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From synthesis to implementation of qualitative evidence

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Scientific investigation has evolved a lot in recent years as a result of methodological development as well as the increase in empirical studies. We share the opinion that despite the growth in research number, there still exists the idea that objective evidence from quantitative studies is vital to respond to clinical needs in health care[1]. However, the same does not apply to the valorization of research results produced within the scope of the qualitative paradigm.

This difference in valuing more positivist studies, perhaps biased by the importance attributed to 'quanti' methods and techniques during the training of health professionals, hampers a Practice Based on Evidence (PBE) that incorporates the results of qualitative investigations. Besides, there are several barriers to the implementation of knowledge in the context, associated with the low scientific literacy of professionals reading the results of primary studies, the option for unidirectional models transferring evidence to the clinic, the ineffective communication and dissemination strategies, and the lack of a collaborative scientific culture between academia and clinic to develop products capable of introducing results in the context[2].

This hindrance extends to studies of evidence synthesis, despite the efforts of Cochrane and the JBI (Joanna Briggs Institute) to value systematic reviews of qualitative studies (narratives, meta-summaries, meta-syntheses, among others). The predominance of meta-analysis as a method of systematizing and evaluating the results of primary studies[1] affects health policy definitions, professional training, and the formulation of normative guidelines for clinical intervention. This option promotes the development of the PBE, although not quenching the context demands since the nature and synthesis of 'quali' research play a significant role in providing true client-centered care by responding to the person's needs and preferences and supporting the individual decision, conscious and responsible in the face of the changes the client and family experience.

Likewise, the synthesis and use of this type of research have the potential to effect desired changes in health, education, and social well-being[1] through understanding how people, families and communities perceive health care generally, and nursing particularly, as well as the way they make decisions concerning their health/disease processes.

Adopting a PBE and deciding care based on knowledge is a complex process that goes beyond the synthesis and elaboration of standardized norms with universal recommendations, such an attitude implies taking decision(s) based on the available evidence(s) and considering the participation of people in need of care and their caregivers[3-4]. Here a clear challenge emerges so that the synthesis of qualitative evidence enables the choice of the best therapeutic option for a person's specific clinical case, however, adjusted to its diversity because the complexity of the individual, clinical and socioeconomic transitions, in most

situations, will not allow that only one type of evidence makes truly knowledge-based and cost-effective decisions[3].

Another challenge is transferring this knowledge quickly and safely into clinical contexts. In this regard, there is a prerequisite for learning a set of knowledge, attitudes and research skills that are not achieved in school and imply in an earlier contact of students with evidence[4] so that in the future, as professionals, they can commit and invest in the search for guiding information for their practice[1] and apply it effectively.

This editorial appeals to researchers to rethink the synthesis and use of qualitative evidence in clinical settings. There is an urgent need to break away from the present model of PBE so that a new practice based on evidence and client preferences[1] can put knowledge at the clinical training in nursing and empower individuals and families.

References

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