

# Medical Practice and Reviews

Volume 5 Number 1 February 2014

ISSN 2141-2596



*Academic  
Journals*

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Pitout JDD, Church DL, Gregson DB, Chow BL, McCracken M, Mulvey M, Laupland KB (2007). Molecular epidemiology of CTXM-producing *Escherichia coli* in the Calgary Health Region: emergence of CTX-M-15-producing isolates. *Antimicrob. Agents Chemother.* 51: 1281-1286.

Pelczar JR, Harley JP, Klein DA (1993). *Microbiology: Concepts and Applications.* McGraw-Hill Inc., New York, pp. 591-603.

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*Full Length Research Paper*

## **Anal melanomas: The sun does not shine on this mucosa**

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Received 5 July, 2013; Accepted 21 August, 2013

**Cutaneous melanomas are rare in the Indian population and mucosal and anorectal lesions are seen but very occasionally. They often masquerade as hemorrhoids leading to delay in diagnosis. This was a retrospective study done in Sri Ramachandra University, where hospital records were perused to record all cases of anal melanomas. Abdomino-perineal resection and wide local excision offer equal survival rates. Novel targeted therapy represents the cutting edge of therapy today.**

**Key words:** Anorectal, malignant melanoma, surgical treatment.

### **INTRODUCTION**

Anal melanomas are uncommon malignancies which account for less than 1% of all melanomas. The anal region is the third most common location for malignant melanomas after the skin and the eye. There are very few meta analyses available given the small number of patients seen. The presence of receptors on melanoma cells is promising as it paves the way for targeted therapy. This study presents small series and review treatment options available for this tumor.

The aim of this study was to look at the presentation of anal melanomas at our institution, analyse the treatment options and review literature.

### **PATIENTS AND METHODS**

This was a retrospective study done in Sri Ramachandra Medical College and Hospital, Sri Ramachandra University, Chennai, India between January 2005 and 2011. Case records, operative registers and histopathology files were perused, data were collected and analyzed.

### **Demographics**

A total of 21 patients constituted the melanoma study population of over a 6 year period. There were 12 male and 9 female patients. There were 10 patients with anal melanomas (8 male and 2 female patients). There was maximum clustering in the 8th decade of life closely followed by the 6th decade (Figure 1).

The patients with anal melanomas present with complaints of bleeding per rectum and were initially thought to be hemorrhoids on primary survey. Digital and proctoscopic examination showed polypoidal or ulcerated lesions on palpation and there was surrounding induration. The lesions were found at the anal verge and up to 3 cm proximally (Figure 2). Six patients had associated pruritus and 2 patients had inguinal lymphadenopathy at presentation. One patient also complained of mucoid blood tinged discharge. Sixty four percent of the patients present with alteration in defaecation, not amounting to constipation.

The patients had a visible black brownish lesion on proctoscopic examination, which on punch biopsy was confirmative for malignant melanoma. Computerized tomography showed the lesion with surrounding edema. Metastatic workup showed extension to the liver, lungs and brain in 2 patients. Histology showed anal glands with clusters of malignant cells with pleomorphic nuclei and

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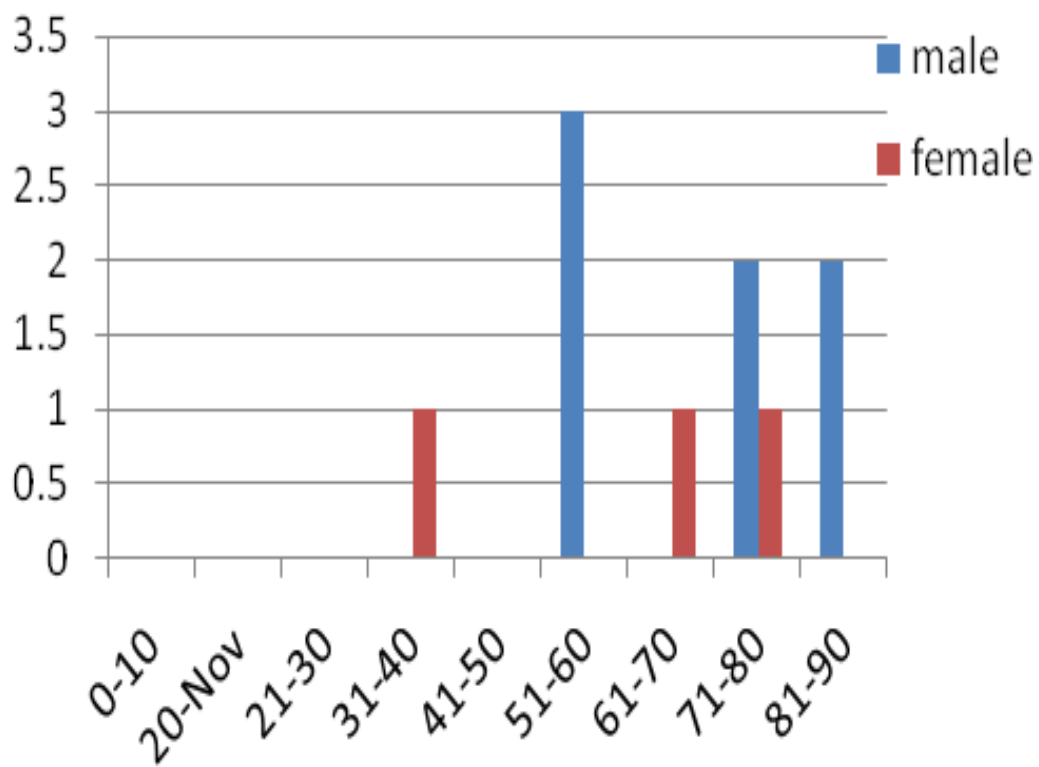
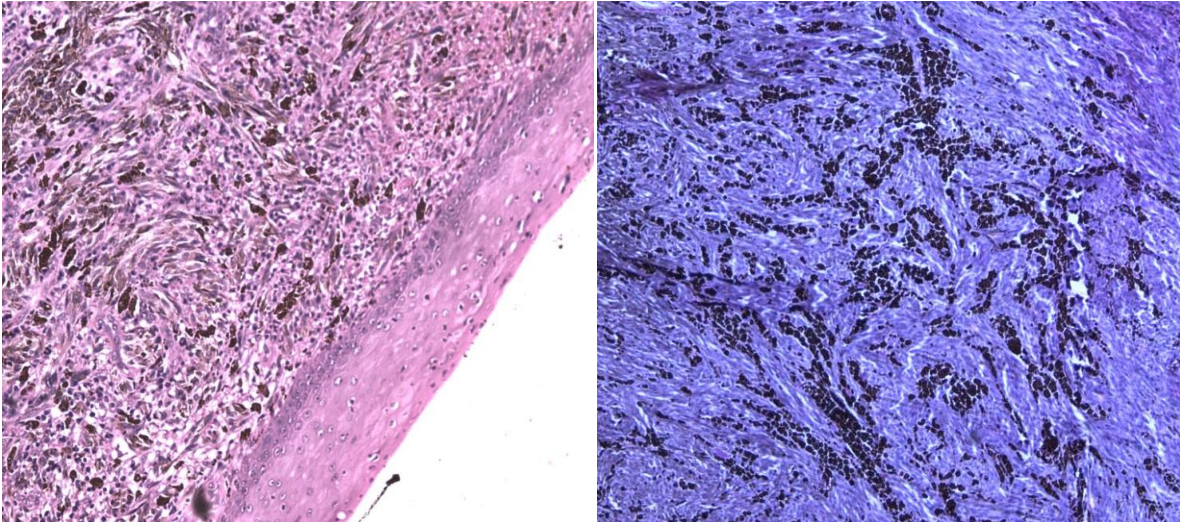


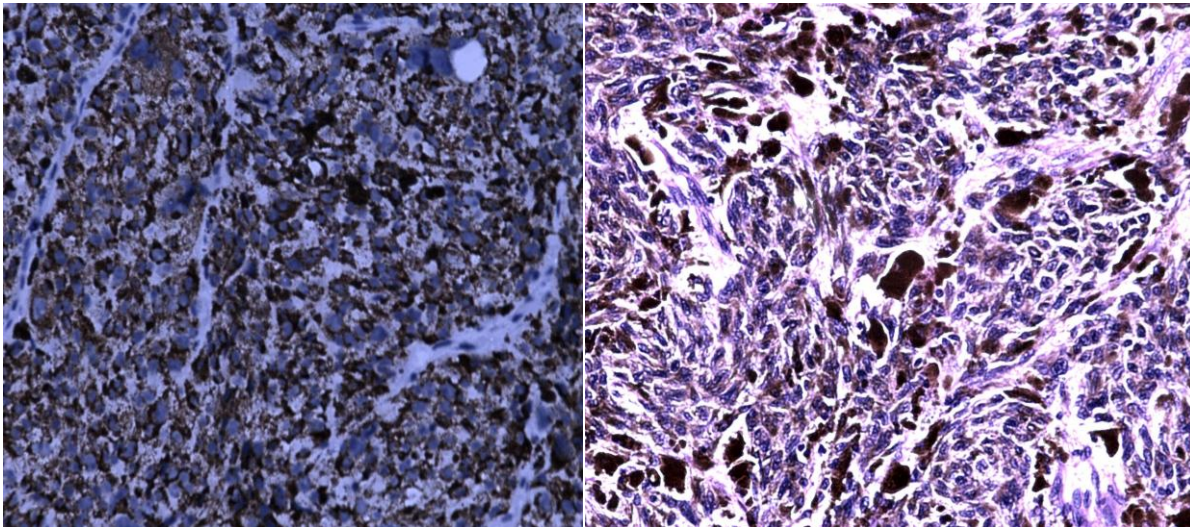
Figure 1. Age and gender demographics.



Figure 2. The anal melanoma prolapsing thro the anal verge.



**Figure 3.** Anal glands with clusters of malignant cells with melanin pigment.



**Figure 3.** The IHC positivity for HMB 45.

abundant melanin pigment (Figure 3). The immunohistochemistry when done was positive for HMB 45, the melanosome protein (Figure 4).

**Treatment**

The 2 patients with metastases were referred for palliative chemotherapy. Of the remaining 8 patients with anal melanoma 6 patients underwent abdomino perineal resection (APR) and four patients underwent wide local excision (WLE). All patients received post operative chemotherapy with cisplatin, vinblastine and dacarbazine. The patients who received palliative chemotherapy for metastatic disease died within two months. Of the 8 patients who underwent operative treatment, 3 were lost to follow up. Of the

remaining 5 patients, 4 were dead at twelve months (3 of the APR group and 1 who underwent WLE). The lone patient survived for fourteen months and had undergone APR.

**RESULTS AND DISCUSSION**

Anal melanomas were described by Moore (1857) and account for 3 to 5% of all large bowel malignancies. The incidence is less than 1% and is higher in males, in black men and increases with age. Squamous cell carcinoma is the most common anal malignancy and is followed by cloacogenic malignancies. Melanomas in the anal canal

arise from the melanocytes which occur in the squamous mucosa distal to the dentate line. The lesions can be in the rectum, anal canal or both with majority arising from the dentate line. They tend to spread sub mucosally and by the time they cause symptoms, they are often beyond surgical cure. Rectal melanomas account for less than 3% of all melanomas and are more common in females as compared to males (McLaughlin et al., 2005; Wanebo et al., 1981; Ramakrishnan et al., 2008). Once a rectal mass is noted, pigmentation is a clue for diagnosis of melanoma; however, macroscopic pigmentation is not always present.

The patients present with bleeding, diarrhea, tenesmus and severe pain on defaecation (Wanebo et al., 1981; Ramakrishnan et al., 2008). The black brown ulceroproliferative tumor is often visible and is always palpable as a nodule or induration, without or with inguinal lymphadenopathy (20%). The differential diagnosis includes thrombosed pile mass, prolapsing polyp or rectal carcinoma. The porto-systemic anastomosis of this area makes it possible for metastases (38%) to the liver, lung, brain, bone and other organs. Digital examination provides information about size, fixation, and ulceration of the lesion. Endoluminal ultrasound evaluates the tumor thickness and nodal status. Biopsy is confirmative in all patients and amelanotic melanomas also occur. Singluff classification grades anorectal melanomas as stage 1 (localized tumor), stage 2 (regional node metastasis) and stage 3 (distant metastasis).

There are often occult metastases at diagnosis and patients continue to die as late as 11 years after diagnosis and therapy. The survival depends on the staging and is not dependent on the surgical radicality. Historically, there was great enthusiasm for APR along with bilateral prophylactic groin dissection and sometimes even pelvic exenteration. However, long survivals were noted even after wide local excision and no difference in survival was noted when the tumors were compared by similar stages. Thibault et al. (1997) showed a survival rate of 22% at five years with APR while WLE showed a five year survival of 16%. Other series have showed no survival benefit between APR 19% and WLE 18%. WLE has less morbidity than APR and avoids a colostomy. Bullard et al. (2003) showed that in a series of 15 patients, there was no difference in local recurrence, systemic recurrence, disease free survival or overall survival between the APR group and the WLE group. Zhang et al. (2010) showed a higher local recurrence with APR versus WLE even though there was no survival advantage. It is important to give three dimensional clear margins in WLE which is possible in small tumors and lesions which are polypoidal. Large tumors are better managed with an APR even though it necessitates a colostomy. The presence of perineural invasion is an important prognostic factor (Ueno et al., 2001). Ballo et al. (2002) demonstrated that adjuvant

radiation controls loco regional disease after WLE.

Adjuvant and neoadjuvant radiotherapy also improves loco regional control, even though it was not offered in any of our patients. Chemotherapy with interferon, interleukin 2, cisplatin, vinblastine, and dacarbazine is effective in the adjuvant setting (Brady et al., 1995). However, no randomized controlled trial data is available given the rarity of these lesions. There is a report of disappearance of liver metastases in a patient with combination dacarbazine, adriamycin and vincristine (Sasaki et al., 2010).

Genetic alterations are found within the receptor tyrosine kinase signaling pathways in cutaneous melanomas, and include *BRAF* point mutation, *NRAS* point mutation, *KIT* point mutations, *EGFR* amplification, *PTEN* gene deletion, *AKT* point mutation and *EGFR* 2 mutations (Curtin et al., 2005). *BRAF* mutations documented in 59% of cutaneous melanomas are seen in 3% of mucosal melanomas. Sorafenib is a bis-aryl urea with potent activity against *BRAF*. Sorafenib inhibits VEGF, PDGFR  $\beta$  and *KIT*. Targeted therapy promises to be the way ahead.

## Conclusion

Anorectal melanomas represent both a diagnostic and therapeutic challenge because of its nonspecific presentation and rarity. Immunocytochemical studies that aid diagnosis includes S 100, HMB 45, microphthalmia associated transcription factor (Mitf), tyrosinase, and Melan A (MART 1). Five years survival is as low as 20% in anorectal melanomas, the possible reasons being delay in diagnosis, inherent aggressiveness of tumor biology and early dissemination of the disease as a result of close contact with the rich lymphovascular supply of the underlying anorectal mucosa.

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*Review*

# Resolving the qualitative-quantitative debate in healthcare research

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Received 20 November, 2013; Accepted 11 February, 2014

**This article was set out to examine the allegations labeled against qualitative research by quantitative researchers. The allegations were that: it is subjective, difficult to replicate in healthcare, and this amounts to little more than anecdote, personal impression or conjecture. In attempting to resolve the allegations, this article relied on extensive literature review and examined evidence that has been put forth in support of qualitative research approach in healthcare. The article also examined the benefits and pathologies of quantitative and qualitative approaches. It is revealed that although each of the two approaches has its own strengths and weaknesses, none can ably offer practical solutions to challenges of validity and reliability in healthcare research. To mitigate such challenges, the paper rests on the use of mixed methods/triangulation so as to neutralize pathologies inherent in each approach. It is recommended that the use of triangulation should be founded on the strong basis of pragmatism. Method integration should be done skillfully and cautiously, because validity and reliability of its findings may not be guaranteed due to its susceptibility to the ontological and epistemological positions of the researcher. The paper concludes that any attempt to resolve this debate creates even more discussions and finds this third paradigm inadequate in some research circumstances. This implies that the debate is far from over.**

**Key words:** Qualitative research, quantitative research, healthcare research, pragmatism, paradigm.

## INTRODUCTION

For decades, there has been a paradigm war between quantitative and qualitative researchers. Each category of researchers claims superiority over the other. Some quantitative researchers have even ridiculed qualitative researchers saying that real men do not collect soft data; and quantitative researchers have been branded number-crunchers (Miles and Huberman, 1994). Pope et al. (2000) also point out a serious criticism against qualitative researchers by the positivists who allege that qualitative data are subjective and that such research is difficult to replicate, and this amounts to little more than anecdote, personal impression or conjecture. However, throughout the paradigm debate, no side has attempted to provide proof in regard to how its research findings

have superseded the other in terms of utility. Perhaps, the failure to provide this proof may either signify a lack of conviction even within each paradigm, as to whether it enjoys monopoly in its contribution to human welfare or failure to embrace pragmatism.

This article examines such criticism in light of the philosophical underpinnings that have shaped the world view of researchers, and underscores pragmatism as a foundation upon which mixed methods approach can be built to strengthen research findings in healthcare.

## METHODOLOGY

The paper relies heavily on literature review in examining the

qualitative-quantitative debate in healthcare research. Literature review is the use of secondary data (Amin, 2004) to justify the particular approach to the topic, the selection of methods, and demonstration that this research contributes something new (Hart, 2001; Levy and Ellis, 2006). The review has been discovered to be reliable in conducting scientific research. Authors such as Randolph (2009) and Onwuegbuzie et al. (2012) have recently emphasized the importance of literature review and view it as the foundation and inspiration for substantial, useful research.

## **Definition of key concepts and phrases**

### ***Applied research in healthcare***

There are many definitions of research advanced in the early literature (Sarantakos, 1998; Babbie, 1998; Blaikie, 1991; Frankfort and Nachmias, 2003; Kerlinger, 2004). This paper relies on the recent definition given by Leedy and Ormrod (2005) who view research as an endeavor that scholars intentionally set out to enhance their understanding of a phenomenon and expect to communicate what they discover to the large scientific community. The definition links field research to practical solving of a problem. For example, a study on why patients prefer self medication as opposed to seeking medical advice should be driven by the desire to get practical solutions to the problem. Seeking pragmatic answers to a research problem is central to applied research.

### ***Evolution of qualitative research in healthcare***

Qualitative research involves the study of phenomena in their natural settings, attempting to make sense of, or to interpret phenomena in terms of the meanings people bring to them (Cresswell, 2003). For several millennia, historians and biographers have recorded the stories of human society using qualitative approaches (Caelli et al., 2003; Sherman and Strang, 2004). This is again supported by McDowell and MacLean (1998) who argue that qualitative data, in the form of words and observation, predated quantitative data in academic study. Such data were used in biology, history, law, and much later, in sociology and political science. However, in healthcare, qualitative research was introduced in the early 1970s (Rambaree, 2007; Cohen and Crabtree, 2008). This implies that although qualitative and quantitative researches were being mixed even in natural science research generally, and in healthcare in particular, natural scientists did not acknowledge it as important.

What is clear, however, is that the persistent acknowledgement of quantitative methods in research ignored the innumerable benefits of qualitative research in healthcare (Lloyd, 2003; Rambaree, 2007).

Consequently, researchers realized that whereas questions of 'what', 'how much' or 'how many,' were answered through quantitative inquiries, other important questions of 'how', 'why' and 'in what way' (Hancock, 2002; Karri and Colyar, 2009), remained unanswered.

Today, as Snider (2010) observes, it has been acknowledged that numbers impress, but unfortunately, also conceal far more than they reveal. Qualitative research is now regarded as a gold standard for quantitative work, because of its inherently more comprehensive approach and greater validity (Murphy et al., 1998; Shank and Villella, 2004).

### ***Qualitative research, its benefits and pathologies in healthcare***

Qualitative research is a broad term applying to a range of research approaches based on theoretical origins in anthropology, sociology,

philosophy, psychology and linguistics (Parker and Carballo, 1990; Yin, 2009; Moriarty, 2011). Currently, there are four major types, namely, phenomenology, ethnography, grounded theory and case study (Miles and Huberman, 1994; Hancock, 2002; Marshall, 1996). This may explain why it is a family of approaches (Drisko, 1997). The main aim of this research was to enable researchers to understand and represent the experiences and actions of people as they encounter, engage, and live through situations (Elliott et al., 1999).

There are numerous benefits of qualitative research which include using the participants' own categories of meaning to collect and interpret data (Bryman, 1992); useful for studying a limited number of cases in depth (Frankfort and Nachmias, 2003); conducting cross-case comparisons and analysis (Johnson and Onwuegbuzie, 2004); providing understanding and description of people's personal experiences of phenomena (Cohen and Crabtree, 2008); and being responsive to local situations, conditions, and stakeholders' needs (Brod et al., 2009).

Today, qualitative research has penetrated natural sciences traditionally dominated by quantitative researchers (Murphy et al., 1998; Nicholls, 2011). Qualitative research relies on transforming information from observations, reports and recordings into the written words rather than into numeric data (Denscombe, 1998; Broom, 2005). That is why the approach has been misunderstood by natural scientists to constitute a mere anecdote, conjecture and personal impression of the researcher.

The current quantitative-qualitative debate has not led to recognition of one best approach in conducting healthcare research (Borrego et al., 2009; Murphy et al., 1998). However, the debate has resulted into an analysis of benefits and pathologies of each approach, and underscores the use of triangulation. As will be seen later, several researchers have cautioned that triangulation through the use of mixed methods or multi-methods should not be seen as panacea. Here, examines the benefits and negative criticisms (pathologies) researchers have labeled against qualitative research in healthcare.

There are three major alleged pathologies against qualitative research in healthcare. First, the bulky nature of data collected and consequent loss of time in data analysis (Miles and Huberman, 1994); second, the allegation that qualitative research is subjective and depends on the researchers whims, personal impression, anecdote and conjecture, which affects reliability and validity of research findings (Pope et al., 2000); and third, the allegation of ethical concerns arising from the inevitable physical contact between the researchers and human subjects, and the disclosure of the participant's identity (Myers and Barnes, 2005).

**Analysis of the pathologies:** The first pathology might be unique to the qualitative researchers in healthcare. However, the bulky nature of qualitative data should be seen as a strong point, because such data is more informative, richer and offers a deeper understanding of the problem than quantitative data (Shamai, 2003; Shank and Villella, 2004; Tewksbury, 2009). This is because it allows the voice of participants to be heard (Scammell, 2010) which is fundamental in solving practical problems using applied research. Moreover, this discussion agrees with Miles and Huberman (1994) who assert that words, especially organized into incidents or stories, have a concrete, vivid, meaningful flavour that often proves far more convincing than pages of summarized numbers. It is unfair to condemn qualitative research on the basis of its bulky data; qualitative findings can be more meaningful with some quantitative explanations.

The last two pathologies cut across research approaches. It should be noted that even quantitative researchers make subjective decisions regarding which data analysis technique and interpretation model to use (Pansiri, 2005). Depending on the research question, quantitative researchers may interact with human subjects more often than qualitative researchers (Ercikan

and Roth, 2006). Moreover, meaning attached to phenomena is always in the mind of the perceiver. Interpretation of words or numbers is only possible through subjective thinking. This thinking may translate into objective conclusions no matter the research approach one employs.

**Some examples of qualitative research conducted in healthcare:** In the past, quality of healthcare was measured principally with reference to the norms set by the healthcare provider (Kramer et al., 1997) without patients' active participation. As such, diagnosis remained inadequate because decisions were made without the views of patients. There is empirical evidence to the effect that qualitative research has been conducted in healthcare with emphasis on patients' views on healthcare delivery and outcomes (Kramer et al., 1997). In addition, qualitative studies have also focussed on health services utilization (McVea et al., 1996; Michelene and Chi, 1997; Chi, 1998), and the experience of illness and people's perceptions of health, ill health, and evaluations of health services in relation to their appropriateness, effectiveness and costs (Bowling, 2002). Much of this qualitative research is conducted by medical practitioners such as Doctors, nurses, laboratory technologists and medical academicians. The following is the applied research that has been conducted.

Researchers, Bronstein and Morrisey (1990) conducted a qualitative research about the distances traveled for inpatient obstetrics care by women residing in rural Alabama in 1983 and 1988. Later in 2001, Janicke et al. (2001) conducted a qualitative study on the utilization of children's health care services. Around the same time, Fidler and Lambert (2001) conducted a study titled, 'A prescription for health: A primary care based intervention to maintain the non-smoking status of young people; and recently in 2009, Schwerdtfeger (2009), pursued a qualitative inquiry into the trauma-focused research procedures among pregnant participants. It is evident from the studies conducted so far, that qualitative studies conducted are applied in nature. However, in all these qualitative studies, it is apparent that qualitative enquiry has not stood alone; rather, its findings have been supported by quantitative research. It can be inferred that researchers are mixing the two approaches so as to produce more meaningful and acceptable findings.

The benefits of a qualitative approach in healthcare research are becoming increasingly recognized by both academics and clinicians (Marshall, 1996; Smith, 2003). Indeed many researchers including positivists and interpretivists (Howe and Eisenhart, 1990; Davis, 2007) agree that good qualitative research has equaled, if not exceeded, quantitative research in status, relevance, and methodological rigour due to the strict adherence to several principles. Yet, the use of integration of methodologies as advocated for by Cresswell (2003) cannot be ignored, and as discussed later in this paper. It is this multi-method integration that offsets likely weaknesses in both approaches.

#### **Quantitative research, its benefits and pathologies in healthcare**

Quantitative research is about collecting numerical data, making observations and measurements of the phenomena which can be subjected to statistical analysis, repeated and replicated by the same or other researchers under similar conditions (Hancock, 2002; Hamilton, 2003).

The ability of quantitative researchers to reduce data to numbers is seen as the major strong point of the quantitative approach in healthcare (Levin et al., 1997; Curry et al., 2006; Caldwell et al., 2005; Nicholls, 2011). Findings are more likely to be accepted if they are quantified (Greenhalgh and Taylor, 1997). This has been seen as the main source of objectivity and reliability of the quantitative research findings (Marshall, 1996; Castro et al., 2010).

If this is the case, one wonders why there is an increasing rate of barriers to the application of quantitative approach in biomedical research in clinical practice (Meyer, 2000).

Perhaps the reason is that while numbers can be used to summarize quantitative data, answering questions of 'why and how' of the data is not tenable using a quantitative approach (Britten, 1995; Hancock, 2002; Borrego et al., 2009). The inability of quantitative findings in healthcare research to answer these questions implies that numbers can mislead, because the full picture of the healthcare study is not revealed (Mahoney and Goertz, 2006). Take an example of studies in healthcare about patient's preference of medicinal local herbs as opposed to modern processed medicines. Findings from such a study summarized in numerical form may lack a pragmatic edification, because of the silence they exert on respondents feelings, explanations and recommendations.

This means that left on its own, quantitative research is insufficient in aiding the researcher to interpret quantitative data.

#### **PHILOSOPHICAL UNDERPINNINGS AS FOUNDATIONS FOR QUALITATIVE AND QUANTITATIVE RESEARCH IN HEALTHCARE**

In this section, three philosophical underpinnings, that is, ontology, epistemology and methodology as foundations of positivism and interpretivism/constructionism, the two paradigms (Figure 1) that categorize researchers are discussed. A discussion of terminologies and partial defence of interpretivism/constructionism is given in the proceeding discussion. The following questions have been resolved hereunder: What are the three philosophical underpinnings and how do they relate to positivism and interpretivism as research paradigms (Figure 1)? Which research paradigm prevails in healthcare research?

Ontology is the study of being/reality. It answers questions of meaning of reality and its nature (Taylor, 1959; Hamm, 1970; Fine, 1991). Ontology, relates to the nature of reality, that is, what things, if any, have existence or whether reality is the product of one's mind (Burrell and Morgan 1979). The researcher's view of reality is the corner stone to all other assumptions, that is, what is assumed here predicates the researcher's other assumptions. As applied to healthcare research, ontology is about the nature of reality that is worth investigation (Guba and Lincoln, 1994).

Epistemology is the study of knowledge and its basis (Hall, 1990; Hartmann and Lange, 2000). It is concerned with the nature, validity and limits of enquiry and also how possible, if it is, to gain knowledge of the world (Hughes and Sharrock, 1997). It is the foundation of true knowledge and is important in the creation of new knowledge, because it provides a means of understanding how researchers generate and acquire scientific knowledge (Ashatu, 2009). Epistemology enables qualitative researchers in healthcare to answer questions of what, how and why (Ashatu, 2009). These questions cannot be answered using positivism alone, yet, their importance is highly manifested in the impact of the generated answers on the beneficiary community. In the context of healthcare research, knowledge of epistemology enables the researcher to

Research approach in healthcare

Paradigms summarised

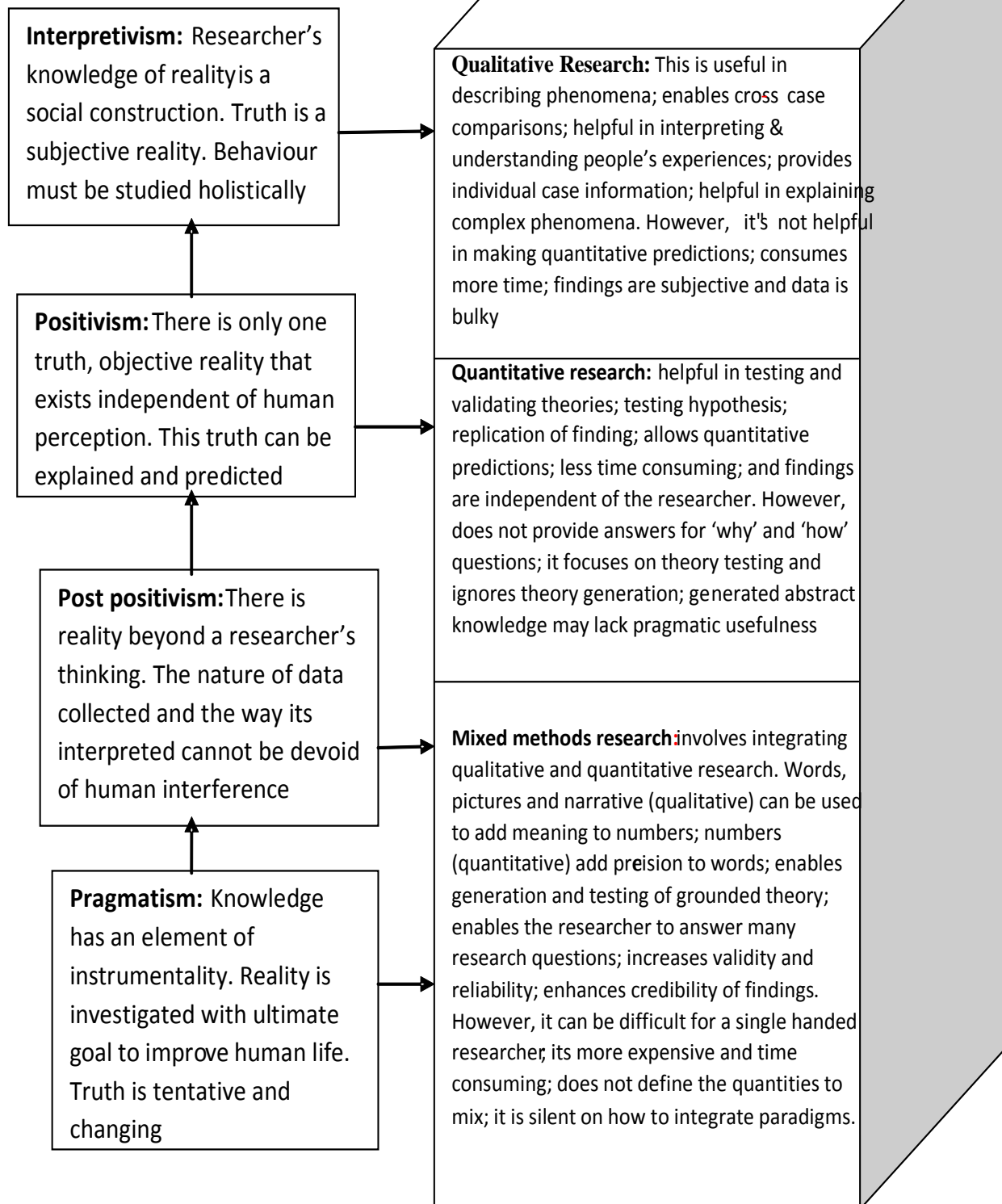


Figure 1. Summary of the relationship between paradigms and research approaches in healthcare.



epitomize various aspects of the phenomenon under investigation and then proceed to ascertain the kind of knowledge he/she intends to acquire about it.

Lastly, methodology is the application of various methods used in understanding reality and its nature (ontology) and various aspects of knowledge the researcher intends to gain about the reality (epistemology). The ontological and epistemological positions will dictate methodological perspectives the research will pursue.

### **Research paradigms in healthcare**

The term 'paradigm' has not only been over-used but also misused. It is common to hear young researchers use the term to refer to a simple idea or an object. To some people, it sounds nice and sophisticated to simply pronounce the term 'paradigm'. The following is the exploration of several definitions of the term advanced by scholars in research. The term paradigm has been defined as a set of basic beliefs that deal with principles (Guba and Lincoln, 1994). This definition is in tandem with one by Rubin and Rubin (2005) who define paradigm as a set of basic beliefs that deals with principles about the nature of the social world. Other scholars such as Gilgun (2005) and Ambert et al. (1995) refer to paradigms as epistemologies or methodological perspectives. The discussion makes use of the definition by Rubin and Rubin (2005) as it brings out, in concrete terms, the alignment between paradigms and the social world which is at the heart of healthcare research.

The philosophical underpinnings discussed earlier are the main tools of healthcare researchers. These researchers fall within two paradigms-positivism and interpretivism/constructionism (Pansiri, 2005).

Pragmatism as a third paradigm has been discussed in the context of mixed methods approach. This has been done deliberately, because pragmatism lays a strong basis for multi-methodology in healthcare research (Pansiri, 2005).

### **Rationale for interpretivism in healthcare research**

Scholars Walsham (1993) and Reed (2008) define interpretivism as description, which posits that interpretive methods of research start from the position that our knowledge of reality, including the domain of human action, is a social construction by human actors and that this applies equally to researchers (Thorne et al., 1997; Wing, 2003). Phenomena are not based on objective truth, but are socially constructed (Lee, 1992; Silverman, 2000, 2001; Moriarty, 2011). Its purpose is not to attempt to generalize data to the population, but to explore individuals' experiences (Vishnevsky and Beanlands, 2004). Which is why, the burden of proof as to whether qualitative data is transferable, lies on the reader of the

research findings and not the researcher (Deetz, 1996; Tobin and begley, 2004). Interpretive researchers attempt to understand the way others construct, conceptualize, and understand events, concepts, and categories, in part because these are assumed to influence individual behaviour (Kaplan and Duchon, 1988; Sale et al., 2002). However, beyond understanding of these events, concepts and categories, and how they impact on individual behaviour, there is nothing useful this paradigm brings. This paper fills the gap by rendering credence to pragmatism which advocates for the wellbeing of society as the ultimate goal of research.

Interpretivism is the father of qualitative research (Rambaree, 2007). According to Sandelowski and Barroso (2002), Ryan et al. (2007), and Roth and Mehta (2008) qualitative research does not regard truth as objective, but as a subjective reality that is experienced differently by each individual. This explains why qualitative researchers assume that human behavior is always bound to the context in which it occurs (Merriam, 2009; Scammell, 2010) and therefore, behaviour must be studied holistically rather than being manipulated (Perone and Tucker, 2003). Subjective meanings have to be attached to the scientific enquiry (Krefting, 1991), because reality is ultimately subjective (Broom and Wills, 2007). This being the case, one wonders as to whose interests these studies are being conducted. The question of what happens after behaviour has been studied holistically is not answered. This paper provides the answer in the discussion about pragmatism and its useful nature in healthcare research.

In spite of the praises poured onto interpretivism and its followers, quantitative researchers have undermined it arguing that it is biased, based on personal impression of the researcher and not sufficient in conducting healthcare research. The following section discusses the positivist position.

### **Application of positivism in healthcare research**

The positivist approach is modeled on the methods of the natural sciences with the goal of discovering social laws analogous to the natural laws uncovered by the methods of natural science (Roth and Mehta, 2008). Positivism assumes that truths can be explained and predicted; and its epistemological belief in objectivity is guided by the quantitative methodology (Wing, 2003; Rambaree, 2007; Moriarty, 2011).

The ontological position of positivists is that there is only one truth, an objective reality that exists independent of human perception. Hence, the researcher and phenomena are independent entities (Hischheim, 1985), and that all phenomena can be reduced to empirical indicators which represent the truth (Sale et al., 2002). This paper discusses two major healthcare issues in respect to the position held by positivists. First, positivists

create an impression that all diseases that affect human life exist and can be reduced to empirical analysis. This is the case because the paradigm contends that reality exists and is awaiting discovery by the researcher. Second, the positivist ontological position implies that the researcher and the nature of diseases being investigated are independent entities which are separable.

To start with, it may be recalled that there are diseases of the past recent disease. Research shows that there was no HIV/AIDS in the world not until early 1980s. This disputes positivist's stance that reality is there and awaits to be discovered. Whereas malaria can be found in many parts of Africa, you may not find Malaria in New Zealand or Britain. However, it cannot be absolutely certain that Malaria will not invade these countries some day, because truth is ever changing (Rorty, 1999; Kadlec, 2006). The claim by positivists about the absolute nature of truth leaves many unanswered questions.

Second, there are many examples to show that the researcher and phenomenon under investigation may interact before, during and after the study (Kuhn, 1962; Pansiri, 2005). A patient of an oncological illness may not avoid including his experiences in the study he/she conducts about people's perceptions of causes of this illnesses. This also applies to a cancer patient medical doctor investigating patient's response to a newly introduced cancer drug. A positivist refugee researcher of healthcare initiatives in a refugee camp may not bypass the environment he/she lives. This justifies the use of multi-methods so as to fill these gaps.

### **Which of the two paradigms ensures validity and reliability of findings in healthcare research?**

Although positivists have dismissed qualitative research as mere conjecture, anecdote, based on personal impression of the researcher and lacks replicability (Pope et al., 2000), there is evidence that neither interpretivism nor positivism offers panacea to challenges of validity and reliability of findings in healthcare research (Golafshani, 2003). Traditional challenges of ensuring validity and reliability have remained a puzzle amidst the use of any of the two paradigms. In order to ensure validity and reliability of research findings, researchers have developed the use of triangulation (Denzin, 1978) or mixed methods (Miles and Huberman, 1994; Krantz, 1995; Johnson et al., 2007; Borrego et al., 2009; Ihtantola and Kihn, 2011). Triangulation/Mixed methods are now recognized as the third research approach. It is claimed that triangulation ensures validity and reliability of research findings. This claim will be discussed subsequently.

### **Resolving the paradigm war**

After decades of qualitative-quantitative debate, scholars recognized that there is no single accepted method of

scientific inquiry (Krantz, 1995), and that lack of recognition of multi-interpretability of reality led to several problems in healthcare research (Lafaille, 1995). This has been the basis of triangulation of research paradigms and methods. Researchers who subscribe to this approach are known as post-positivists.

### **The case of pragmatism in healthcare research**

The preceding discussion has shed light on the interaction between qualitative and quantitative researchers. This interaction is lubricated by the philosophical backgrounds of each category of researchers. However, there are two unanswered questions. First, what should be the ultimate goal of researchers? And second, to what extent is the claim that truth/reality is out there and is independent of the researcher? The first question cuts across qualitative and quantitative research. The second question is specific to quantitative researchers. Pragmatism attempts to provide answers to these questions.

One of the popular proponents of pragmatism is John Dewey who was a positivist (Kadlec, 2006). He contended that the critical potential of experience can and must be tapped if scientists are to mount an effective challenge to the entrenched interests in the study of reality. He further maintained that even the slightest manifestation of any intellectual activity whatever, in language, contained a specific conception of the world (Goldkuhl, 2012). Dewey, being a natural scientist, realized that laboratory experiments cannot be devoid of human construction of the world. Studying reality would therefore dictate that the researcher interacts with the environment in which the study is conducted (Reason and Bradbury, 2001). For example, studying traditional preventive and curative measures of malaria in tropical Africa may not achieve much if it excludes studying and understanding experiences of people who have been affected or infected by malaria. As such, the researcher must interact with people who are affected or will be affected by the phenomenon being studied (Johnson and Onwuegbuzie, 2004). This is the starting point of building a bridge between positivists and interpretivists.

Most importantly, pragmatism transcends other paradigms and puts emphasis on the end result of research. Whereas positivism and interpretivism prescribe for the study of reality for its own sake, pragmatists see no value of any scientific enquiry into phenomenon if the ultimate purpose is not to increase human welfare (Pansiri, 2005). In the healthcare research, a study of myths held by the oncologically challenged patients in the remote parts of Africa would focus on the end result of demystifying these patients and help them to appreciate the cause of abnormal malignant growth on their body. Likewise, the study of people's understanding of pathogen-friendly environment should have, as its ultimate goal, to create awareness among populations on how to make a good human environment.

Such studies however, are not aimed at uncovering and discovering ultimate truth, but rather a temporary and tentative truth which is expected to change in future. Pragmatism therefore unveils a changing reality and creates a basis for pragmatic researchers to explore and investigate the discovered reality, so as to ascertain certain elements of the phenomenon that have changed over time.

However, pragmatism in healthcare research is not a bed of roses. Not all research is about improving human condition (Bryman, 2007). Some scientific studies are conducted for various reasons such as satisfying curiosity, gaining an academic award or promotion on the job. These reasons have little to do with the ultimate goal of pragmatism, yet, they are important. Moreover, there may be useful yet non-untrue beliefs, and non-useful but true beliefs (Rylander, 2012). It appears pragmatism does not recognize and appreciate any enquiry into non-useful beliefs.

One question not yet answered by pragmatists is, whose pragmatic findings are they? In other words, pragmatic researchers need to categorically define beneficiaries of the research findings if this paradigm is to make sense (Greenwood and Levin, 1998).

Notwithstanding the criticisms labeled against pragmatism, it remains an important paradigm in applied scientific research. Moreover, research in healthcare focuses on improving human welfare which is the foundation for pragmatism. This paper concurs with Rorty (1999) who contends that pragmatism is important in building a basis upon which mixed methods research is conducted. This explains why this discussion advocates the use of pragmatism, while designing multi-methods for triangulation so as to focus on human welfare as the end result of the scientific enquiry in healthcare.

### **Putting triangulation/mixed methods in context**

The increasing sophistication of healthcare research has rendered qualitative and quantitative research inadequate. The qualitative-quantitative debate has given birth to a third research paradigm universally recognized as triangulation/mixed methods (Tobin and Begley, 2004; Johnson, et al., 2007). Triangulation is a combination of methodologies in the study of the same phenomenon (Denzin, 1978). It involves combining complementary methods in qualitative and quantitative approaches so as to neutralize weaknesses in each. In healthcare, triangulation has been used, for instance, to study barriers to treatment or patient records (Lukas et al., 1996) clinical trials, survey of attitudes and beliefs and epidemiological measures to better understand health problems (Mitchell et al., 2007; Almarsdóttir and Traulsen, 2009).

Scholars have supported the combination of the two research paradigms on the basis that they share the goal of understanding the world in which we live (Haase and Myers, 1988); sharing a unified logic, and use the same

rules of inference; and lastly, they share a common goal of improving human condition. But no approach can claim superiority over another.

According to Denzin (1978), triangulation takes four types mainly, data triangulation, researcher triangulation, theory triangulation and methodological triangulation. This implies that in order to apply the use of mixed methods in healthcare research effectively, various sources of data must be explored; multiple researchers used, multiple uses of perspectives and theories; and the use of more than one method (Borrego et al., 2009; Clark, 2010).

### **Justification for the use of mixed methods in healthcare research**

Some scholars have discussed the advantages of using mixed methods in healthcare research (Baum, 1995; Bowling, 2002). According to Fry et al. (1981), the use of mixed methods serves the following purpose: (1) enabling testing of quantitative models, (2) enhances the discovery of more explanatory concepts and categories, (3) helps to explain the margin of error, (4) facilitates collection of better quality data, (5) researcher is able to counter anomalies faced in analyzing quantitative data using the strengths of qualitative contexts, (6) use of qualitative methods to supplement quantitative analysis may contribute to the generation of new ideas, insights, hypotheses, and understandings.

One may argue that the totality of all uses of mixed methods is validation of research results (Ashatu, 2009). This validation is enhanced by the synergy of the two approaches. This is made possible by the fact that the use of mixed methods improves the quality and scientific power of data in healthcare research, e.g. poor adherence to treatment thought to be effective, behavioural factors contributing to disability and translational needs of health (Almarsdóttir and Traulsen, 2009; Creswell and Zhang, 2009; Klassen et al., 2009).

Some scholars have appreciated the use of mixed methods from the point of view of validity and reliability in nursing especially when the quantitative measures are used alongside qualitative measures (Morse, 1991; Chi, 1998; Morgan, 2007). According to McDowell and MacLean (1998) and Pansiri (2005), triangulation/mixed methods take advantage of the particular strengths of one approach in compensating for known limitations in the other under particular circumstances. At the end, the validity of theoretical propositions is improved and a more complete picture of the phenomenon under study is obtained (Ihantola and Kihn, 2011).

### **Triangulation/Mixed methods not a panacea: A critique**

Notwithstanding the justification for triangulation/use of mixed methods (Clark, 2010), it has been acknowledged

that it is not a panacea for all researches and research problems in some circumstances (Collins et al., 2006; Greene, 2007). There is an increasing debate as to whether validity and reliability of findings in healthcare research can be guaranteed on the basis of mixed methods (Blaikie, 1991; Ihanola and Kihn, 2011).

The main fear is that triangulation of methodologies in differing ontological and epistemological assumptions can be challenging to combine (Blaikie, 1991). Scholars such as Curry et al. (2009) have observed that the increased methodological sophistication of mixed methods research in the social and behavioural sciences demands for the use of high quality research skills. It is important to note that most quantitative researchers have a strong academic background in quantitative methods and may lack qualitative research skills (Blaikie, 1991). On the other hand, most qualitative researchers have a strong background in qualitative methods and may lack knowledge of quantitative skills. Yet, in order to produce high quality research findings in healthcare, a mixture of qualitative and quantitative skills are needed.

Triangulation can be difficult for a single handed researcher and is more expensive and time consuming (Cresswell, 2003); does not define the quantities to mix. It is also silent on how to integrate paradigms (Almarsdóttir and Traulsen, 2009). Yet, paradigms provide a starting point for any scientific enquiry.

The degree of validity and reliability is largely dependent on the researcher's methodological skills (Bryman, 1992). In fact Tobin and Begley (2004) advise that there is need to recognize the epistemological cannons of approaches used if research is to demonstrate a true mixture of perspectives. Triangulation must be carefully thought out and articulated. Figure 1 summarizes the main discussion of this paper and depicts a lack of an absolute answer to the qualitative-quantitative debate.

Figure 1 also summarizes the relationship between the four paradigms, that is, interpretivism, positivism, post positivism, pragmatism on one hand, and approaches to research, that is, qualitative, quantitative and mixed methods research on the other.

A thread of arrows runs through paradigms from pragmatism to interpretivism. This has been done deliberately to emphasize Pansiri's (2005) view that pragmatism is the foundation of the mixed methods research. Now, if the researcher employs mixed methods, it obviously implies that some elements of interpretivism and positivism will be combined since mixed methods calls for the mixing of methodologies (Johnson and Onwuegbuzie, 2004). However, it is also possible in some rare circumstances, and depending on the research question, to rely more on a single paradigm, while seeking answers to the research problem (Creswell, 2003). In this case, the researcher will still find pragmatism helpful since truth is tentative, and reality is ever changing, and the ultimate goal of research is to improve human welfare,

which pragmatism advocates (Rorty, 1999).

## CONCLUSION

In the preceding discussion, it has been argued that the allegations labeled against qualitative research in healthcare by positivists have been based on misinformation about the methods used by interpretivists/constructionist. Yet, interpretivists seem not to appreciate the value of quantitative research findings. It has been argued that qualitative and quantitative data are complementary. The article also points out that the qualitative-quantitative dichotomy has given birth to a third paradigm known as mixed methods or triangulation. Although, this approach has come to reconcile the debate, its main challenge arises from the ontological and epistemological differences among researchers of differing paradigms. Besides, the focus of method integration is on the practical usage of the research findings and not reconciling the conflicting approaches for its own sake.

## RECOMMENDATIONS

From the discussion, it is apparent that the qualitative-quantitative debate is far from over. In fact, the discussion reveals that neither pragmatism nor mixed methods has been helpful in resolving the conflict. This is partly because scientific problems lack a homogenous originality. Such problems are discovered in different conceptual and contextual environments, and approach to them depends on the researcher's philosophical underpinning. This calls for further scientific investigations into the possibility of either strengthening the use of multi-methodology approach or developing a fourth paradigm.

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