive interviews, 3 weeks apart
Phase II	98 Patient Interviews —10 patients from each physician (total of 120) 104 recruited to the study, 6 dropped out, leaving 98 —1 interview per patient, semistructured and conducted in patients' homes
Phase III	SUBSTUDY Ethnographic Substudy —4 physicians' offices —participant observation
Phase IV	Physician Focus Groups —2 focus groups, 4 to 5 physicians per group

Figure 11.1. Phases of the Qualitative Research Study

The 12 family practice physicians who agreed to participate in the study were motivated to do health promotion work in their practice, were involved currently in some form of health promotion work, and already had established their own individualized strategies for engaging in health promotion activities. Motivation was determined by the physicians' interest in participating in this form of intensive and intrusive research, which required a substantial time commitment on their part.

The qualitative or field research style was selected as the research strategy. While knowledge, attitude, and practice (KAP) surveys and structured interviews direct the researcher into the general area of how a problem is perceived intellectually, qualitative field research illuminates the context for these cognitive perceptions. Through observation of physician practice and the elicitation of physician

and patient-driven stories and narratives, the researcher identifies and uncovers the constraints and contingencies that limit effective prevention and health promotion. Furthermore, while KAP surveys can be administered easily to a broad cross-section of participants, qualitative field research requires a limited number of participants and uncovers a personal and social world of "lived experience" (cf. Schutz, 1973) that elucidates how these professional health promotion choices are made, on what basis they are made, and what the perceived outcomes will be both personally and for their patient population. We originally hoped to work with 15 physicians; 12 agreed to participate fully in the study.

The Research Process

PHASE I: PHYSICIAN INTERVIEWS

In Phase I of the study, we sought to generate physicians' general impressions of how it is they engage in health promotion activities in their practice. This more general discussion was designed (a) to earn the cooperative interest of the physician in the study; (b) to elucidate perceptions of barriers to health promotion work, such as time, cost, training, and patient's world-view; (c) to determine how it is the physicians have overcome these problems to become more effective.

Physicians were interviewed on two separate occasions before they began to recruit patients for smoking cessation counseling and participation in the study (Phase II). The interviews were scheduled 2-3 weeks apart and were conducted in each physician's office by an experienced member of the research team. Each interview lasted approximately 1-1 1/2 hours. During these sessions the physicians were interviewed using semistructured, open-ended interviewing techniques (Agar, 1980; Pelto & Pelto, 1978), and each received an honorarium for his or her time. A set of questions was developed to elicit physicians' statements regarding (a) their personal interest in health promotion and professional experience, (b) their perception of their patient population, (c) the place of health promotion in family practice, and (d) the barriers to doing clinical preventive medicine. These questions served to guide the interview process rather than dictate it. The following is a sample of some of the questions used in the first interview:

1. How would you describe your practice?
2. What kind of patients do you normally see?
3. How do you define, or think about, the notion of health promotion?
4. Do you normally provide health promotion advice? In what instances would you do this? To whom? Can you give examples?
5. How would you go about advising someone to stop smoking?
6. How do you communicate the element of risk to a patient who will not stop smoking?
7. Does your approach change relative to age or sex?
8. Keeping in mind the topic of health promotion, are there any cases that have posed a moral problem or dilemma for you, anything in approaching or dealing with patients that you found or still find difficult? For example, some doctors report that they find it difficult to counsel someone to quit smoking while still smoking themselves.
9. Do you as a doctor have the right or responsibility to try to change a patient's behavior?
10. How do you think your patients perceive you?
11. How do other doctors differ from you in their attitudes to health promotion?

Permission was obtained from each of the physicians to audiotape the interviews. The tapes then were transcribed onto a microcomputer to facilitate analysis. Field notes were written by the field researchers after each interview. We recommended that the field notes be divided into three content areas: (a) a subjective description of the events of the interview, as well as description of the setting, mood, and degree of rapport established; (b) a list of key words that emerge in the interview (e.g., "too busy, one voice, life-style," etc.); and (c) a list of questions that should be asked of those physicians to advance emerging explanations of health promotion work in their practices. The transcripts, as well as the field notes recorded by the interviewer following each session, proved useful in developing questions for the second set of physician interviews. These questions were tailored to each physician and were designed to follow up or explore in more detail issues raised in the first interview.

PHASE II: PATIENT INTERVIEWS

While the purpose of Phase I was to determine physicians' general perceptions of health promotion work, our intention in the second and

third phases of the study was to study the actual methods, approaches, and strategies used. We expected to learn about (a) areas of agreement and disagreement between patient and physician, (b) the kind of recommendations and advice offered to patients and the advice's perceived appropriateness, (c) differing perceptions of risk, and (d) significance and meaning attributed to physician interventions. We garnered this information through patient interviews (Phase II) and participant observation of the interactions of four physicians with patients in the clinical setting (Phase III).

Each of the 12 physicians was asked to recruit 10 smokers to the study. These patients agreed to discuss quitting with their physicians and to be interviewed by one of the members of the research team following the visit. Patients were advised that their participation in the study did not necessitate an actual decision to quit on their part and that the information they volunteered would be confidential and would not be reported back to the doctor.

Physicians were given control over which patients they selected for recruitment. They were encouraged, however, to identify both "difficult" and "easy" patients. Physicians were asked to counsel and advise these patients to quit smoking in their usual fashion and during normally scheduled office hours.

While physicians selected patients to participate in the study, actual recruitment was done by receptionists in the physicians' offices. These receptionists were trained in a standardized recruitment procedure, and a highly specific patient recruitment log was developed to assist them in the process. Each receptionist/nurse was asked to recruit 2 patients per week until a total of 10 patients were recruited to the study.

Within 48 hours after the first physician visit, patients were contacted by a member of the research team to schedule a home or workplace interview. Again permission to audiotape the session was obtained from each participant, and a set of questions designed to elicit their perceptions of the physician counseling procedure was used to guide the interview. The following is a sample of some of the questions used in the patient interviews:

1. Can you recall some of the things Dr. ____ talked about or told you about your smoking?
2. Did he or she ask you to try to quit smoking?
3. Did he or she suggest how you could do this? How?

4. Do you agree with what he or she told you?
5. Do you think he or she adequately understands your views and opinions concerning smoking? Do you think he or she adequately understands why you smoke? Do you think he or she sufficiently understands what quitting would involve for you?
6. How much help do you think your physician can be to your quitting attempt?
7. How do you feel about Dr. ____ talking to you about your smoking and these things? Do you mind? Are you appreciative? Does it bother you? Why?
8. Does he or she explain things sufficiently?
9. Do you find it easy to talk and discuss matters with him or her?

Field notes were written up by the interviewer after each session, and 20% of the audiotapes were transcribed. Because it was too costly to transcribe all of the interviews, each interviewer was expected to evaluate and grade his or her interviews according to the following subjective criteria: (a) the degree to which new information was presented, (b) the qualitative depth and richness of interviewees' responses, and (c) the variability in forms of explanation. Yes and no answers to questions were graded low, while responses with "thick description" were graded high and recommended for transcription.

In total, 104 patients were recruited to the study. Of these 104 individuals, 6 dropped out. Of the remaining 98 participants, 43% had smoked for 10-19 years; 34.7% were between the ages of 30 and 39 years; and 68.4% were married. Also, 63 of the participants were females, and 35 were males.

PHASE III: ETHNOGRAPHIC SUBSTUDY

The ethnographic substudy, or participant observation component, was initiated while the physicians were recruiting patients for smoking cessation counseling. Four of the 12 physicians agreed to participate in the substudy; in these physicians' clinics Dennis Willms spent approximately 2 half-days per week for a period of 2 weeks observing the range of clinical strategies used in their day-to-day practice. The investigator was present in each physician's clinic on the half-days that the first four patients recruited were scheduled to see the physician. At the physician's professional discretion the investigator observed additional physician-patient encounters in which

health promotion advice may or may not have been offered. The investigator was introduced to the patient as a researcher interested in studying physician-patient interactions, and the individual's consent for the investigator to be present was obtained. Over 100 patient encounters were observed, and a physician encounter record was completed for each (see Figure 11.2).

PHASE IV: PHYSICIAN FOCUS GROUPS

In the fourth and final phase of the study, each of the 12 doctors was invited to participate in a focus group discussion with 5 of their colleagues who also had participated in the study and 3 members of the research team. Nine of the 12 physicians took part in two focus group discussions. These were designed to permit the physicians to critically develop, refine, and test each other's assessments of health promotion work. With this method of gathering information, we moved out of the domain of individual experience to the shared and consensual agreement of physicians as a professional group, thus allowing us to substantiate further the generalizable findings of the study.

In sum, five sets of data were collected over the course of the study: (a) texts of physician interviews comprising over 700 pages of verbatim discourse, (b) texts of patient interviews totaling approximately 250 pages, (c) field notes from both the patient and physician interviews, (d) texts of the two focus group interviews, and (e) over 100 patient encounter records from the substudy.

Analysis and Interpretation

We approached these five data sets with three goals. The first was to identify emergent themes and issues and to develop a coding scheme that would be applied to the transcribed text of patient and physician interviews. This application would allow for any helpful quantification of some of our results, as well as easy retrieval of verbatim statements by physicians or patients around specific points. The verbatim quotations would be used subsequently to illustrate our conclusions. The codes also would allow us to look for relationships/patterns among various themes. Our second goal was to compile, from the texts of field notes and the interviews, a case study for each

Physician #: _____ Patient #: _____ Occupation: _____ Brought to Clinic by Family/Friend: _____	Age: _____ Sex: _____ Visit #: _____	Date: _____ _____ _____
PHYSICIAN	PATIENT	
Entering Examination Room 1 ¹	BEHAVIOR (1)	
	DISCOURSE (2)	
	PREVENTION/ HEALTH PROMOTION (3)	
1 ² Exiting Examination Room		
Prescription (s): New _____ Renewed _____ Comments: _____ Other Recommended Therapies: _____ Referral (s): _____ Follow-up Requested: Yes _____ No _____		

1. In this space, the researcher records the behaviors and actions of the physician and patient.
2. In this space, the researcher documents the discourse between the physician and patient in the examination room.
3. In this space, the researcher documents any references in the discourse to health promotion or disease prevention.

Figure 11.2. Physician/Patient Encounter Record

physician which would capture that individual's style and method of delivering health promotion advice. Our third goal was to generate

10000	PHYSICIANS' COMMENTS
10200	Health Promotion: Definition and Activities
10301	Definitions: Health promotion, disease prevention
10302	Content areas of health promotion and disease prevention (eg.,smoking cessation, weight loss, alcohol reduction)
10303	Approaches to health promotion: methods of health promotion
10304	Comments and analysis of effectiveness at health promotion, disease prevention, lifestyle counseling
10305	Explanatory models: health, disease, smoking
10306	Factors that encourage/discourage doing health promotion

Figure 11.3. Examples of Coding Scheme

a set of hypotheses and questions for future research using both the case studies and the identified themes and issues.

CODING OF VARIABLES AND EMERGENT THEMES

The texts of field notes and interviews with the physicians and patients were read by several members of the research team. Each team member constructed a preliminary list of issues and themes that then were compared, discussed, and reworked. The result was a 5-digit coding scheme (see Figure 11.3). The first digit indicates the source of the comments. The digit 1 refers to physician comments, 2 to patient comments, and 3 to the researchers' comments. The second and third digits specify a particular domain of comments, such as "Physician-Patient Relationships." The fourth and fifth digits indicate a specific theme within a domain. For example, the code number 10601 was applied to physicians' statements (as indicated by the initial digit 1) regarding "Elements/ingredients/components in the physician-patient relationship necessary to induce change toward better health in a patient." This was one of two themes relating to physicians' statements within the domain of comments on "Physician-Patient Relationship" (as indicated by the second and third digits 06). A list of thematic categories is shown in Figure 11.4.

Using a specialized software package, Ethnographic Theme Search (ETS), designed for use in a previous study (Willms et al., 1990), we

10000	PHYSICIANS' COMMENTS
10100	Clinic/Practice/Work Environment
10200	Resources (external to practice)
10300	Health Promotion: Definitions and Activities
10400	Patients
10500	Physicians
10600	Physician-Patient Relationship
10700	Reflecting/Philosophizing on Health Promotion
10800	Life History: At Home
10900	Life History: At University
11000	Life History: At Work
11100	Training
20000	PATIENTS' COMMENTS
20100	Physician's Interventions
20200	Past Interventions
20300	Perception of Physician's Interventions
20400	Philosophizing about Physician's Interventions
20500	History of Smoking
20600	Risk Perception
20700	Quitting Smoking
20800	History of Patient-Physician Interactions
20900	Patient-Physician Relationship
21000	Philosophizing about Doctors
21100	Experiences with Other Doctors
21200	Life History
30000	RESEARCHER'S COMMENTS
30100	Comments on the Participant
30200	Comments on the Interview
30300	Comments about Doctors
30400	Comments on Smoking/Quitting
30500	Comments on Important Events in the Participant's Life

Figure 11.4. General Headings for the Coding Scheme

retrieved "discrete units of text." Each consisted of the interviewer's question and the coded response of the participant under a particular rubric such as "Approaches to health promotion: methods of health promotion" (10303). Additionally ETS allowed us to retrieve discrete units of text that contained co-occurrences of codes. For example, we could search for co-occurrences of particular codes

such as 10303 (see above) and 10107, "Length of time at this practice," using the "Text" function. This capability allowed us to investigate suspected relationships between themes and to discover unanticipated relationships. The "Quantification" function of ETS provided us with descriptive statistics of the co-occurrences.

CASE STUDIES/PROFILES

In order to preserve the idiosyncratic, personal details of the physicians' work experience as they emerged from their discourse on individual methods, as well as to preserve their styles and approaches to health promotion, case studies ranging in length from 5-20 pages were written for each of the 12 physicians. These case studies are a compilation of relevant quotes organized around the following subjects: description of practice and patient population, health promotion strategies, and barriers and frustrations to doing health promotion.

Generally the case studies begin with a description of the physician's practice and patient population, which includes details relating to type of practice, other health professionals and support staff employed, kinds of patients seen most frequently, and areas of practice the physician considers to be of a health promotion nature. For example, Dr. Dyck (a pseudonym) shares office space with two other physicians who graduated from a university in southern Ontario the same year he did. Each of the three physicians has his or her own solo practice, although they fill in for each other during vacations. They share one full-time nurse between them. Dr. Dyck describes his practice as a "fairly overall general practice." Although the other two doctors have not done obstetrics for a number of years, he continues to do so. "We do a lot of baby care," he says, "a lot of well female exams." He notes, "The opportunity to do preventive medicine is fairly high here."

A large portion of the case study is devoted to a summary of the various methods, approaches, and "tricks" the physician described using, as well as any comments on when and in what contexts he or she employs certain strategies. Dr. Dyck, for example, in attempting to convey the hazards of smoking, tends to "use a number of his own experiences" recounting incidents of smoking patients who died of cancer. He says that he makes use of his patients to help him. One woman patient became an "expert on crib death" after losing

her own child. He refers couples whose infants have a higher risk to this lady. His office nurse is an ex-smoker, and he sometimes refers patients who want to quit smoking to her. She is "glad to talk to them about how she quit and the difference it's made."

Accompanying the description of the physician's health promotion strategies is a summary of the physician's thoughts on the problems and frustrations of doing health promotion work. In Dr. Dyck's case, he says the most frustrating aspect of doing preventive medicine and health promotion is the "time element." Only a certain amount of time is allotted for each patient visit, and you have to "prioritize it; you have to deal with immediate physical complaints, and you may have to call them back to deal with some of the other problems." He often schedules another appointment to deal with health promotional issues, especially when he is "highly concerned . . . that is, the patient is 100 pounds overweight, smoking and drinking."

Another problem he encounters is that "many patients can't see a connection between stress and their 'physical symptoms.'" He uses popular analogies to try to explain this to them. For example, he asks them what their stomach felt like just before they had to make their first speech in class and then tells them, "The same thing can happen if you're under stress at work, only it might affect your heart, your stomach, your bowels, your kidneys." Dr. Dyck says that much of his patient counseling revolves around stress-related issues.

Each of the case studies is complemented by a physician profile drawn from the texts of field notes and interviews with the patients (see Figure 11.5). Similar to the case studies, the physician profiles are a compilation of relevant quotes relating to the patients' expectations of their physician, their perceptions of his or her intervention, and his or her rapport with the patient. Figure 11.5 contains two excerpts from the patient interviews for Dr. Dyck.

HYPOTHESES AND PROBLEMATIC

Our analysis of the case studies, the physician profiles, and the identified themes and issues suggested a number of hypotheses and questions for further investigation. These covered a range of areas, including organization of health care delivery, the patient-provider relationship, physician roles, patient expectations, and competing definitions or notions of health. For example, with respect to patients' expectations, we found that patients generally are looking for

Dr. Dyck obviously adapts his style to suit each patient's idiosyncrasies, so that he can suitably impress them with his advice and effect their compliance. For instance, with one younger patient who is a fairly new mother, his emphasis on encouraging her to quit smoking is on the health of her young son and the importance of providing a good environment for him. And he has been successful in impressing upon the woman that it is her responsibility to do something about this in such a way that she can reflect upon his suggestion and make her decision. "He always suggest. . . but he doesn't push. . . so that I don't feel that I'm being forced" (1102 p. 5). "I think people are responsible for themselves. . . I think a doctor maybe should tell them. . . the facts. . . (and) offer as much help as he can" (1102 p. 8). This is exactly what Dr. Dyck has done in her situation. "He's giving me pretty well the information I wanted. . . gave me the booklet" (which she has read), has suggested that the patient "try to plan that you're not going to be around smoking people. . . don't go to parties" (1102 p. 5).

In general, the patients feel that the doctor understands them and their predicaments well. They have a great deal of confidence in him and his capabilities and it seems as if they feel a real sense of partnership with Dr. Dyck, which has obviously been developed through the years. Dr. Dyck's use of humor as a means of gaining a sense of intimacy with his patients seems to prove a very effective approach, since it is appreciated even by those patients who do not wish to listen to his advice and make serious lifestyle changes. "I don't want to quit, to go through that misery. . . I'd rather go through childbirth again rather than the pain of quitting smoking" (1005 p. 4). "He doesn't hassle me . . . he says, 'You shouldn't be smoking, you've got emphysema!' (1005 p.1), but he knows I'm addicted. That's about it (p.3) . . . he's a character, he's easy to get along with . . . he's more approachable than some doctors are . . . he's got all of our trust" (1005 p. 6). They also recognize that in treating physical ailments, the patient's "state of mind" becomes a most important element since "40, 50, 60, or 70% of it is in the mind" (1006 p. 31).

Figure 11.5. Physician Profile

a physician who understands their subjective complaints, offers helpful advice and counsel, and perhaps most important, treats them as subjects, moral agents, in control of their own bodies and not as objects of experimentation. Patient expectations may be related to how patients are empowered to become more involved in their own health and well-being. They also raise the question of how physicians can learn to attribute more power in decision making to patients and their families so that the process becomes one of negotiation between the physician's expert opinion and the patient's autonomy and self-directedness, and how family and community supports can be brought to bear on the process of healing.

Another set of questions that emerged from our analysis concerns the extent to which physicians adopt an almost monochromatic professional persona. Is it fair to say that a physician is not permitted to allow personal life to emerge in professional life and work? Do persons who become physicians adopt a cultural image of "physician-like-ness" and the characteristics and traits that support the personification of the ideal physician? Are physicians expected to present

themselves as always being on an even keel, a presentation of professionalism that epitomizes stability, security, invulnerability, and unalterability?

In this respect, the presented image of invulnerability may be seen as analogous to the position of the indigenous healer in traditional societies. It attributes to them a source of power. They are on the margins of society—mysterious, aloof, different, not an average person—and therefore seemingly not as dependent on others, more powerful, and having more control. We ask ourselves whether there are times when physicians must become “vulnerable” so as to heal? Our data would suggest such times exist. Rules and a framework are lacking, however, for directing these shifts in power and authority.

Our data also suggest that perhaps a new specialty is emerging, as yet only informally, among physicians relating to health promotion. For example, Dr. Meyers and Dr. Phillips (pseudonyms) are recognized by other physicians in their communities as “experts” in dealing with smoking cessation and depression, respectively. Other physicians refer patients to them for counseling. It remains unclear to what extent this change is externally or internally driven. For example, to what degree has the emergence of “expert opinion” among physicians interested in life-style issues been brought about because certain life-style behaviors are being medicalized unnecessarily.

Conclusions

This chapter provides an overview of steps taken in systematically conducting a qualitative research study. While much more detail could have been presented in elucidating each phase of the project and our interpretation of results—the harsh light, soft focus of ethnography (Peacock, 1986)—our wide-angle lens provided a general view of the landscape of qualitative research methods and focused on necessary anchors for entering the field so as to see and to understand more clearly. We have covered a range of qualitative concerns: (a) the issue of problem formulation; (b) the qualitative or field research design, with consideration given to issues of reliability and validity through time and method triangulation; (c) the identification of emergent issues and themes; and (d) the generation of problems and hypotheses.