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Teaching Against the Grain: The Challenges of Teaching Qualitative Research in the Health Sciences

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Conference Report:

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Abstract: This essay reflects on the proceedings of an invitational workshop on the nature and challenges of teaching qualitative research (QR) in health science settings. The context of this workshop is the increasing interest in QR in the health sciences and the inadequacy of pedagogy and institutional support for QR. We argue that there are special problems associated with teaching in an environment that embraces numerically based forms of knowledge and marginalizes unconventional research. Changes in the health research environment (e.g. applied research funding) and in the university environment (e.g. faster and briefer training) do not mesh easily with core premises of QR and can have a homogenizing, "dumbing down" effect on teaching. Teaching across wide disciplinary and professional divides, and among students with little or no social theory, can promote teaching QR as procedure, and at the lowest common denominator. Teachers must deal with the disruptive effects on students and other faculty of the critical dimensions of QR, and manage the structural constraints and political demands of thesis supervision. Despite the challenges of teaching "against the grain," the rewards and promise of teaching qualitative research in such environments remain, and we call for further discussion and leadership in this area.

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1. Introduction

The purpose of this essay is to reflect analytically on the proceedings of a recent workshop on the nature and challenges of teaching qualitative research (QR) in the health sciences. By "health sciences" we refer loosely to a range of professional academic faculties (e.g. medicine, nursing, public health, physical therapy, pharmacy, health administration), and to some research communities (e.g. epidemiology and clinical/biomedical research). We argue that although teaching QR in the health field has much in common with teaching QR in other disciplines and fields of application, the specific institutional location of such teaching has unique and challenging consequences for both those who teach and those who learn. Training needs for qualitative science are significantly different than those for natural science, and have to be both conceptualized and realized in different ways. Producing high quality researchers requires much more than methodological training; the need for theoretical knowledge and understanding puts special demands on educational programs. The teaching and learning of QR in the health sciences are inextricably linked to the cultural and institutional environment in which research methodology is embedded. Solutions to current problems and opportunities for enhancement are thus contingent upon structural and administrative change to buttress and support the most effective pedagogy. Teaching and research are closely intertwined and many of the problems of teaching cannot be resolved without concomitant change in research practice. [1]

2. Growing Interest in QR in the Health Sciences

In Canada and internationally, interest in qualitative research (QR) has grown significantly within the health sciences in recent years. Qualitative research exploring the social determinants of health, clinical decision making, practitioner-patient interaction, patient experiences of illness, health care delivery and other social elements of health and health care now appear regularly in medical, nursing, and other health research and professional journals. There is a journal devoted entirely to qualitative research in the health domain (*Qualitative Health Research*) and several of the top medical journals (*particularly the British Medical Journal*) have published introductory articles on qualitative methods (e.g. POPAY & WILLIAMS 1998; POPE & MAYS 1995). Health research funding agencies have begun to support multi-method and qualitative research designs and to commission major methodological reviews of QR (e.g. RAGIN, NAGEL & WHITE

2004; MURPHY, DINGWALL, GREATBATCH, PARKER & WATSON 1998). Expanding acceptance of QR in the health sciences has occurred for many reasons, including general post-modern shifts in the philosophy of science, recognition of the limitations of conventional health research approaches (e.g., experimental design, clinical trials, epidemiological surveys) for understanding the experiential, behavioral and social structural dimensions of health and health care, and the concerns of publishers and granting agencies with how to evaluate qualitative science (EAKIN & MYKHALOVSKIY 2003). [2]

On the basis of our communication with colleagues in Canada and internationally, and of our experiences as teachers of QR in several medical and health professional faculties, we suggest that this emerging interest in QR has not, for the most part, been accompanied by a corresponding shift in the knowledge and resources needed to support such research. Uptake of QR has been marked by an underdeveloped appreciation of what it is (e.g. simply "a new toolbox of methods"), what qualitative research practice involves ("talk to people and pick out themes"), what kind of knowledge it can generate ("ungeneralizable anecdotes" or "lay perceptions"), how it can be assessed (procedural checklists), and, most importantly, what education and training is needed (a course or two). Typically not appreciated is the significantly different philosophical understandings of QR regarding evidence and explanation, the need to draw theoretically from outside the biomedical sciences (especially from the social sciences), and the non-formulaic nature of the research process (EAKIN & MYKHALOVSKIY 2003). [3]

In our experience, in Canada and elsewhere, there is a shortage of investigators, research personnel, and, less frequently recognized, teachers, with sufficient expertise to fulfill the promise of qualitative approaches to health research. Teaching qualitative research to those schooled primarily in traditional modes of scientific thought (especially positivism) and to those with limited theoretical background outside of the natural or biological sciences, is a very challenging undertaking. Educational resources and institutional supports for the development of qualitative research expertise are limited, the quality of training is uneven, and teaching experience is seldom shared or pooled across the health disciplines or between institutions. Many of those teaching QR in the health field have not been formally schooled in QR methodology—they have learned it "on the hoof" so to speak, which creates particular challenges for their capacity to take on formal classroom teaching and thesis supervision. [4]

Little is known about how QR skills are currently being generated in the health sciences, or about the key pedagogical and structural dimensions of such training. The relatively limited literature on teaching qualitative research is heavily focused on undergraduate teaching in disciplinary settings such as sociology, with fewer contributions from other fields and particularly little on teaching in the health sciences. Some of this literature is practical "how to" pedagogical guidance on course design and teaching methods (e.g. BOGDAN 1983; KEEN 1996; COBB & HOFFART 1999; CONNOLLY 2003; FRANKLIN 1996; HARLOS, MALLON STABLEIN & JONES 2003). Others offer strategies for providing

experiential learning (SCHMID 1992; RIFKIN & HARTLEY 2001; HOPKINSON & HOGG 2004) and for addressing particular challenges of teaching QR, such as teaching "craft" (MCALLISTER & ROWE 2003), theory (TALLEY & TIMMER 1992), and "passion" (STARK & WATSON 1999). Fewer authors relate pedagogy to context, such as in KLEINMAN, COPP and HENDERSON's (1997) discussion of student resistance to ideas that run counter to their underlying notions of science. Seldom is the teaching of QR itself taken as the object of inquiry (a thoughtful exception is HAMMERSLEY 2004). [5]

3. A Workshop on Teaching

As a first step in expanding our knowledge of the teaching of QR, particularly in the health sciences, and in building capacity for qualitative health research, an invitational workshop was convened in Toronto, Canada in October, 2004 by Joan EAKIN, a sociologist who has been conducting and teaching qualitative health research in medical faculties since the early 1970's, and by Eric MYKHALOVSKIY, also a sociologist, who has more recently begun qualitative teaching and supervision in a health sciences context. The workshop was funded by a consortium of Canadian health research organizations that have training-related interests in QR (see Appendix 1). [6]

The objectives of the workshop were to:

- bring together individuals who are involved in teaching QR in the health sciences, and provide them with an opportunity to pool, learn from, and expand their experience, knowledge, insight, and creative responses to this particular pedagogic challenge;
- identify and discuss the particular opportunities, problems, and solutions associated with teaching QR in the health sciences, using a broad notion of "teaching" that includes formal methodology course instruction, graduate thesis supervision, and other less formal educational exchanges;
- identify the institutional and other structural arrangements that affect the teaching and learning of QR in the health sciences, including conceptions of science, theory and method, cultural practices of research, salience of applied research concerns, the organization of interdisciplinary training within departments, and the political context of funding and publishing;
- provide opportunities for linking qualitative research instructors and for sharing resources. [7]

Invited participants included individuals from across Canada involved in teaching QR in academic health science settings. The group included a mix of senior, mid-career and junior-level faculty, post doctoral fellows, and senior students. Participants came from a broad range of disciplinary/professional backgrounds, mirroring the highly multi-disciplinary knowledge bases from which qualitative research is being taught. To broaden and deepen the discussion at the workshop, and to facilitate comparative perspectives, a few faculty members teaching in social science faculties were included, as were two internationally known

qualitative health research instructors from the United Kingdom and Mexico (see Appendix 2). [8]

The organization and focus of the workshop reflected pre-workshop telephone consultations with the participants regarding priority interests and concerns. The program consisted of a combination of full-group keynote presentations and roundtable discussions on particular topics led by opening commentaries (prepared in advance) by two or three participants. With the exception of the keynote plenaries, formal papers were not presented. Rather, the emphasis was on exchange of ideas that emerged live in the course of discussion. The core topic areas embedded in the program are shown in Table 1, along with an illustrative issue.

Topic	Illustrative issue
personal experience learning QR and entering the field	what can be extrapolated from our own experience learning to do QR
the politics of teaching "against the grain"	teaching QR from a marginalized position where the randomized clinical trial is the gold standard
the centrality of social theory to QR	challenges of teaching in highly applied research settings to students with limited backgrounds in social science and different notions of theory
course design and syllabi	adapting to mixed backgrounds; meeting calls for profession-centered relevance; introductory vs. advanced curricula
supervision and thesis committees	working within models designed for conventional health science research; being the "qualitative" person on committees
apprenticeship, mentoring, and professional development	beyond the classroom and thesis supervision; what else is needed to train a qualitative researcher; teaching survival skills
multidisciplinary settings	communicating across diverse disciplinary and professional boundaries; hierarchies of legitimacy; lack of shared language
the critical dimension of QR	how to teach and deal with the implications for students and other faculty
judgment and ethics	beyond consent forms; practical constraints for in-class applied learning

Table 1: Core Topics of Workshop Discussions [9]

Capturing and representing the core matters discussed between 23 people over the course of two days is no simple matter. As participant-observers (in the true sense of the term) we identified a number of undercurrents that ran through the workshop discussions. Although we ground our account in the actual proceedings of the workshop, and draw heavily on the well of ideas generated by participants, this analysis reflects our own selective interpretations and insights. Most of these issues, of course, are as germane to the *practice* of QR as to the *teaching* of QR. Indeed, the challenges of practicing qualitative research in health settings surfaced continually throughout the discussions. The focus here is on the teaching dimensions of these core issues. Throughout we emphasize the context in which the teaching of QR takes place, particularly on the structural and institutional conditions that set the terms of teaching practice. [10]

4. Broad Definition and Sites of Teaching

The notion of "teaching" adopted for the workshop incorporated locales and situations far beyond classrooms and thesis committees. Teaching and mentoring occurs with students, colleagues, research employees, research teams, and the research community more generally. Recognition of the multiple sites of education and training, and of their common and distinctive pedagogical demands, is an important step in exploring where and how teaching and learning occurs, identifying their unique problems and demands, and locating potential solutions and opportunities. [11]

5. International Comparative Perspective

A comparative approach is as useful to apprehending and meeting the challenges of qualitative research teaching as it is to qualitative analysis generally. The workshop suggested that the challenges of teaching QR (at least those identified at the workshop) resonate with experience outside of Canada. Some problems (e.g. the paucity of teaching materials, methodological expertise, and like-minded peers) vary between countries; others (e.g. those related to scientific skepticism and the struggle for legitimacy) are widely and similarly encountered and responded to. Location at the periphery of the research community and deeply held commitment and passion for the approach leads teachers to find their work simultaneously frustrating and energizing. Marginality imposes extraordinary demands on teachers (e.g. the ability to articulate methodological issues in comparative and philosophical terms, to defend the methodology without being defensive or offensive), but it also calls for flexibility and imagination that can bring great vigor to the teaching process. [12]

6. The Scientific Positioning of QR

The teaching of QR reflects the broader challenges of doing QR in the health science domain. Many of the teaching issues thus relate to preparing students to survive in a world of applied qualitative health research that is in many respects inimical to the requirements of well done qualitative inquiry. For example, QR teaching is affected by an external scientific environment that generally favors

numerical forms of knowing and marginalizes unconventional forms of research. This context can promote a misleading dichotomization of research on a qualitative-quantitative dimension and unproductive mixed-method teaching. It may also encourage a misguided sense of superiority on the part of qualitative researchers and an inability to appreciate the pedagogic value of conflicting perspectives. [13]

Thus, students must be taught not only the theoretical and methodological foundations of QR but also the position of QR in the dominant contemporary research establishment and the "tricks of the trade" for succeeding in such a context. [14]

7. Restructuring of Health Research

Qualitative health research is being introduced into research training curricula at a time of considerable restructuring of university-based research in Canada. Of note is the trend within health research towards the more active involvement in research content on the part of the government and other research funding agencies. This has a number of implications for teaching QR. First, it has tended to bring pressure on university-based academic research to meet applied ends, including specific administrative, policy, and practice concerns. This can pre-determine research questions in ways that do not always correspond easily with the more open forms of qualitative inquiry. [15]

This in turn raises questions about how QR should be taught. Workshop participants noted that training for rapid policy-centered research is quite different from training for theoretically-informed interpretive inquiry. Funding relations that tie research to formal, extramurally-sponsored research projects can promote the reification of a concept of research that has increasingly less in common with the blurred boundaries of research and non-research that characterizes traditional qualitative field work. Coupled with other developments, such as those related to the ethical governance of research, this context can narrow the craft of research and drive, shape, and potentially restrict pedagogy in QR. [16]

In Canada and elsewhere there is also currently a strong shift towards multi- and transdisciplinary research in the health field. Research is considered more satisfactory and cutting edge if it brings together perspectives and methodologies from different knowledge domains. Although there is much discussion elsewhere of the practical research implications of multidisciplinarity (e.g. GIACOMINI 2004), at the workshop the significant point was that expectations of multidisciplinarity, and the corresponding emergence of cross disciplinary research teams, have significant implications for the teaching of QR. One concern is how to balance depth in training through disciplinary teaching with training for intellectual breadth across disciplines. A further challenge is how to teach qualitative method to students with extremely diverse epistemological and methodological backgrounds, and, most importantly, how to capitalize on the potential inherent in transdisciplinary thinking without compromising the primary potential of QR. [17]

The restructuring of health research also affects the teaching of QR through the emergence of a discourse on research ethics focused on individual protection of research participants. The structures in place for ensuring ethical research include local university ethics boards with increasingly standardized procedures within, some would argue, increasingly narrow frames of reference. The teaching challenge here is how to teach students to respect the ethics requirements of these boards while also opening up space for critical thought on ethics and for discussion of the broader, contingent nature of the ethical in research (e.g. ethical considerations beyond the micropolitics of the interview, such as in fieldwork, or at the broader political level). It is also true that in at least some cases, student projects based in ethnographic observation are placed at risk by ethics review procedures, raising serious concerns about the possibility of basic training in certain traditions of qualitative research under current ethics review arrangements. [18]

8. Changes in the University Environment

In Canada, QR in the health sciences is being introduced at a time of constriction in general university resources. One important consequence of this is growing pressure to graduate students with increasingly shorter periods of training. This has numerous implications for teaching QR, including the fact that students (especially those with little social science background) have insufficient time to gain depth in disciplinary theory and substance, and are driven at least in part by financial dependence. For example, students may not take the "risk" of lower grades (and potential loss of funding) by taking courses in unfamiliar territory. Or, there may be systemic barriers to encouraging cross disciplinary exploration (e.g. unavailability of pass-fail options to counteract student funding dependency on top grades). Limited time and curricular choice can lead to a tendency to homogenize, standardize, and simplify QR, and compound the already existing challenges of building qualitative expertise and sophistication from "scratch" at the graduate studies level. [19]

The teaching of QR is also affected by the relatively low value accorded to teaching as opposed to research in the health sciences (at least in research-intensive universities). This is particularly problematic for junior faculty who carry much of the QR teaching load in health science departments. Teaching QR, including sitting on thesis committees and supervision, can be very time-consuming, and compound the challenges facing junior faculty pursuing tenure and other forms of career advancement in the health sciences. This situation, combined with a research training culture framed by the demands of the bio-medical sciences, points to the need to find ways to incorporate teaching into the faculty member's own research projects via apprenticeship forms of training. [20]

9. Teaching QR as Bridge Building

Teaching qualitative research in the health sciences involves various forms of bridge building and translation between research traditions. QR is internally varied and bounded by organizing principles quite different from those of prevailing health science cultures and conventions. It is very difficult for QR teachers, using a social science and qualitative research vocabulary, to speak comprehensibly to students whose first language and culture is epidemiological, biomedical, or clinical. The process of exposing these particular students to alternative ways of knowing, involves constant work of translation from a technical vocabulary for analysis to one that understands analysis as a complex, interpretive social process. [21]

Speaking across differences while also recognizing points of commonality is an ongoing challenge in this form of teaching. There is a need to find ways to teach qualitative research methodology on its own terms, rather than in ways that continually reinsert a simplistic comparison with positivist, quantitative approaches. There is a danger of over-homogenizing qualitative research in ways that don't speak to its internal variations. Further, bridge building can also invite an overly standardized version of the methodology in response to the students' (and teachers') search for *terra firma* and legitimation (e.g. the widespread use of "grounded theory" as an all-purpose methodological lexicon). In multidisciplinary settings where there is wide variation in the backgrounds and core competencies of students and insufficient resources to permit multiple courses at different levels of sophistication, there is a tendency to teach to the lowest common denominator. [22]

The bridge building dimension of teaching QR goes well beyond translating the qualitative approach to students; it also includes the constant necessity to represent this form of research coherently and convincingly to colleagues, committee members, research associates, community research partners, and funders. Not only must teachers have the capacity to do this effectively themselves, but they must also be able to teach students the critical skill of articulating the logic and method of QR succinctly, and convincingly. Bridge building demands a sharp and accessible vocabulary that does justice to the methodology while at the same time being comprehensible and convincing to those with varying disciplinary and professional backgrounds and standards of judgment. [23]

10. Social Theory as Foundation and as Method

One of the biggest challenges to bridge building relates to that of teaching social theory within an institutional and scientific context that tends to separate methodology from theory. In the health sciences, QR is perceived primarily as a different set of methods, a different set of tools and procedures for collecting and analyzing data. The centrality and role of social science theory in all aspects of QR—specifically the notion of social theory as a method for understanding health-related phenomena—is not widely understood within the health sciences. Further, many of the students seeking training in qualitative methods come from

professional backgrounds and have limited if any exposure to social science theory. [24]

Solid grounding in social theory is a huge part of what makes for good qualitative research. Our exemplars of highest quality research tend to be ones that make innovative and creative use of theoretical perspectives, especially in relation to the social and psychological dimensions of health and health care where QR is purported to be most relevant. The challenge for teachers is how to teach students to recognize and understand what theory is, what it is for, how it is connected to methodology, what its possibilities are for framing health issues, and how and when it can be used most effectively. [25]

A number of ways to teach social theory in health sciences curricula were discussed at the workshop. One approach mentioned by several attendees at the workshop was to integrate theory into methodological teaching by teaching issues of epistemology and/or introducing a variety of paradigms and inquiry traditions in QR as a way to explore different approaches to data collection and analysis. A second approach is to teach particular traditions of inquiry in depth, so that students acquire a comprehensive sense of what it means to do research from a particular theoretical place, and appreciate the complexity of theory in relation to research practice. Both approaches, however, require ways to be found for health science students to get exposed to social theory outside of their own departments, which comes with its own set of institutional and administrative challenges (i.e. cross departmental teaching arrangements, integrated curricula). [26]

Further practical complications to teaching social theory and qualitative methodology surfaced during the workshop. Some examples include the challenges of getting students to unlearn existing understandings of social theory (e.g. theory considered as a particular substantive model of behavior rather than as an underlying set of philosophical assumptions); the condensation of graduate programs (which results in little time for developing sophistication in social theory); the challenges of teaching students with widely divergent theoretical backgrounds; the tendency for students to take up theory merely as legitimizing labels. All of these challenges can limit students' ability to integrate theory into research and method, and can make their use of theory in QR artificial and heavy-handed. [27]

The teaching of theory in QR needs its own dose of reflexivity. Too great an emphasis on the theorization of data can, according to some, function to restrict QR only to academics with formal theoretical training, or preclude value being attached to community-based or practitioner-centered research, or impede multidisciplinary team research. In other words, coupling methodology too tightly with social theory can cut QR off from the research environment in which it is located. [28]

Although historically QR has been taught in the health sciences by those trained in distinct disciplinary traditions (e.g. sociology, anthropology), it is likely that QR will increasingly be taught by graduates of health sciences programs, whose

knowledge of the social sciences is derivative rather than primary. This will have implications for teachers' access to (and capacity to teach) social theory themselves. [29]

11. The Disruptive Dimension of QR

Teaching QR in the health sciences involves teaching against the grain and produces tension. Because it does not adhere to conventional scientific practice, and because it often has a critical component built into it, QR can be disruptive of the established training and epistemological assumptions of epidemiology and health sciences programs within which it is taught. Colleagues may feel uncomfortable with the implicit challenge to established research orthodoxies. Further, and often more significant, qualitative approaches can seriously challenge students' assumptions and ways of thinking. Some students feel betrayed by the limitations of their prior training; others feel excited and energized by the prospects of new forms of knowledge that speak to dissonances they have experienced in their professional work. [30]

The disruptive capacity of QR can be demanding and difficult for those who teach it. Much time and energy has to be focused on educating colleagues and on opening up suitable spaces within established health science curricula for the proper teaching of QR. Humane and productive ways must be found to prompt students to question their existing epistemological assumptions, and to embrace new approaches to conceiving scientific inquiry. The pedagogical challenge under these circumstances is how to recognize, tap into and draw on the malaise, frustration and discomfort of students without alienating them or pushing them too far. Effective ways must be found to build constructive reflexivity into the curriculum. However, all of this requires skill, sensitivity, effort and time beyond the usual demands of teaching methodology. [31]

The potential for disruption inherent in teaching QR has implications beyond what is required to manage it effectively and to put it to productive use. There are, for example, ethical issues related to the pedagogic value of unsettling and the obligations of teachers to deal with the emotional fallout of unsettling (e.g. How far should students be pushed to question their deeply held epistemological commitments? How are teachers to provide emotional reassurance to anxious students?). Such "emotion work" is hidden teaching labor, with a gender subtext, that is not generally acknowledged as a significant aspect of teaching in the health sciences. [32]

A further implication of the disruptive dimension of teaching is the disjunction between the critical dimension of QR and traditional forms of teaching evaluation. The effects of teaching may be of longer term than can be recognized within the evaluative period of a course, or may not be immediately appreciated by students. Although being dislodged is seldom explicitly part of what students seek from a course, course evaluation items are often built around the notion of the extent to which pre-existing expectations are met, rather than violated. This may

put QR teachers at a disadvantage in terms of student evaluation and deprive them of appropriate teaching feedback and sense of reward. [33]

Because interest in QR is still growing, much university teaching is done by junior faculty members. Those who are in the early stages of their careers may find the disruptive dimensions of QR difficult to handle, especially in their relations with other faculty. Where they exist together in the same department, there is a role for more senior faculty to assist and support junior colleagues as they learn to navigate these tricky waters. [34]

12. QR in the Health Professions

Teaching QR to students trained in the health professions (rather than in established disciplines in the social sciences) presents particular challenges. Students bring with them general orientations from their clinical health care training and work environments, and tend to be oriented more to applied rather than theoretically-informed research. Although some aspects of clinical practice are consonant with the skills and orientation required of QR (e.g. some qualitative interviewing skills), others may not be (e.g. therapeutic stance, adherence to normative practice models) and may have to be circumvented or otherwise reconciled with the rather different purposes of research. The critical aspect of QR can sometimes be at odds with entrenched professional beliefs and practices, and may be particularly problematic in current times when new health professions are seeking entry to and legitimacy within the health research field. [35]

The diverse professional locations and backgrounds of students have other teaching implications, including the challenge of responding to students' demands for clinically relevant and occupation-specific teaching materials. Not surprisingly, students prefer learning with literature and examples that reflect their professional experiences. However, studies of direct relevance to particular professions, especially in those fields with no fully developed research traditions, can be poor exemplars or misleading, and QR instructors struggle to balance relevance with quality. [36]

13. Thesis Supervision

Supervision of thesis work, either as primary supervisor or as a member of a thesis committee, is as challenging as formal in-class teaching, though in different ways. The styles of supervision that are typical in social science settings are quite different from those in faculties of medicine and health sciences departments. The natural/clinical science model is one in which a faculty member/teacher is the principal investigator (PI) on a large grant that produces employment opportunities for graduate students as well as projects for their thesis work. The students' interest or thesis work is often subordinate to the overall PI's research project, and their thesis is a subset of a broader project led by the teacher/PI. In the social sciences, and with qualitative research, the research culture is one of students selecting their own topics, albeit within the general substantive and methodological reach of the supervisor. This makes for a

very different organization of work and relationship between supervisor and student (employment and training relations are less blurred than in the natural/clinical science model), and for differences across the research process (e.g. independent conceptualization of the research problem, the generation of original, student-collected data, intellectual ownership and authorship). At the workshop it was widely acknowledged that supervising qualitative theses is extremely time consuming and demanding work, but that it is rarely reflected in the allocation of teaching loads. [37]

In the health sciences, supervisors frequently find themselves heading committees of individuals with quite varied knowledge of and experience with QR. In these cases teaching goes beyond the challenges of teaching students and includes the need to instruct/educate other faculty members (often their superiors, in the case of junior faculty) on supervisory committees, and in other situations in which their students' work is being appraised. In situations where students are pursuing qualitative research as a component of a mixed method thesis, or as a stand-alone qualitative study in a situation in which the supervisor is not a qualitative methodologist, faculty are sometimes brought onto a committee as a methodologist, often late in the study, only to discover that the student is lost and has only a surface grasp of qualitative methodology. The entire committee sometimes has little interest in the qualitative component, or the qualitative committee member is seen as the solution to the methodological gap between student and supervisor. Where the supervisor has no real knowledge of qualitative research, the qualitative expert can find himself or herself playing the role of de facto supervisor, but without any credit. Such ancillary supervision can be extremely difficult to achieve, is sometimes shrouded in conflict, can be costly to the careers of junior faculty, and can be damaging to the student. [38]

14. Assessing Quality

Many concerns regarding supervision are linked to the question of standards of quality and how they are to be determined. Although there are standards for thesis work in particular disciplines, there is a less clear articulation of standards for evaluating qualitative health sciences theses. Since individual faculty members are generally exposed to only a small number of qualitative theses, they tend to lack a shared sense of what constitutes acceptable quality. Theses vary greatly in level of theoretical and methodological sophistication and are very diverse in terms of substantive content. QR teachers report how difficult it is handle weak research, particularly since the fundamental weakness often only becomes apparent in the later stages of research (i.e. in the analytic and writing stages). Slavish adherence to methodological criteria, inappropriate use of theoretical nomenclature without recourse to deeper philosophical underpinnings of a particular tradition of inquiry, and insufficient/ineffective writing are common problems that are difficult to manage as supervisors and committee members. Workshop participants perceived a need for dialogue to develop a common sense of judgment despite the complexity of QR and the absence of standardized prescriptions. At the same time there was some fear that pressing for higher standards of teaching and research could have unintended negative

consequences for QR in health sciences departments where QR is marginalized or where resources to support QR are minimal. [39]

15. Mutual Support

Qualitative teachers in health faculties are typically few in number, and are often isolated from others with similar teaching experience and responsibility. In normal daily academic life there is little time to reflect on issues of teaching, and even less opportunity to connect with others with similar experiences in similar institutional locations. The workshop tapped into a clear need for more dialogue and mutual self-help. At the workshop, the opportunity to be together and to talk frankly with others in similar situations brought out a certain amount of commonly experienced emotion, frustration, and strain. Some of the sense of struggle was eased by the recognition of the structural origins of problems, by a new sense of peer group and shared commitments, and just the chance to make private grievance public. International perspectives on the challenges of teaching QR extended the sense of community beyond the Canadian context and further de-personalized the troubles inherent in teaching QR in the health sciences. [40]

16. Teaching Against the Grain

The workshop brought out the nature of the challenges associated with teaching against the grain of conventional health science. The risks of such pedagogy—for teaching faculty as well as for students—are important to recognize for them to be collectively and individually avoided, minimized, or mitigated. However, the workshop also reminded participants of the rewards of teaching critical, reflexive, theoretically informed research, and of enabling others to participate in a form of research that produces deep understanding and constant marvel. As such, the workshop functioned to reaffirm commitment to QR and to re-energize efforts to promote its potential as source of understanding in the health field and to build capacity for teaching it in Canada and elsewhere. [41]

17. Leadership in the Teaching of QR

There was agreement at the workshop that the education and training of first-class qualitative researchers are critical to the capacity of qualitative research to live up to the emerging aspirations and expectations to which it is held within the health research field. The workshop was a singular event, certainly in Canada if not also internationally. The workshop participants agreed that extension of this effort is important and interest was expressed in the need for leadership in this area. Convening QR teachers again, and in other settings (e.g. at international conferences) was suggested, as well as the need to begin to publish in this area. It was suggested that student involvement should be extended and deepened in any future endeavors. [42]

Although the observations made in this essay are focused on the specific challenges of teaching QR in the health field, it is likely that much of what was raised in this workshop is relevant to the teaching of qualitative research in any

context, and that, indeed, broadening the conversation would be a productive development for all who are interested in the pedagogy of qualitative research. [43]

Appendix 1: Workshop Funders

Canadian Institutes of Health Research (CIHR)

Institute of Health Services and Policy Research

Institute of Population and Public Health

Strategic Research & Training Program, Health Care Technology and Place

Department of Community Health and Epidemiology, Dalhousie University

Department of Public Health Sciences, University of Toronto

Nova Scotia Health Research Foundation

St Michael's Hospital Inner City Health Unit, Toronto

Appendix 2: Workshop Participants

Sharon Batt, PhD student, Department of Bioethics, Dalhousie University

Natalie Beausoleil, Division of Community Health, Faculty of Medicine, Memorial University of Newfoundland

Brenda Beagan, School of Occupational Therapy, Sociology & Social Anthropology, Dalhousie University

Rosaline Barbour, Chair of Health & Social Care, School of Nursing & Midwifery, University of Dundee

Karen Black, Pediatrician, Isaac Walton Killam Health Sciences Centre, and MSc student, Department of Community Health and Epidemiology, Dalhousie University

Marie Campbell, Professor Emerita, Studies in Policy and Practice, Faculty of Human and Social Development, University of Victoria

Franco Carnevale, Associate Professor, School of Nursing and Faculty of Medicine, McGill University

Joan Eakin, Professor, Department of Public Health Sciences, Faculty of Medicine, University of Toronto

Marcia Facey, PhD student, Department of Public Health Sciences, University of Toronto

Arthur Frank, Professor, Department of Sociology, University of Calgary

Denise Gastaldo, Associate Professor, Faculty of Nursing & Centre for International Health, University of Toronto

Sylvie Gendron, Professeure Adjointe, Faculté des Sciences Infirmières, Université de Montréal

Nancy Halifax, Postdoctoral Fellow, University of Toronto

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