Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory

Helene Starks
Susan Brown Trinidad
University of Washington

The purpose of this article is to compare three qualitative approaches that can be used in health research: phenomenology, discourse analysis, and grounded theory. The authors include a model that summarizes similarities and differences among the approaches, with attention to their historical development, goals, methods, audience, and products. They then illustrate how these approaches differ by applying them to the same data set. The goal in phenomenology is to study how people make meaning of their lived experience; discourse analysis examines how language is used to accomplish personal, social, and political projects; and grounded theory develops explanatory theories of basic social processes studied in context. The authors argue that by familiarizing themselves with the origins and details of these approaches, researchers can make better matches between their research question(s) and the goals and products of the study.

Keywords: qualitative methods; phenomenology; discourse analysis; grounded theory

Qualitative research methods enable health sciences researchers to delve into questions of meaning, examine institutional and social practices and processes, identify barriers and facilitators to change, and discover the reasons for the success or failure of interventions. As with all research endeavors, choosing the method that is best suited to the line of inquiry is vital to obtaining the desired results. A judicious choice of method guides the research toward the intended aims and helps ensure that its products are useful and well received.

The purpose of this article is to introduce and compare three qualitative approaches that are commonly used in health research: phenomenology, discourse analysis, and grounded theory. In writing this article, we had three audiences in mind: novice qualitative researchers, researchers who might be familiar with one of these approaches but not the others, and teachers of qualitative methods courses. For the first two audiences our goal was to provide a framework to help researchers choose an analytic approach that aligns the desired product of a study with the researchers' assumptions, existing knowledge, and reasons for engaging in research. For the third audience our goal was to create a tool that teachers could use to introduce these approaches to students. We begin our analysis with a brief comparison of the history of ideas, goals, methods, and products of these three approaches. We then use a single data set to illustrate how the approaches differ in practice.

Introducing the Three Approaches

We have depicted the similarities and differences across the three interpretive approaches in Figure 1. The figure approximates an hourglass, in which greater differences are observed at the beginning and at the end of the research project. The approaches converge in the analytic phase, sharing methodologies for decontextualizing and then recontextualizing data. They then diverge again in the postanalytic phase, in which the research findings are framed and packaged for the target audience.

Figure 1
Similarities and Differences of Three Interpretive Approaches With Respect to History, Goal, Philosophy, Methodology, Analytic Method, and Product

	Phenomenology	Discourse Analysis	Grounded Theory
HISTORY	European Philosophy	Linguistics/Semiotics	Sociology
PHILOSOPHY	There exists an essential, perceived reality with common features	Knowledge and meaning is produced through interaction with multiple discourses	Theory is discovered by examining concepts grounded in the data
GOAL	Describe the meaning of the lived experience of a phenomenon	Understand how people use language to create and enact identities and activities	Develop an explanatory theory of basic social processes
METHODOLOGY Formulating a research question	"What is the lived experience of [the phenomenon of interest]?"	"What discourses are used and how do they shape identities, activities, and relationships?"	"How does the basic social process of [X] happen in the context of [Y environment]?"
Sampling	Those who have experienced the phenomenon of interest	Those situated in one or more of the discourses of interest	Those who have experienced the phenomenon under different conditions
Data Collection: Observations	Observe participants in the context where the phenomenon is experienced	Observe participants in conversation in their natural environment	Observe participants where the basic social process takes place
Interviewing strategy	Participant describes experience; interviewer probes for detail, clarity	Both engage in dialogue; interviewer probes for intertextual meaning	Participant describes experience; interviewer probes for detail, clarity
ANALYTIC METHODS Decontextualization & Recontextualization: Process of coding, sorting, identifying themes and relationships, and drawing conclusions	Identify descriptions of the phenomenon; cluster into discrete categories; taken together, these describe the "essence" or core commonality and structure of the experience	Examine how understanding is produced through a close look at the words. Interested in *how* the story is told, what identities, activities, relationships, and shared meaning are created through language	Open, axial, & selective coding: Examine concepts across their properties & dimensions; develop an explanatory framework that integrates the concepts into a core category
Role of Analyst's Views	Bracket views	Examine own place in the discourse(s)	Bracket views
AUDIENCE	Clinicians, practitioners & others who need to understand the lived experience of the phenomenon of interest	Policy makers & interventionists who need to understand the discourses in use to craft effective messages	Researchers & practitioners who seek explanatory models upon which to design interventions
PRODUCT	A thematic description of the pre-given "essences" and structures of lived experiences	Description of language-in-use; identify how different discourses shape how identities, relationships, and social goods are negotiated and produced	Generate theory from the range of the participants' experience

Phenomenology, discourse analysis, and grounded theory are the products of different intellectual traditions. However, their coevolution in the history of ideas means that the boundaries between them are porous. This is depicted in the figure by the vertical dotted lines that separate the three approaches. In what follows, we provide a brief summary of the intellectual lineage and basic value commitments of phenomenology, discourse analysis, and grounded theory.

Phenomenology

Phenomenology is rooted in early 20th-century European philosophy.[1] It involves the use of thick description and close analysis of lived experience to understand how meaning is created through embodied perception (Sokolowski, 2000; Stewart & Mickunas, 1974). Phenomenology contributes to deeper understanding of lived experiences by exposing taken-for-granted assumptions about these ways of knowing. Sokolowski (2000) wrote about this as follows:

> Phenomenological statements, like philosophical statements, state the obvious and the necessary. They tell us what we already know. They are not new information, but even if not new, they can still be important and illuminating, because we often are very confused about just such trivialities and necessities. (p. 57)

In phenomenology reality is comprehended through embodied experience. Through close examination of individual experiences, phenomenological analysts seek to capture the meaning and common features, or essences, of an experience or event. The truth of the event, as an abstract entity, is subjective and knowable only through embodied perception; we create meaning through the experience of moving through space and across time. The phenomenological perspective is nicely captured in a remark attributed to Einstein that expresses the difference between embodied time and chronologic time: Put your hand on a hot stove for a minute and it seems like an hour. Sit with a pretty girl for an hour and it seems like a minute. That's relativity.

Discourse Analysis

Discourse analysis evolved from linguistic studies, literary criticism, and semiotics. It is concerned with language-in-use; that is, how individuals accomplish personal, social, and political projects through language.[2] Discourse analysts argue that language and words, as a system of signs, are in themselves essentially meaningless; it is through the shared, mutually agreed-on use of language that meaning is created. Language both mediates and constructs our understanding of reality. It also defines the social roles that are available to individuals and serves as the primary means through which they enact their identities (Chandler, 2002; Lyons 1971). Careful analysis of language, using what Gee (2005) has described as the seven "building tasks" of language (significance, activities, identities, relationships, politics, connections, and sign systems and knowledge), can shed light on the creation and maintenance of social norms, the construction of personal and group identities, and the negotiation of social and political interaction. Discourse analysis involves tracing the historical evolution of language practices and examining how language both shapes and reflects dynamic cultural, social, and political practices (Crowe, 1998; Gee, 2005; Hayakawa & Hayakawa, 1991).

Grounded Theory

Grounded theory originates from sociology, specifically from symbolic interactionism, which posits that meaning is negotiated and understood through interactions with others in social processes (Blumer, 1986; Dey, 1999; Jeon, 2004). These social processes have structures, implied or explicit codes of conduct, and procedures that circumscribe how interactions unfold and shape the meaning that comes from them. The goal of grounded theory is to develop an explanatory theory of basic social processes, studied in the environments in which they take place (Glaser & Strauss, 1967). Grounded theory examines the "six Cs" of social processes (causes, contexts, contingencies, consequences, covariances, and conditions) to understand the patterns and relationships among these elements (Strauss & Corbin, 1998). Within this approach knowledge of social realities is achieved through careful observation of behavior and speech practices.

The Approaches as Methods

Each of these interpretive approaches addresses questions of meaning and understanding. When they are employed as research methods, differences emerge with respect to how the researchers frame research questions, sample participants, and collect data.

Framing the Research Question

Phenomenologists ask questions about lived experiences, as contrasted with abstract interpretations of experience or opinions about them (van Manen, 1990). Discourse analysts explore how knowledge, meaning, identities, and social goods are negotiated and constructed through language-in-use. Grounded theorists inquire about how social structures and processes influence how things are accomplished through a given set of social interactions.

Sampling

Morse (2000, 2001) has written that in qualitative research studies sample size depends on five things: the scope of the study, the nature of the topic, the quality of the data, the study design, and the use of shadowed data (when participants speak of others' experience as well as their own). For the methods we describe, data are most often gathered through interviews or focus groups, although texts of various types also may be used. Each approach involves use of purposive sampling methods to recruit participants who have experienced the phenomenon under study. The concept or the experience under study is the unit of analysis; given that an individual person can generate hundreds or thousands of concepts, large samples are not necessarily needed to generate rich data sets. The exact number of individuals needed, and the number of interviews per individual, depends on the goals and purpose of the study.

Phenomenologists are interested in common features of the lived experience. Although diverse samples might provide a broader range from which to distill the essence of the phenomenon, data from only a few individuals who have experienced the phenomenon—and who can provide a detailed account of their experience—might suffice to uncover its core elements. Typical sample sizes for phenomenological studies range from 1 to 10 persons.

Within discourse analysis sampling different groups that participate within a given discourse can illuminate the ways in which participants appeal to external discourses and identify their influence on the discourse under study. Sample size depends on the analytic objective and the data source. For example, it is possible to use a single person's narrative and compare it with written documents; alternatively, larger sample sizes might be required to understand variations in language-in-use across persons and settings.

Grounded theory relies on theoretical sampling, which involves recruiting participants with differing experiences of the phenomenon so as to explore multiple dimensions of the social processes under study. The researcher continues to add individuals to the sample until she reaches theoretical saturation; that is, when the complete range of constructs that make up the theory is fully represented by the data. Although it is impossible to predict what sample size will saturate a given theory, typical grounded theory studies report sample sizes ranging from 10 to 60 persons.

Data Collection

Data collection strategies for all three approaches can use a mix of observation, interviews, and close reading of extant texts. Through observation researchers can gather data about how participants behave in their natural settings and make meaning out of their experiences. In phenomenology observation of how participants live in their environment through time and space provides clues about how they might embody meaning. For discourse analysis observing participants' speech provides insight about how the participants deploy language to accomplish their objectives and position themselves in relation to others. In grounded theory observation allows the researcher to see how social processes are constructed and constrained by the physical and social environments in which they are practiced.

Although observation can be a rich source of data, it is often impractical in health research because of the potential for intrusiveness and logistical difficulty.

Thus, qualitative research frequently relies on interviewing as the primary data collection strategy.[3] A semistructured interview format can work well for any of the three methods we describe here. In a phenomenological or grounded theory study the objective of the interview is to elicit the participant's story. Both the researcher and the participant assume that their words will be understood as spoken and intended (i.e., their words will speak for themselves). The researcher/interviewer presents herself as the listener and asks participants to give accounts of their experience of the phenomenon. She asks probing questions to encourage the participant to elaborate on the details to achieve clarity and to stay close to the lived experience.

The objective of an interview for discourse analysis is to capture the participant's language, including any references or appeals to other discourses. In discourse analysis it is not assumed that the researcher and participant necessarily mean the same thing when they use the same words. In the interview, then, both the interviewer and the interviewee are understood to use language to present themselves and the people and events about which they speak in a certain way. In this context words are not assumed to speak for themselves. Thus, the interviewer might need to ask clarifying questions about the meaning the participant intends to convey through the use of specific terms.

Analytic Methods

The general methods of interpretation are fairly similar across the three approaches. Interpretive analysis is an iterative, inductive process of decontextualization and recontextualization (Ayres, Kavanaugh, & Knafl, 2003; Morse & Field, 1995). During decontextualization the analyst separates data from the original context of individual cases and assigns codes to units of meaning in the texts. In recontextualization he or she examines the codes for patterns and then reintegrates, organizes, and reduces the data around central themes and relationships drawn across all the cases and narratives. All three interpretive methods distill textual data to a set of categories or concepts from which the final product can be drawn.

Coding

Creswell (1997) has described a systematic process for coding data from a phenomenological inquiry in which specific statements are analyzed and categorized into clusters of meaning that represent the phenomenon of interest. Taken-for-granted assumptions are explored,

and special attention is given to descriptions of what was experienced as well as how it was experienced. van Manen (1990) wrote that phenomenological analysis is primarily a writing exercise, as it is through the process of writing and rewriting that the researcher can distill meaning. Analysts use writing to compose a story that captures the important elements of the lived experience. By the end of the story the reader should feel that she has vicariously experienced the phenomenon under study and should be able to envision herself (or someone else who has been through the experience) coming to similar conclusions about what it means.

The objective of a discourse analysis is to understand what people are doing with their language in a given situation. Thus, the coding phase for a discourse analysis entails identifying themes and roles as signified through language use. For example, coding and analysis could compare an interviewee's use of the word *patient* as compared to her use of *person*, or explore how the speaker uses technical language and professional jargon to make implicit claims of expertise or authority. Gee (2005) described the analytic process as one of searching for textual evidence to show how language accomplishes the seven building tasks.

Grounded theory involves a constant comparison method of coding and analyzing data through three stages: open coding (examining, comparing, conceptualizing, and categorizing data); axial coding (reassembling data into groupings based on relationships and patterns within and among the categories identified in the data); and selective coding (identifying and describing the central phenomenon, or "core category," in the data) (Dey, 1999; Strauss & Corbin, 1998). Ideally, each interview or observation is coded before the next is conducted so that new information can be incorporated into subsequent encounters. Themes identified through the coding of initial interviews may also be explored in follow-up interviews.

The Role of the Analyst and Assuring Trustworthiness

Qualitative analysis is inherently subjective because the researcher is the instrument for analysis. The researcher (or the research team) makes all the judgments about coding, categorizing, decontextualizing, and recontextualizing the data. Each of the approaches has its own techniques for monitoring, documenting, and evaluating the analytic process and the researcher's role to assure rigor and trustworthiness.[4]

In phenomenology and grounded theory the researcher engages with the analysis as a faithful witness to the accounts in the data. Even as the researcher immerses herself in the data, she must be honest and vigilant about her own perspective, preexisting thoughts and beliefs, and developing hypotheses. In phenomenology and grounded theory researchers engage in the self-reflective process of "bracketing," whereby they recognize and set aside (but do not abandon) their a priori knowledge and assumptions, with the analytic goal of attending to the participants' accounts with an open mind (Gearing, 2004; Sokolowski, 2000; van Manen, 1990). Additional reflexive practices include consulting with colleagues and mentors and writing memos throughout the analysis to help analysts examine how their thoughts and ideas evolve as they engage more deeply with the data (Cutcliffe, 2003; Finlay, 2002). Memos also serve the function of establishing an audit trail, whereby the analyst documents her thoughts and reactions as a way of keeping track of emerging impressions of what the data mean, how they relate to each other, and how engaging with the data shapes her understanding of the initial hypotheses (Cutcliffe, 2000).

Likewise, the discourse analyst remains cognizant of, and explicit about, her perspective and position in the analytic process, including how her role as a participant in the professional academic discourse shapes her thinking. In so doing, she uses her knowledge to situate the analysis so that the reader can weigh the evidence with an understanding of the analyst's perspective in mind (Finlay, 2002). Analytic credibility depends on the coherence of the argument: Readers will judge the trustworthiness of the process by how the analyst uses evidence from the interviews to support the main points and whether the building tasks of language converge toward a convincing explanation (Gee, 2005).

Audience and Product

The products of research will vary based not only on the analytic approach but also on how far the analyst carries the interpretation and synthesis of her findings. The products of qualitative analyses can range from thematic surveys (relatively close to the data) to interpretive explanatory theory (farthest from the data) (Sandelowski & Barroso, 2003). Generally speaking, phenomenological analyses produce rich thematic descriptions that provide insight into the meaning of the lived experience. Phenomenologies are often written as anecdotes or thematic stories, drawing on elements

Table 1
Informed Decision Making (IDM) as Seen Through the Different Approaches

	Phenomenology	Discourse Analysis	Grounded Theory
Purpose	To understand primary care providers' (PCP) experience of decision making with patients under conditions of clinical uncertainty	To shed light on the reasons for the limited or incomplete adoption of IDM by PCPs	To develop effective training and education for PCPs about how to approach prostate cancer screening discussions
Research question	What is the lived experience of PCPs as they discuss prostate cancer screening with their patients?	What discourses are used in IDM, and how do they shape PCP and patient roles and identities in the doctor–patient relationship?	How does IDM about prostate cancer screening happen between PCPs and their average-risk patients?
Audiences	PCPs, medical educators, professional societies, and other guideline-developing bodies	Medical educators, guideline-developing bodies, clinic directors	Clinic directors, curriculum designers, patient educators, PCPs

reported from different narrators to create a blended story. Such accounts allow the reader to get a feel for what it is like to have the experience. Audiences for these analyses include clinicians and others whose practice would be enhanced by understanding how individuals live through and make sense of a particular experience.

The products of discourse analysis use evidence from participants' narratives and other texts to expose the ways in which people use language to accomplish their objectives; as such, discourse analyses often have a pragmatic aim and require more analytic abstraction. Clinicians, interventionists, and policy makers can use discourse analysis to understand how framing and language can help achieve a desired outcome (such as promoting healthy behaviors), to understand why a particular practice is heading in a certain direction, or to gain support for a proposed policy.

Although the goal of grounded theory analysis is to produce theory, some analysts identify patterns only within and between categories. Such truncated analyses produce conceptual thematic descriptions rather than explanatory theories. When the analyst synthesizes all the data, however, she builds a theory around a core category that explains the central phenomenon present in the data. The findings of a complete theory are often presented diagrammatically to demonstrate how the core category relates to the other dominant themes. Audiences for grounded theories include clinicians, practitioners, and researchers who are interested in designing interventions to support people engaged in the social processes explained by

the theory, and other researchers who design studies to test the theory in practice.

Applying the Three Approaches to a Single Data Set

To illustrate how the approaches generate different analyses and products, we present three brief analyses of the same data set: an interview study with 25 primary care physicians (PCPs) that explored their use of informed decision making (IDM) in the context of prostate cancer screening. IDM emphasizes the importance of patients' values and preferences in health care decisions. Patients' priorities are to be balanced with the clinician's expertise to arrive at the best choice for the individual patient. IDM is particularly useful when decisions have (a) insufficient medical evidence to support recommending a particular course of action, (b) potential outcomes that are highly variable and/or include substantial harms, and (c) outcomes that patients will value differently based on their personal situation and beliefs (Briss et al., 2004; President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1982; Rimer, Briss, Zeller, Chan, & Woolf, 2004). All three of these conditions apply in the case of prostate cancer screening (U.S. Preventive Services Task Force, 2002).

The rich data from this interview study were well suited to this exercise of trying all three analytic approaches. In Table 1 we have summarized the differences with respect to the purpose, research questions, and audience.

Phenomenology: PCPs' Lived Experience of Decision Making Under Uncertainty

The purpose of this analysis is to understand how PCPs experience an uncertain clinical decision-making process within the larger context of the doctor–patient relationship. The PCP's professional identity is complex and multifaceted; depending on the situation, he might act as a trusted expert, a scientist, a patient advocate, a confidant, or a healer (among other possibilities).

Many of our interviewees described feelings of angst, confusion, frustration, and resentment arising from a conflict of duties and obligations. They expressed their discomfort with feeling that, through no fault of their own, they cannot meet their patients' needs or expectations because of the lack of clear recommendations for prostate cancer screening. Compounding this is the knowledge that regardless of whether their patients choose to be screened, there is always the possibility of significant negative consequences. Some patients who are not screened will die of a cancer that might have been successfully treated. Others who decide to be screened will receive false positive results that will require weeks or months of additional testing and worrying. Still others will be screened and treated, possibly experiencing the side effects of incontinence or impotence, for a cancer that would never have become symptomatic.

Because there is insufficient clinical evidence on which to base a recommendation, PCPs feel unable to provide one; even so, they struggle with declining to make a recommendation. As one physician remarked,

> I feel, for PSA [prostate specific antigen] testing, it's just hard. There's so much uncertainty out there I never . . . I feel like if I ask a patient, "What do you want to do?" they're going to say, "Heck if *I* know! It's obvious from talking with you, Doctor, *you* don't even know. So bouncing it back to me is going to be *no* good."

The lack of clinical evidence was cited as a major problem. One interviewee expressed his frustration with the lack of evidence this way:

> It's hard [to have these discussions with patients] because the data stinks, and there's so much misinformation and so much promotion of prostate cancer screening that it puts the primary care physician who wants to be evidence-based in a very difficult position . . . And so, you leave the patient with, this "Well, I have no clue what to do," kind of a handout. And, you know, the bottom line of every handout says, (fake cheery voice) "So, if you have further questions, talk to your doctor." (sarcastic) <u>Great</u>!

This analysis reveals aspects of PCPs' lived experience of decision making under uncertainty. The product of the research is a thematic description of the common elements of the experience, such as the "gut-sinking" feeling that reflect the difficulties that physicians experience in discussing prostate cancer screening with their patients. The audience for these findings includes other physicians who could use these stories to make sense of their own difficulties with decision making under uncertainty.

Discourse Analysis: How the Discourses of Medicine and Public Health Construct Doctor–Patient Roles and Identities

Through the lens of discourse analysis we can shift our attention to how PCPs' many possible roles are constructed and negotiated in interactions with patients. In the IDM study we can see how the discourses of medicine and public health shape the roles available to physicians and patients in the context of decision making under uncertainty.

For example, the discourse of medicine suggests that physicians should be expert diagnosticians, scientists practicing evidence-based medicine, and advisors to their patients. Within the profession particular respect is accorded to those who know. Under conditions of uncertainty some PCPs make a distinction between science's not having the answers

> Usually I end up having to talk to [the patient] at some point about the issue of, unlike other cancers, there's very little we know about prostate cancer in terms of the screening.

And the individual physician's not having the answers

> What I would really like to have—and I know these exist, so I guess it's mainly my own fault that I don't have it, honestly—is the accepted age-based normal range for PSA, and secondly, the likelihood of prostate cancer based on PSA reading and age.

A more thorough analysis could explore the ways in which expertise and authority play out through language practices in the office encounter, clarifying what is at stake for the participants.

From the public health discourse, the message is that good doctors screen their patients appropriately and good patients seek screening at appropriate intervals.

As one physician commented, "Let's just put it this way: There's no commercial out there telling you not to have a prostate test." Another told us that she measures the success of a discussion of screening by the patient's ability to "defend his choice" to be screened or not. PCPs thus find themselves arguing against the dominant public health discourse about health maintenance and cancer. They are in the difficult position of trying to explain that although in general cancer screening is a good idea, there are ways in which prostate cancer might be a "weird cancer" and one for which screening might not always be the best choice.

Examining PCPs' descriptions of how they talk with their patients about prostate cancer screening reveals which discourses they and their patients bring to the encounter as well as what other factors in the conversation trigger use of one discourse over another. Patients' expectations and how they engage in the dialogue, as well as PCPs' perceptions of their "sophistication," also shape which discourse will be used in any particular exchange between doctor and patient. The analysis can help us see how the interlocking discourses of medicine and public health can help or hinder the implementation of IDM techniques by PCPs. We can also consider how some of the conflicts in identity and role due to uncertainty might be exacerbated by the competing demands of the discourses and expectations the participants bring to the conversation. These results could be used by medical educators to help PCPs assess patients' baseline assumptions and expectations and address these in discussions that warrant informed decision making.

Grounded Theory: Making the Most of the Visit

The goal of this grounded theory analysis is to develop a theory that explains what circumstances lead to prostate cancer screening discussions in primary care settings and how and why physicians and patients engage in these discussions. In this analysis we use the six Cs to discover the contingencies and conditions that shape the clinical encounter.

In the IDM study we learned that many factors affected whether and how PCPs discuss prostate cancer screening. First is the limitation imposed by tight appointment schedules (10- to 15-minute time slots were common). PCPs described the tradeoffs they make "just to get through the clinic day" and stay more or less on time. One commented,

Most people in primary care, when they start a clinic session, it's a survival kind of thing, really. It is really fast-paced. There's no lollygagging. You're always behind, or at least at risk for becoming behind, by things that come up that you didn't anticipate, or that you did, but that the schedule just doesn't allow for.

They explained that it is more efficient to simply do the same thing for everyone, using a relatively standardized "spiel" to discuss the pros and cons of screening, a strategy that might be viewed as counter to the individualized nature of IDM. PCPs also noted that many of their older male patients simply do not make frequent outpatient visits. PCPs talked about needing to "pick [their] battles" to "make the most of the visit." This usually meant focusing on the complaint that brought the patient into the office. When physicians felt they had time to address health maintenance topics, they often prioritized prevention and screening issues that they considered to be of greater clinical importance and proven benefit, such as screening for colorectal cancer or counseling on diet and exercise.

Patients' expectations were also a factor in prostate screening discussions: PCPs were more likely to have an involved conversation when patients had not already made up their minds about whether to be screened. In this context, we saw the physicians doing what they could to meet their patients' needs, offering information, expert advice, and ways to think about the pros and cons of screening and treatment.

In this last example we see overlaps with the two previous analyses about meeting both parties' expectations of what it means to be a doctor. In the context of the grounded theory analysis, however, this factor is less important than the core category: making the most of the visit. The product of this analysis would be a substantive theory about the logistical, professional, and personal constraints that limit PCPs' use of IDM techniques to discuss prostate cancer screening with their patients. Clinic directors and others with an interest in promoting informed decision making around prostate cancer will need to address these constraints before they are likely to succeed in their efforts.

Conclusions

This article is the product of our struggles to learn how to choose the most appropriate method for a particular qualitative research project. The examples from the IDM study—although, admittedly, very brief—highlight how the analytic approach shapes how one frames research questions, attends to data and their meaning, and draws conclusions based on the analysis. This side-by-side comparison is intended to help researchers

become familiar with the origins, history of ideas, and embedded assumptions of these approaches and, thus, empower them to make better matches between their research question(s), audience, and the goals and products of the study.

Notes

1. For a comprehensive list of philosophers who have contributed to phenomenology, see van Manen (2000).

2. Many disciplines of linguistics have incorporated discourse analysis into their methods. For a full range of perspectives, see Schiffren, Tannen, and Hamilton (2001).

3. For an excellent resource on valuable interviewing skills, see Hermanowicz (2002).

4. For additional reading on issues of trustworthiness, see, for example, Angen (2000), Davies and Dodd (2002), Guba (1981), Pyett (2003), and Whittemore, Chase, and Mandle (2001).

References

Angen, M. J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research*, *10*, 378-395.

Ayres, L., Kavanaugh, K., & Knafl, K. A. (2003). Within-case and across-case approaches to qualitative data analysis. *Qualitative Health Research*, *13*, 871-883.

Blumer, H. (1986). *Symbolic interactionism*. Berkeley: University of California Press.

Briss, P., Rimer, B., Reilley, B., Coates, R. C., Lee, N. C., Mullen, P., et al. (2004). Promoting informed decisions about cancer screening in communities and healthcare systems. *American Journal of Preventive Medicine*, *26*(1), 67-80.

Chandler, D. (2002). *Semiotics: The basics*. London: Routledge.

Creswell, J. W. (1997). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

Crowe, M. (1998). The power of the word: Some post-structural considerations of qualitative approaches in nursing research. *Journal of Advanced Nursing*, *28*, 339-344.

Cutcliffe, J. R. (2000). Methodological issues in grounded theory. *Journal of Advanced Nursing*, *31*, 1476-1484.

Cutcliffe, J. R. (2003). Reconsidering reflexivity: Introducing the case for intellectual entrepreneurship. *Qualitative Health Research*, *13*, 136-148.

Davies, D., & Dodd, J. (2002). Qualitative research and the question of rigor. *Qualitative Health Research*, *12*, 279-289.

Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry*. San Diego: Academic Press.

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, *12*, 531-545.

Gearing, R. E. (2004). Bracketing in research: A typology. *Qualitative Health Research*, *14*, 1429-1452.

Gee, J. P. (2005). *An introduction to discourse analysis: Theory and method* (2nd ed.). London: Routledge.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory; Strategies for qualitative research*. Chicago: Aldine.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Resources Information Center Annual Review Paper*, *29*, 75-91.

Hayakawa, S. I., & Hayakawa, A. (1991). *Language in thought and action* (5th ed.). Orlando, FL: Harcourt.

Hermanowicz, J. C. (2002). The great interview: 25 strategies for studying people in bed. *Qualitative Sociology*, *25*(4), 479-499.

Jeon, Y. H. (2004). The application of grounded theory and symbolic interactionism. *Scandinavian Journal of Caring Sciences*, *18*(3), 249-256.

Lyons, J. (1971). *Introduction to theoretical linguistics*. Cambridge, UK: Cambridge University Press.

Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd ed.). Thousand Oaks, CA: Sage.

Morse, J. M. (2000). Determining sample size. *Qualitative Health Research*, *10*, 3-5.

Morse, J. M. 2001). Using shadowed data. *Qualitative Health Research*, *11*, 291-292.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. (1982). *Making health care decisions: The ethical and legal implications of informed consent in the patient-practitioner relationship*. Washington, DC: Author.

Preventive Services Task Force. (2002). Screening for prostate cancer: Recommendation and rationale. *Annals of Internal Medicine*, *137*(11), 915-916.

Pyett, P. M. (2003). Validation of qualitative research in the "real world." *Qualitative Health Research*, *13*, 1170-1179.

Rimer, B. K., Briss, P. A., Zeller, P. K., Chan, E. C., & Woolf, S. H. (2004). Informed decision making: What is its role in cancer screening? *Cancer*, *101*(5 Suppl.), 1214-1228.

Sandelowski, M., & Barroso, J. (2003). Classifying the findings in qualitative studies. *Qualitative Health Research*, *13*, 905-923.

Schiffren, D., Tannen, D., & Hamilton, H. E. (Eds.). (2001). *The handbook of discourse analysis*. Malden, MA: Blackwell.

Sokolowski, R. (2000). *Introduction to phenomenology*. Cambridge, UK: Cambridge University Press.

Stewart, D., & Mickunas, A. (1974). *Exploring phenomenology: A guide to the field and its literature*. Chicago: American Library Association.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Albany: State University of New York Press.

van Manen, M. (2000). *Scholars*. Retrieved July 17, 2007, from http://www.phenomenologyonline.com/scholars/scholars.html

Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in qualitative research. *Qualitative Health Research*, *11*, 522-537.

Helene Starks, PhD, MPH, is an assistant professor in the Department of Medical History and Ethics and an adjunct assistant professor in the Department of Health Services at the University of Washington, Seattle.

Susan Brown Trinidad, MA, is a research manager in the Department of Medical History and Ethics at the University of Washington, Seattle.