Qualitative methods in general practice research: experience from the Oceanpoint Study

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**Background.** The Oceanpoint Study is a collaborative study between general practice and medical anthropology.

**Methods.** The study involved a qualitative ethnographic approach including long-term participant observation, in-depth interviews, health diaries and focus group discussions. Qualitative methods are suited to describing the phenomenological perspectives of people through the generation of rich detailed accounts which leave participants’ perspectives intact.

**Results.** The use of these methods in this study has enabled the researchers to explore a range of community beliefs and practices concerning health and illness. The underlying concerns and approach of general practice medicine are similar to those of the qualitative research tradition.

**Conclusions.** The experience of being a general practitioner parallels the experience of an ethnographer conducting qualitative research and the paper explores the similarities and differences between them and discusses the usefulness of such collaborative research.

**Keywords.** Qualitative methods, ethnography, general practice research.

**Introduction**

There is an increasing interest in the use of qualitative methods in general practice research and a growing appreciation of the insights offered by these methods. The majority of primary care research is quantitative, utilizing experimental designs, epidemiological studies or quantitative surveys. These forms of research are useful for exploring particular types of research questions, but may be of limited value for many of the questions posed by general practice. Quantitative methods provide reliable data which may be applicable to larger populations, but they are limited in their ability to account for the meanings and interpretations that inform peoples’ actions. For example, epidemiological studies can help to identify risk factors for coronary heart disease but are of less value in explaining the meanings of risk behaviours in the community. Quantitative surveys may enumerate the numbers of people using a variety of different doctors and other health service providers but are inadequate to provide insight into why people choose to see different doctors, or use alternative healers. For research questions attempting to understand complex behaviours or meanings, qualitative research strategies are also valuable to general practice research.

This paper explores the usefulness and practicalities of conducting qualitative research through an examination of the various methods used in a collaborative study of the context of general practice within the Australian suburban community of Oceanpoint. There are many parallels between the concerns and perspectives used in general practice and qualitative research which make the latter well suited to many of the questions posed in general practice. The Oceanpoint Study also stimulated considerable reflection among the research team on the nature of general practice and the usefulness and difficulties involved in employing and interpreting anthropological techniques.

**Differences between qualitative and quantitative research**

Qualitative and quantitative research methods differ in their philosophical traditions, concerns and techniques. Quantitative research follows the 'positivist' tradition which regards the hypothetic-deductive method as the only legitimate basis for 'scientific' knowledge. This philosophy of knowledge uses the natural world as a model in which the behaviour of people is seen as the outcome of internal or external variables to be
investigated by the detached, neutral observer. Qualitative methods are derived from a separate philosophical tradition which approaches people as social beings who actively interpret the world and their experiences of it. Their behaviour is understood as not simply the outcome of variables but arising from their interpretations of events and experiences informed by their wider social context. The aim of qualitative techniques is not to develop an overarching law of behaviour that can be used to predict outcomes, but rather to understanding what makes actions intelligible and the ways in which people make sense of the world, that is, their culture.

Qualitative research methods emphasize the rigorous description of the qualities of a phenomenon, rather than enumeration. They aim to produce rich, detailed accounts that leave the participants' perspective intact. Unlike quantitative methods which start with a hypothesis and a methodology designed to prove or disprove the hypothesis, qualitative methods work inductively with a relatively open and unstructured research strategy, the objective being the discovery of the frames of meanings and multiple perspectives of those being studied and understanding the context in which behaviours take place. This also involves an avoidance of preconceived schemes or frames of reference in relation to those they study. Analysis takes place in a recursive fashion, as new questions are generated in the course of the research. Finally, within qualitative research, there is a conscious acknowledgement of the subjectivity of the researcher and recognition of the ways in which the study is influenced by the social background, biases, status and presence of the ethnographer.

General practice and qualitative research
Qualitative methods continue to be under-represented in general practice research, partly because of their time-consuming nature and a lack of familiarity with the techniques, and a failure to understand the differing epistemological, or philosophical, traditions of qualitative and quantitative research. However, as Murphy and Mattson note: "to limit the research topics which can be legitimately posed in family practice to those which are open to the hypothetic-deductive method is to deny the discipline significant sources of knowledge." The underlying concerns and approach of general practice medicine parallel those of the qualitative research tradition. The Royal Australian College of General Practitioners defines general practice as: "the provision of primary, continuing comprehensive whole-patient care to individuals, families and their communities." These characteristics emphasize general practice as the point of first contact for patients and its quality of having an ongoing, comprehensive, whole-patient orientation that includes reference to the family and social context of the patient. In the provision of primary care, it is recognized that the general practitioner (GP) often deals with ill-defined illness involving a range of organic and social processes. Because of this, the GP attaches importance to the subjective aspects of medicine, both in understanding the patient's perspective and in focusing upon the whole person as a subject of care rather than just the disease entity which is the object of concern in most medical specialities. More often than not, patients are considered within the context of their family and community often through long-term relationships between the patient and the doctor. For these reasons, a research approach which is able to take into account the social and subjective meanings of doctors and patients within this relationship may be the most appropriate for general practice research. A closer look of the day-to-day activities of the GP highlights the similarities between qualitative research and the practice of primary medicine. The experience of being a GP parallels the experience of an ethnographer conducting qualitative research: the doctor is often based in a community for a long term, developing relationships with members of that community and growing to understand the 'local knowledge' of the community and many of the individuals within it so as to better interpret the signs of illness and complaints of those people when they present as patients. In the consultation itself, the GP, like an ethnographer, engages in an interview with the patient, needing to establish rapport and come to an understanding of the patient's perspective and experience, feelings and values through using open-ended questions and probes. In this way the practitioner attempts to understand and interpret the patient's experience. Like an ethnographer, the GP must interact with a wide variety of people, many of whom share entirely different understandings, backgrounds and life experiences. Both the ethnographer and the GP negotiate their relationships to these different people so as to minimize barriers to understanding. Unlike the ethnographer, however, the GP is orientated towards praxis, and must propose an action or course of therapy for the patient.

The Oceanpoint Study: collaboration between general practice and anthropology
In 1994, an ethnographic study commenced into the context of general practice in the suburban community of Oceanpoint, Australia. The broad aim of the study was to identify the social and cultural context of general practice in order to describe the characteristics of the pluralistic health care in a suburban community, to understand how GPs fit into the range of health resources used by residents, and to understand the factors influencing people's decisions to use GPs. In order to best address these concerns, a collaborative study between general practice and medical anthropology was designed, employing a range of qualitative
methods. A discussion of the various methods used in this study will provide examples of the uses of such techniques in studying general practice.

The research team
The Oceanpoint Study involved a collaboration between members of the Discipline of General Practice and members of the Department of Anthropology and Sociology at the University of Newcastle, as well as the Hunter Urban Division of General Practice in Newcastle. Two members of the team are practising GPs, and three are anthropologists specializing in medical anthropology. The varied nature of the research team provided an opportunity for all members to learn more about the practices of each others' disciplines and the research benefited from the varied experience and perspective of each member.

Methods

The setting
Oceanpoint is a small suburb with a population of 2715 people within a discrete geographically defined area, surrounded by ocean and bushland. The community is internally differentiated providing a wide range of household types, socio-economic levels and phases of the domestic cycle. There is one group general practice located within the community as well as a variety of other practices within easy transportation in surrounding suburbs. In addition there are a variety of other medical services and alternative healers in the local area such as chiropractors, herbalists, naturopaths and acupuncturists who are used by members of the community.

The study
The study involved a qualitative ethnographic approach including in-depth interviews, health diaries and focus group discussions, combined with an analysis of official statistics on the community where these were available. The use of a variety of qualitative methods ensures the reliability and validity of the data collected as it allows for the continual confirmation and testing of information from a variety of sources.

Underlying these various methods was participant observation. Two of the research team members lived in the community, one had been a resident for 8 years and the other moved to the community for the purpose of the study and was resident for 18 months. Participant observation entails the researcher becoming involved in the community which is being studied, establishing and maintaining relationships with that community in order to study processes, relationships amongst people and events, continuities over time and patterns of behaviour as well the broader socio-cultural context from an 'insider's' viewpoint.

Informants were obtained through 'snowball' sampling of local community groups such as the local Bowling Club, the parent's committee of the local primary school and Church organizations. These various organizations were initially contacted about the study and people who volunteered were asked to suggest other people in their social or family networks who might like to be interviewed. Such snowball sampling was combined with a sampling frame purposively targeting the major demographic groups across different socio-economic groups, age ranges, family structure and sex groups within the community to ensure that we obtained a sample that was a representative distribution of the adult population of the community. For example, the local play-group and pre-school provided access to mothers of young children, the Bowling Club and retirement village provided access to older citizens, whilst the local Lions club facilitated contact with men. In addition, all local health service providers, including the local GPs and alternative therapists were interviewed for their opinions about health and health services in the community.

In-depth interviews
From these contacts, people volunteered to be part of the study and had an initial 1-hour in-depth interview in which they were encouraged to talk at length about their health and other aspects of their lives. Such interviews are similar to the techniques used by GPs to gain information in clinical medicine and counselling. However, they differ in an important respect. The form of interviewing used in this study was not structured around a specific focus as it is in a consultation, rather it was relatively open. It did not involve a predetermined interview schedule but rather followed from the concerns and stories told by informants with interviewers probing for more information on a series of themes as they emerged in the course of the interview. In such an interview, the interviewer does not control the interview but may guide the interview towards the discussion of certain topics. This style of interview was considered the most appropriate for the research as it is grounded in informants' own experiences and allows them to express issues of concern, consistent with the exploratory goals of the study. With the participants' permission, these interviews were recorded by tape and transcribed verbatim, providing a rich source of detailed narratives about informants' health experiences and opinions.

This type of interview obtains a depth of data unobtainable through usual survey techniques. For example, in the course of the interview informants were asked about recent health experiences. These narratives often revealed a range of critiques and agendas of care and service different to opinions obtained by direct questions. The self-structured narratives of interviewees reveal their understandings, priorities and identities.
Further probe questions facilitated the recall of details of care and service that may be more difficult for the informant to explain than those mentioned in direct response to the open-ended questions. In total 112 people of various ages, sex and socio-economic background were interviewed. Table 1 summarizes their characteristics.

The majority of interviews took place in the homes of the respondents or wherever they felt most comfortable. This also provided insights into the social context of informants. On occasion the spouse of an informant was present during the interviews, in which case they participated in a joint discussion. These were found to be some of the most fruitful interviews undertaken.

The interviews have provided a rich source of information on peoples' constructions of health and illness, notions of the body, the role of the environment in health, care for chronic conditions and narratives concerning experience with illness as diverse as stress, coronary heart disease and chronic fatigue syndrome.

Focus groups
In addition to the interviews, seven focus groups involving a total of 49 people were conducted with people recruited through several different community organizations. A focus group discussion is a structured group discussion with a moderator and six to ten participants assembled to discuss a particular issue. A 'moderator' facilitates the discussion, stimulating discussion between the participants. An 'observer' watches the discussion and takes notes and may give suggestions to the moderator on topics to explore further. It is characteristic of a focus group discussion that the participants be allowed to discuss issues between themselves and that the moderator guides the discussion. It is not as structured as a group interview where a set of questions are rigidly followed. Successful focus groups are characterized by rapid, stimulating discussion between all participants about a series of issues. The questions asked of the group are usually 'focused'. This means that they concentrate on one or two main topics and try to get very detailed information about how the people think about the area of interest. The participants usually share some characteristics such as age, sex or religion, or they may be people sharing a particular medical problem or service.

In the case of the Oceanpoint Study, the focus groups explored perceptions of GPs and ideas of health risk and preventive behaviours both to confirm information obtained in interviews and to gain further insight and reflection from informants in a way that is only possible through the group dynamics that occurs in a focus group. The responses initially obtained within focus groups are more likely to reflect socially stereotyped or normative statements and these can be used to stimulate debate and reflection as to why people think in those ways. For example, in this study, the focus groups allowed the researchers insight into what are the common conceptions of services in general and public opinions concerning doctors which in turn influence perceptions of the services they utilize. All members of the research team participated in these focus groups as either moderators or recorders of the discussions.

Health diaries
Another method used in the study included health diaries for a longitudinal study of self-care and health care-seeking behaviour. As a tool for prospective data collection, health diaries have been used to document symptoms and seeking behaviours, the use of pharmaceuticals and continuity of care in general practice. They have also been used in international settings to obtain data for morbidity for a range of diseases and in family planning. In the Oceanpoint Study, health diaries were chosen to facilitate the collection of the everyday health actions and decisions that are rarely obtained through interviews as people usually consider them to be too boring and normal to tell others about them. Participants were asked to simply record on a specially designed calendar the days on which they or someone in the household were feeling ill, what they were feeling, what they did about it and to specify whether they sought advice from anyone.

Twenty-three households with a total of 64 people participated in the health diaries across a 6-month period, resulting in 102 person-months of data. These households were selected from the people who had previously been interviewed and were interested in becoming further involved in the study. Households where a member was experiencing a severely incapacitating chronic or terminal illness were not included at the researchers' discretion as it was felt that it would constitute too great an additional burden for them or their carers. The households that did participate included a range of different types, including young families with small children and infants, families with older children, recently retired people living in the local mobile home village, elderly couples and elderly people living alone in self-care units in a local retirement village.

The health diaries were a labour-intensive part of the study. Participating households were contacted every month to pick up the previous month's diary and receive the next month's diary. In the initial stages, a 2-weekly
phone call was conducted to remind people to fill in their diary but this was discontinued after 3 months when such intensive prompting was considered redundant. At the monthly visits, the diary acted as a stimulus for a discussion about the household's health and a reminder for the participants of what had occurred throughout the month. Additional information obtained through these short monthly interviews were noted by the researchers. The same researcher attended each month to develop rapport and ensure continuity. The technique was most successful with those households where the researcher had developed a close, friendly and trusting relationship.

The health diaries provided a wealth of information on the illness trajectories across the 6-month period, allowing for detailed case studies of people's resort to care and changing definitions and treatments for their symptoms. In addition, data concerning self-care and medication usage, including the use of various home remedies, sources of information and health-seeking behaviour, were documented, including the use of GPs and alternative healers. Some limitations noted by the researchers involved the tendency for some participants to doubt the usefulness of their information concerning everyday illness and a reluctance by some to continue as they felt that it encouraged them to dwell upon their illnesses. Households were free to leave the study whenever they chose and six households dropped out of the study for a variety of reasons including lack of time and loss of interest. In addition, some people were reluctant to write in their diaries the occurrence of illness episodes which were of an extremely sensitive nature, but in most cases they were prepared to talk about them to the visiting researcher instead.

**Analysis**

The combination of these various techniques resulted in a range of data from detailed minutiae of self-care for colds in the health diaries, to narratives about coronary heart disease in interviews, and group discussions about preventive behaviours, along with observations, field notes and health information from the popular media. All field notes, interview transcriptions and focus group data were organized using "The Ethnograph 3.0", a computer program which facilitates the management, coding and analysis of qualitative data. The use of this program allowed the rapid retrieval of segments of coded text across a number of different interviews or fieldnotes for comparison and contrast.

The process of analysis of this data thus involved its reduction into usable forms, examining, comparing, conceptualizing and categorizing data through thematic codes and then relating similarly coded segments of data with each other and other categories of data in order to develop concepts for further investigation and to theorize relationships between concepts. It also involved the intensive examination of particular cases, especially in terms of the narratives or illness trajectories across time. This allowed us to develop ideas about how a narrative is organized and what this might say about that person's experience or what a single case can tell us about patterns of use of services to begin to develop models to be tested against other cases. Triangulation of findings from a number of different research methods and contexts as well as the input and feedback from the various members of the research team ensured a high level of validity and reliability in the findings. This process of analysis proceeded throughout the study. Unlike quantitative research where the researcher sets out with a specific hypothesis which is then proven or disproved, qualitative studies such as this one are inductive, that is theory is constructed from creative interaction with the data and the research questions may change throughout the study as the project proceeds. As Patton has suggested: "Because each qualitative study is unique, the analytical approach used will be unique. Because qualitative inquiry depends, at every stage on the skills, training, insights and capabilities of the researcher, qualitative analysis ultimately depends on the analytical intellect and style of the analyst. The human factor is the great strength and the fundamental weakness of qualitative inquiry and analysis."

Upon reflection between members of our multidisciplinary team, the observation was made that a similar iterative analytical process is involved in everyday general practice where the human factors, such as feelings, intuition and sometimes serendipity, are often involved in the relationship between the doctor and patient and the process of diagnosis and prognosis. A doctor categorizes and looks for relationships and patterns in presenting symptoms and needs to interpret a range of information and narrative from the patient, as well as to synthesize and take into account local information, social context and their personal knowledge. The doctor often uses considerable creativity in the process of formulating a hypothetical diagnosis which is then tested using biomedical scientific deductive techniques.

**Conclusions**

The Oceanpoint Study has produced a corpus of research data that can be drawn upon by GPs in their training and clinical practice and make a contribution to the development of anthropological theory regarding urban health behaviours. Already some of these data have been presented at a range of general practice and anthropological forums with a range of subject matter such as notions of stress, constructions of risk and coronary heart disease, reactions to health promotion, community perceptions of GPs and their service, and notions of the role of the environment in health.
There is a growing appreciation and evaluation of the insights and other forms of knowledge offered by qualitative methods in general practice research. In collaborative studies between anthropology and medicine, there is a need to find ways of translating and communicating each discipline's theoretical perspective to the other. Social science and medicine are two different cultures into which people are gradually socialized and taught to view and explain the world in particular ways, and specialists in these fields need to recognize and overcome their 'ethnocentricism' to develop useful and productive forms of collaboration. Just as medical practitioners find the anthropological terminologies confusing, so too can anthropologists find medical terms difficult. Anthropologists often find it difficult to reduce their context-rich and theoretically detailed arguments into a shortened form that is understandable and congruent with the information processing style of their medical colleagues or fulfils the demands of medical journals. The process of anthropological analysis can seem to be woolly and unscientific to those trained in the 'hard' sciences where statistical tests of significance define what is important and what can be ignored. Unfortunately, no such easy solution exists within the qualitative tradition. As Zyzanski et al. suggest: "recognising the value of qualitative research for the work of primary care requires some transcending of the principles and standards embodied in the prevailing quantitative paradigm."

But the distinctions are deeper than mere linguistic and stylistic differences. The medical profession is problem- and praxis-orientated. Doctors are expected to provide interventions to health problems and their ways of thinking and acting are orientated towards this. However, anthropology is descriptive, interpretive and reflexive with an orientation that is philosophical and theoretically driven. The anthropologist works with a range of theoretical perspectives which are drawn upon to provide different ways of seeing an issue, whilst the medical profession is a praxis-driven discipline, often unconcerned with the underlying theories of society and their profession upon which they operate. This tension between the praxis-orientated medical personnel and the theory-orientated sociologist/anthropologist can lead to frustration on both sides, with the anthropologist annoyed at the reductionism of the medical doctors whilst they in turn grow impatient with the long period of time spent in conducting anthropological research and the failure of the anthropologists to provide clear suggestions and interventions from it. In addition, the critiques of medicine that form part of the sociological and anthropological tradition, draw defensive responses from the medical profession who see themselves as getting on with the job of curing people. However, these differences are often stereotypes and, as has been found in this project, the actualities of medical and anthropological work have more common ground than is usually described.

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References