Title:
Asking new questions: A reflection on AMEE 2009

Short Title:
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As recently as five years ago, the medical education journals were rife with articles (Albert, 2004; Bligh, 2003; Norman, 1998) arguing about the nature and contents of appropriate research in medical education. Despite inroads that had been made, as qualitative researchers we still felt like we were struggling to justify our places in the medical education research community. It was a big deal to be accepted to present qualitative work at a medical education conference, and many of us had worked, over the years, to make our methodologies and theoretical frameworks more accessible and more palatable to quantitative audiences.

At this year's AMEE conference in Malaga, Spain, we were struck, as a group, by how much things have changed over the past five years. Instead of having to seek out the few sessions that might include qualitative research, such research was now so common as to be unavoidable. More than one Research Report session that we attended included spirited, educated discussion about the intricacies of both quantitative and qualitative methodologies and theories, including ways in which they might complement each other. We heard Steven Durning reinforce the notion that qualitative research is now an accepted and valued part of AMEE in his 'Educational Research' Spotlight during the closing plenary, wherein he noted both the presence of 'more qualitative and mixed methods work and [that] the research in general was of higher quality' (Durning, 2009). Finally, we were amazed that we had forty interested, engaged people attend our full-day introductory workshop on qualitative research methods and that we had to turn away others on the waiting list and even at the door!

At the beginning of that workshop we took some time to reflect on why the participants were there – to make explicit what was implicit in their having signed up for the workshop. We wondered if they were there to learn about qualitative methods because they encountered qualitative research in their reading of medical education journals, or because they were becoming involved in such research in their own institutional and professional settings. We speculated that some might be invited to review qualitative research papers for medical education journals in their areas of content expertise, and so would want to understand qualitative methods in order to identify good research in this domain.

So, we thought, an understanding of the basics of qualitative research might be helping these medical education researchers fulfill some practical needs. This notion, however, only piqued our curiousity even further. While we are encouraged by the growing interest in the theories and methods that we use, we cannot help but wonder about what is now fuelling it. In other words, we feel that it is important to reflect on why an understanding of qualitative methods is currently more relevant for, and popular among, researchers in medical education than it was in the past.

Our sense is that part of the answer must lie in what medical education research is getting from qualitative research that it didn't have before. What, then, can qualitative research methodologies help us to understand in ways that we didn't already? What can we learn using qualitative methods that we don't already know and that we aren't as likely to learn any other way? Is the increasing interest in qualitative methods due to the types of questions they allow researchers to ask?

Let us consider this last question for a moment. For us, the biggest strength of qualitative methods is the capacity they have for generating 'in-depth accounts from individuals and groups by talking with them, watching their behaviour, and analysing their artefacts (such as diaries, meeting minutes, photographs)'(Kuper *et al.*, 2008). Qualitative methods are used to study individuals and how they construct meaning but are ideally suited for studying groups of people. They are especially good for studying interactions within and between groups in their particular contexts. Different approaches allow, for example, researchers to explore and explain the social and cultural contexts in which students and their teachers function, perhaps enabling a more comprehensive understanding of aspects of the medical education system, such as the "hidden curriculum" (D'Eon *et al.*, 2007; Hafferty & Franks, 1994), not readily visible via experimental research.

Another strength of qualitative research is that it allows research participants to speak with their own voices rather than limiting them to a finite range of choices (Denzin & Lincoln, 2000). For example, a quantitative researcher might analyse for the significance of factors thought, on the basis of previous research, to correlate with medical students' choice of specialty for their post-graduate training. A qualitative researcher, on the other hand, might ask the students to discuss specialty choice in the context of their broader life experiences and medical school culture. This approach allows the researcher to explore the subtle distinctions of how student identities and needs come to shape each of their unique choices within a shared medical school context.

One research domain that is beginning to be enriched by qualitative research is, surprisingly enough, assessment. This is surprising because medical education has been using quantitative assessment methods to excellent effect for many years. Psychometrics

has enabled us to create valid and reliable assessments of such things as medical content knowledge and technical skills (Martin *et al.*, 1997; Wass *et al.*, 2001). However, as some of us have previously argued (Kuper *et al.*, 2007), psychometric testing works with psychological constructs – that is, for things that are a property of the person being tested, things that are supposed to be 'objectively there' or not – like knowing the blood supply of the abdominal organs or being able to tie a surgical knot. It is fair to say that there is an increasing awareness that many important components of being a physician (e.g. collaboration, empathy, professionalism) might be better thought of as 'social constructs' – as the outcomes of interactions, taken in context, between more than one person or group (Martimianakis *et al.*, 2009). For example, one patient's empathic physician is another patient's insincere money-grubber, and what is perceived as appropriate interprofessional collaboration in 2009 might well have been perceived as wholly inappropriate in 1909 – or may well be in 2059. Qualitative methodologies are poised to form the basis for creating new assessment tools for crucial socially-constructed aspects of clinical practice.

Just as qualitative methods can help us look inward, at interactions within the medical environment, they can also help us look outward, at the ways in which our medical schools interact with the medical system and with society. As medical education researchers, the environment in which we work and in which our students learn is always going to be coloured by our society's social policy choices. The big picture decisions that affect our medical curriculum, that affect what we need our future doctors to be trained to be, go beyond health care funding to things like welfare, housing, immigration and education policies. Our understanding of such societal influences and how to respond to

them also calls for research – the kind of research traditionally done by researchers in social science disciplines like sociology, anthropology and and political science. So if the medical education research community wants to address the research needs of the medical schools and to answer our own research questions in these areas, we need to expand our approaches to include the qualitative methods largely used in social science research.

Needless to say, this appreciation of the strengths of qualitative research in no way suggests a radical turn away from quantitative research. Psychometrics and other quantitative, statistical research paradigms continue to contribute immensely to our understanding of medical education. But there are important questions for which numbers don't provide suitable answers, and there are opportunities for applying new thinking and approaches to questions we thought we had already answered.

So, is part of the burgeoning popularity of qualitative methods about expanding the nature of the questions that can be asked and answered in medical education research? We would argue that it is. Our experiences at AMEE 2009 illustrated to us the richness of research possibilities enabled by AMEE's current inclusivity. We realized that we are now part of a research community for which the crucial thing isn't the particular method, but rather the responsibility to ask and answer important questions in ways that are rigorous, meaningful and helpful.We can't wait to see what we learn at AMEE next year!

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