A n innovative and exciting conference took place recently at Coventry University in May 2000. This first Qualitative Evidence-Based Practice Conference brought together qualitative researchers and evidence-based practitioners from throughout the United Kingdom and around the world. The conference emerged from two main motivations. The first was our realization that few places existed where those interested in qualitative evidence-based practice could share their ideas and their research. We were excited to learn from colleagues that many were doing qualitative research but disappointed about their struggles with gaining acceptance within the quantitative domain of evidence-based medicine. The second was a desire to begin to grapple with the possibilities for such research at a time when there is an increasing demand for occupational therapists to undertake such activities as quality assurance and outcome-based practice.

The 3-day conference offered delegates the opportunity to explore the spectrum of qualitative research and to discuss the role of qualitative approaches in evidence-based practice. The conference was both multidisciplinary and multiprofessional in nature, with delegates from the fields of health and social care, higher education, management, and business studies. For us, the conference not only reflected an increasing interest in qualitative evidence-based practice, but also showed us that this kind of research has not yet received global acceptance. This lack of acceptance was evident from the many queries from conference participants before the conference about whether it was possible to have “qualitative evidence-based practice,” a debate many of us had at the conference. Yet one final reflection from an American delegate will always stand out: “Thank you for taking a risk and doing this conference; I feel I have just spent 3 days in a sweet shop!”

What was fascinating about bringing together such an interdisciplinary mix were the ways in which complex issues about doing and managing qualitative research raised common issues and concerns across all fields. For example, many delegates raised concerns about the lack of acceptance and support for qualitative research, the struggles of data management and the insufficient funding for qualitative evidence-based practice. These concerns became apparent not only through a series of hands-on workshops, where delegates could explore and discuss the process of interpreting qualitative data and practice the skills of critically appraising qualitative research papers, but also through interesting discussions that emerged from the keynote speeches.

Delegates heard keynote lectures from a number of eminent speakers. Professor Mike Bury, a sociologist from the University of London, argued that the current research emphasis on client or personal narratives can be seen to stem from changes in morbidity patterns, the expansion of information about disease and illness, and public debates about the effectiveness of medicine. He then presented three types of narrative form used in research:

1. contingent narratives that address beliefs about the origins of a disease, the causes of an illness episode, and the immediate effects of illness on everyday life;
2. moral narratives that provide accounts of changes relating to the interplay of the person (in terms of his or her identity), illness, and social identity; and
3. core narratives that reveal connections between a layperson’s experiences and deeper cultural levels of meaning attached to suffering and illness.

Although we agreed with Bury’s concerns about using narrative analysis with caution (he had argued that narrative forms can be used simplistically and without rigor), to some extent we believed that occupational therapists were already effectively and sensibly using this approach in the context of clinical evaluation and intervention and as a research method. However, it seems that in occupational therapy this form of

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**Conference Report: Qualitative Evidence-Based Practice**

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qualitative evidence is not always valued or used as much as it could be (Taylor, 2000).

What was encouraging was the research presented by two occupational therapists using different narrative approaches. Beth McKay of Brunel University used life history to explore the lives of women with severe mental illness, a group whose needs are little known or researched. Using reflective narratives, Susan Ryan of the University of East London presented fascinating data from her study of the voices of recently qualified occupational therapists.

The whole issue of what counts as evidence and how standards of quality in qualitative evidence are maintained presents us with a minefield of difficulties. These complex issues were addressed by Professor David Field, Director of the Centre for Cancer and Palliative Care Studies in London. Having presented his perspectives on the contribution of qualitative research to palliative care practice as applied to the experiences of death, dying, and bereavement, Field reported the findings of an evaluative review of qualitative research published in 49 English-language journals. He argued that assessing the quality of qualitative research needs to be tackled with a range of approaches (e.g., examination of the appropriateness of methodology adopted and the rigor of the analysis and interpretation) so that we can make sound judgments about the contribution of such research to practice.

The use of documentary evidence in qualitative research was explored further in a paper presented by Moira Helm from Canterbury School of Occupational Therapy. She argued that occupational therapists in both clinical practice and research make little use of documentary evidence, such as state, government, and independently produced records; media (video and Web-based materials); and visual documents, such as photographs. Helm demonstrated the use of documentary evidence in her study of the relevance of occupational therapy practice to clients living in deprived socioeconomic conditions in South Africa. Her multimedia presentation included photographs; recent South African legislation relating to notions of inclusion, diversity, and transformation; and stories of people’s lives in informal settlements. The issue of disability and poverty was explored further by Lana van Niekerk, an occupational therapist from the University of Cape Town. She used participatory action research to steer the development of a community-based project designed to develop the entrepreneurial skills of persons with disabilities living in informal settlements around Cape Town.

Professor Gareth Williams, a sociologist from Cardiff University, gave a keynote address that challenged many of us to consider how we might use qualitative evidence to influence policy. He suggested that qualitative evidence-based practice could help us answer questions about why services are not used and what affects successful service delivery. Occupational therapists Angela Fisher of Coventry University and Frances Gair of Coventry National Health Service (NHS) Trust presented data from a recent study of policy issues. Their study was an illuminative evaluation of the perspectives of young persons with psychosis. They argued that, as yet, there has been no comprehensive research within occupational therapy of the impact of adopting early intervention programs in ways that strategically target young people in the United Kingdom. Such studies and evaluations would seem to be vital at a time when U.K. government policy is demanding diverse client-led services across the NHS that are informed by contemporary evidence-based practice as part of the National Service Framework for Mental Health (Department of Health, 1999). Fisher and Gair’s findings suggest that the adoption of such programs would be of value to service users and their families across the United Kingdom. Presently, however, referrers and occupational therapists perceive such client-led services as high risk, largely because the new, forward-thinking government policies that promote user-led services have not considered the full impact of implementation in practice. Hence, these researchers also recommend that further practical policies be put in place in order to meet the ideals of the government policies more effectively.

Marie Donaghy, a principal lecturer in physiotherapy at Queen Margaret University College in Edinburgh, presented the concluding keynote address. She argued that in the field of medicine, both qualitative and quantitative approaches are essential to maintaining and improving standards of client care. She made a case for a unified approach that could bring together strategies associated with the artistry of professional thinking (e.g., reflection on practice, critical self-appraisal, clinical reasoning) with strategies that can facilitate clinical effectiveness (e.g., research, audit, clinical guidance).

Reflections and Challenges
This conference gave us an opportunity to meet like-minded boundary pushers, to explore and debate our research, and to find ways of realigning our theory and practice so that they make sense to those with whom we work and learn.

However, amid the debates about evidence-based practice, evidence-based medicine, and what is seen to count as evidence, we are aware that a piece of the puzzle is often missing—the rather vital link between evidence-based practice and problem-based learning. This link will be explored more fully at the 2001 conference. What is important about this link is that the use of qualitative forms of process-based learning is increasing worldwide (Savin-Baden, 2000). Qualitative forms of learning in professional education, such as problem-based learning, will in the long term have a significant impact on the way practitioners view evidence. Thus, evidence will be seen not just as valid and reliable statistical data, but as integrated forms of data and a whole host of qualitative evidence. The kinds of qualitative evidence we tacitly value, but in fact often use (although we may not confess to it publicly), are illness narratives, narrative reasoning, and storytelling.

Although many of the papers and discussions at the conference explored the range and boundaries of qualitative research, another area for discussion and debate at the 2001 conference must be the application of qualitative evidence-based practice to the broader context of practice. We know that some qualitative evidence is already valued through clinical reasoning and reflective practice, but we as occupational therapists believe that we need to be more explicit about acknowledging and valuing our narrative
accounts and not just dismissing them as less significant components of our own storied lives.

Conclusion
The first Qualitative Evidence-Based Practice Conference was a place where delegates presented and explored their clients’ journeys as research was undertaken. Delegates also presented the challenges they as therapists encountered personally and professionally while doing the kind of research that requires collaboration and co-inquiry to ensure rigor in collecting and making sense of qualitative evidence.

Further details of the 2000 conference plan, abstracts, and text of selected papers can be found at the conference Web site (www.leeds.ac.uk/educol/qebp2000.htm). Details for the 2001 conference, Qualitative Evidence-Based Practice: Taking a Critical Stance, can be found at www.leeds.ac.uk/educol/qebp2001.htm.

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