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Which medical subspecialties use qualitative research? A bibliometric analysis

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ABSTRACT

Objectives Qualitative research addresses 'how' and 'why' questions in healthcare. It captures the complexity of clinical practice by providing insights into experiences, behaviours and context often missed by quantitative methods. The objective of this review was to explore the volume, trends and adherence to reporting standards in qualitative research across hospital-based medical subspecialties.

Design Longitudinal bibliometric review.

Setting and participants Ovid Medline, Embase and Emcare were searched for qualitative research published between 2000 and 2024 in 12 medical subspecialties. For each subspecialty, the number and percentage of qualitative publications was identified. Adherence to reporting standards was assessed in a random sample of publications covering all subspecialties.

Results Between 2000 and 2024, 715 471 qualitative research studies were published across 12 medical subspecialties, representing 1.36% of all studies (52 620 042). Neurology and oncology had the highest number of qualitative studies (116 835 and 106 360). Although infectious diseases contributed a lower absolute number of qualitative studies (59 947), they had the highest proportion relative to all studies (4.07%). Conversely, nephrology and haematology exhibited the lowest number of qualitative studies (14 510 and 29 198) and smallest proportions (0.90% and 0.81%). Overall, the annual proportion of qualitative research increased from 0.64% (6052/945 008) in 2000 to 1.95% (56 909/2 919 825) in 2024. However, the relative positions remained largely stable over time.

Adherence to reporting standards was generally good, particularly in relation to methodological coherence. However, there was under-reporting of positionality (where researchers consider how their identity and standpoint may influence the research process) and reflexivity (where researchers critically reflect on how their assumptions and decisions shape the study).

Conclusions Qualitative research is under-represented in medical subspecialties but has increased steadily over time, with notable variation in adoption between subspecialties. While overall adherence to reporting standards is good, greater attention to positionality and reflexivity is needed to enhance transparency and rigour.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Comprehensive searches were developed from 12 existing strategies and conducted across key databases covering a 25-year period.
⇒ Assessment of adherence to reporting standards provided insight into methodological rigour of published qualitative studies.
⇒ Some medical subspecialties were excluded due to database indexing limitations and overlap.
⇒ Searches were restricted to Ovid databases because including other databases would have prevented automated deduplication, and manual deduplication was not feasible given the large number of results.
⇒ It was not possible to assess reporting standards for all studies, so only a representative random sample was evaluated.

BACKGROUND

Qualitative research provides unique insights into the perspectives and experiences of patients, carers and healthcare professionals, capturing aspects of care that quantitative approaches may overlook.[1–3] Despite its value, some critics commented on the subjectivity, generalisability and resource requirements of qualitative research, views that may have limited adoption in certain fields.[4 5] This is compounded by the longstanding preference for quantitative methodologies among researchers, journal editors and funding bodies.[6] Consequently, qualitative research remains under-represented in the clinical literature, with previous reviews showing it accounts for only a small fraction of published studies. However, these reviews were restricted to selected journals, specific fields or short timescales, which limits the applicability of their findings to other research contexts.[7–9]

Medical subspecialties differ in research culture, clinical complexity and patient populations.[10] Studies of quantitative research provide evidence that these differences affect research practices, as the uptake and quality of studies varies across medical

subspecialties.[11–13] Evidence is lacking on whether similar patterns exist for qualitative research.[7] Understanding this variation could help identify subspecialties where qualitative methods are underused and highlight areas where adherence to reporting standards could be strengthened to enhance the trustworthiness and utility of qualitative findings.[14–16]

This review aims to explore and compare patterns of qualitative research across hospital-based medical subspecialties, with attention to trends over time and adherence to reporting standards.

METHODS

Study design

A bibliometric review was conducted to quantify and describe trends in qualitative research across medical subspecialties from January 2000 to December 2024 in accordance with guidance by Donthu *et al*.[17]

Defining medical subspecialties

12 hospital-based medical subspecialties were included based on those assessed in a previous randomised controlled trial (RCT) bibliometric analysis by Strippoli *et al*: allergy and immunology, cardiology, dermatology, endocrinology and diabetes, gastroenterology, haematology, infectious diseases, nephrology, neurology, oncology, respiratory and rheumatology. These included subspecialties are predominantly organ or system-specific medical fields with consistent bibliometric indexing in databases and reliable retrieval using search strategies. The 'Nutrition and metabolic' subspecialty was excluded due to conceptual and indexing overlap with gastroenterology and endocrinology.[11] Subspecialties like geriatrics, palliative care and acute medicine, which have a broader scope spanning multiple organ systems, were excluded as they are less consistently indexed, which makes it more difficult to reliably capture relevant studies in bibliometric analyses.

Eligibility criteria

Studies were eligible if they were described by their authors as employing qualitative methods or were classified as qualitative research using Medical Subject Headings (MeSH) or Emtree terms (online supplemental table 1). Only primary research was included; systematic reviews, narrative reviews, conference abstracts, editorials, case reports and letters were excluded. Studies including both adult and paediatric populations were included; no age restrictions were applied. To reduce bias related to the COVID-19 pandemic's impact on publishing patterns, a validated filter developed by the National Institute for Clinical Excellence was applied to exclude COVID-19-related publications.[18] Searches covered 2000–2024, reflecting increased recognition of qualitative research compared with pre-2000[19] and the introduction of the 'Qualitative Research' MeSH in 2003.[20]

Data sources and search strategy

Medline, Embase and Emcare were searched using the Ovid platform. A single database platform was chosen to ensure consistency and to avoid the complex challenges of deduplication across multiple sources. Manual deduplication was considered to enable the inclusion of additional databases such as CINAHL and PsycINFO; however, this approach was deemed impractical given the anticipated large volume of search results. Because there are no filters in databases to reliably identify qualitative research, we developed a customised search strategy informed by 12 published approaches (online supplemental table 2).

The draft search was iteratively refined and its specificity assessed by manually screening the first 50 records for each subspecialty. The final strategy was reviewed using the Peer Review of Electronic Search Strategies checklist to ensure transparency, accuracy and reproducibility (online supplemental table 3).[21]

Subspecialty-specific MeSH and Emtree terms were identified using the permuted index function in Ovid (online supplemental table 4). Full search strategies are provided in online supplemental appendix 1. Duplicates were removed using the in-built function of the Ovid platform. Following bibliometric conventions, retrieved records are referred to as studies.[22–25]

Data analysis

For each subspecialty, the number and percentage of studies that were qualitative were analysed by publication year. Percentages were accompanied by 95% CIs calculated using binomial distribution methods. χ^2 tests were conducted to compare subspecialties. All statistical analyses were carried out using Stata MP V.18. Graphs were produced using GraphPad Prism V.10.

Adherence to reporting standards

Assessment of adherence to reporting standards was undertaken using the Joanna Briggs Institute Critical Appraisal Tool for Qualitative Research.[26] This tool evaluates the methodological rigour, credibility and trustworthiness of qualitative research. From the subspecialty with the highest and lowest number of qualitative studies, 100 studies were randomly selected per subspecialty according to the inclusion criteria in online supplemental appendix 2. These subspecialties were selected to allow comparison of adherence to reporting standards in subspecialties with relatively low versus relatively high numbers of published qualitative research, representing opposite ends of the spectrum. A sample size of 100 qualitative studies per subspecialty was chosen to balance depth of assessment with practical feasibility. To contextualise these findings and characterise reporting practices more broadly, a stratified sample of 10 studies per subspecialty was drawn across all 12 medical subspecialties (n=120). Selection was performed using a random number generator (random.org).[27] Studies without accessible full texts were replaced with another randomly selected study.

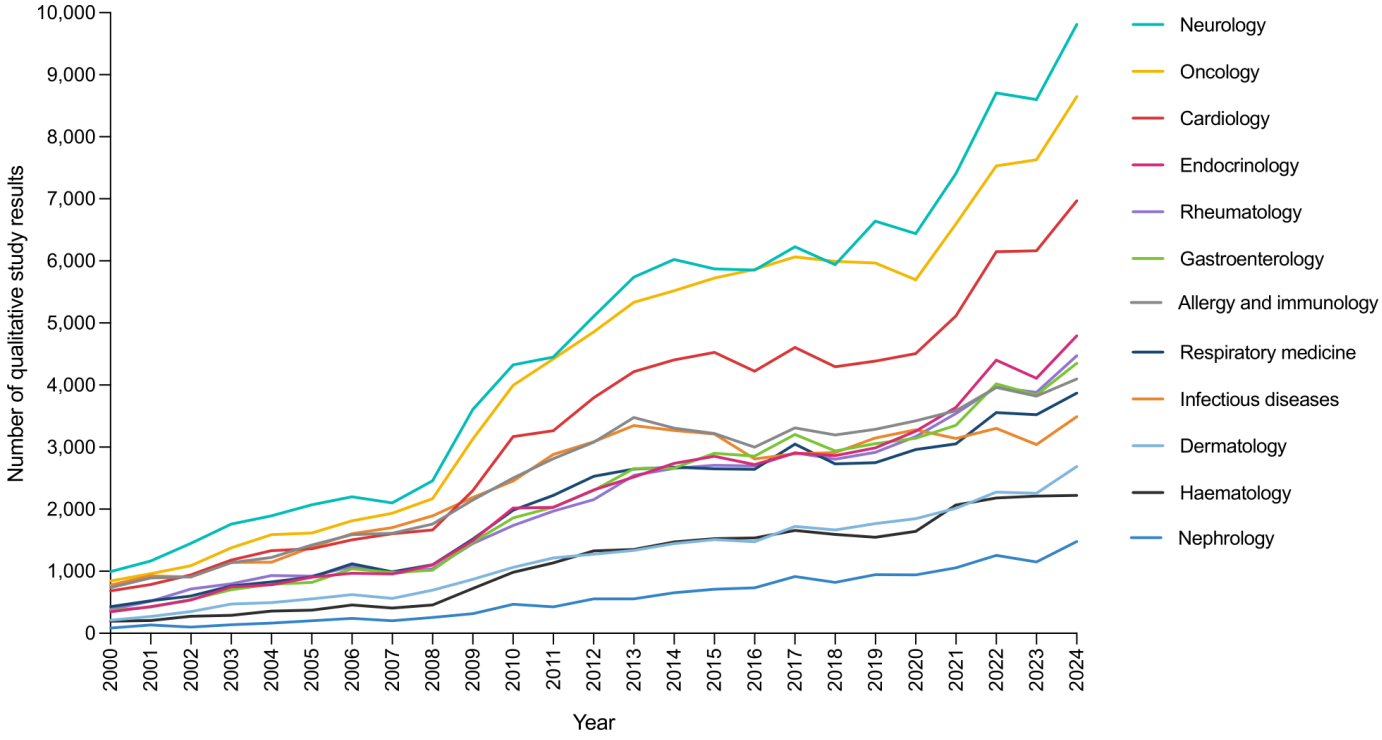


Figure 1 Absolute number of qualitative studies in 12 medical subspecialties 2000–2024.

RESULTS

Qualitative studies across 12 medical subspecialties

Across the 25-year period, a total of 715 471 qualitative studies were published representing 1.36% of all studies (52 620 042). The proportion of qualitative studies to all studies increased 1.6-fold, from 0.64% in 2000 (7242/990 080) to 1.05% in 2024 (56 909/2 919 825). Trends were broadly consistent across all subspecialties, with a notable surge in 2009 when most subspecialties experienced a 20–40% increase compared with the previous year.

Neurology had the highest absolute number of qualitative studies (116 835) and nephrology the lowest number (14 510). Figure 1 and table 1 show the absolute number of qualitative studies in each subspecialty. The corresponding raw counts and additional data are provided in online supplemental tables 5–8. The year-on-year percentage change in the number of qualitative studies across the 12 medical subspecialties is shown in online supplemental appendix 3.

The proportion of qualitative studies to all studies varied substantially across subspecialties. Haematology had the lowest proportion at 0.81% (95% CI 0.76% to 0.86%) (28 198/3 484 718) compared with 4.07% (95% CI 3.92% to 4.24%) in infectious diseases (59 947/1 471 313). Figure 2 and table 1 show the proportion of qualitative studies to all studies in each subspecialty. The change

Table 1 Number and percentage of studies that were qualitative in 12 medical subspecialties (2000–2024), from highest to lowest number

Medical subspecialty	Qualitative studies, n	All studies, N	Proportion of studies that were qualitative, % (95% CI)
Neurology	116 835	6 762 214	1.73 (1.68 to 1.78)
Oncology	106 360	8 550 339	1.24 (1.21 to 1.28)
Cardiology	83 155	7 341 430	1.13 (1.10 to 1.17)
Allergy and immunology	63 525	3 900 341	1.63 (1.57 to 1.69)
Infectious diseases	59 947	1 471 313	4.07 (3.92 to 4.24)
Endocrinology and diabetes	54 403	3 497 662	1.56 (1.49 to 1.62)
Gastroenterology	53 318	5 184 755	1.03 (0.99 to 1.07)
Rheumatology	52 925	3 911 146	1.35 (1.30 to 1.41)
Respiratory	51 637	4 216 396	1.22 (1.17 to 1.28)
Dermatology	30 658	2 690 186	1.14 (1.08 to 1.20)
Haematology	28 198	3 484 718	0.81 (0.76 to 0.86)
Nephrology	14 510	1 609 542	0.90 (0.83 to 0.98)

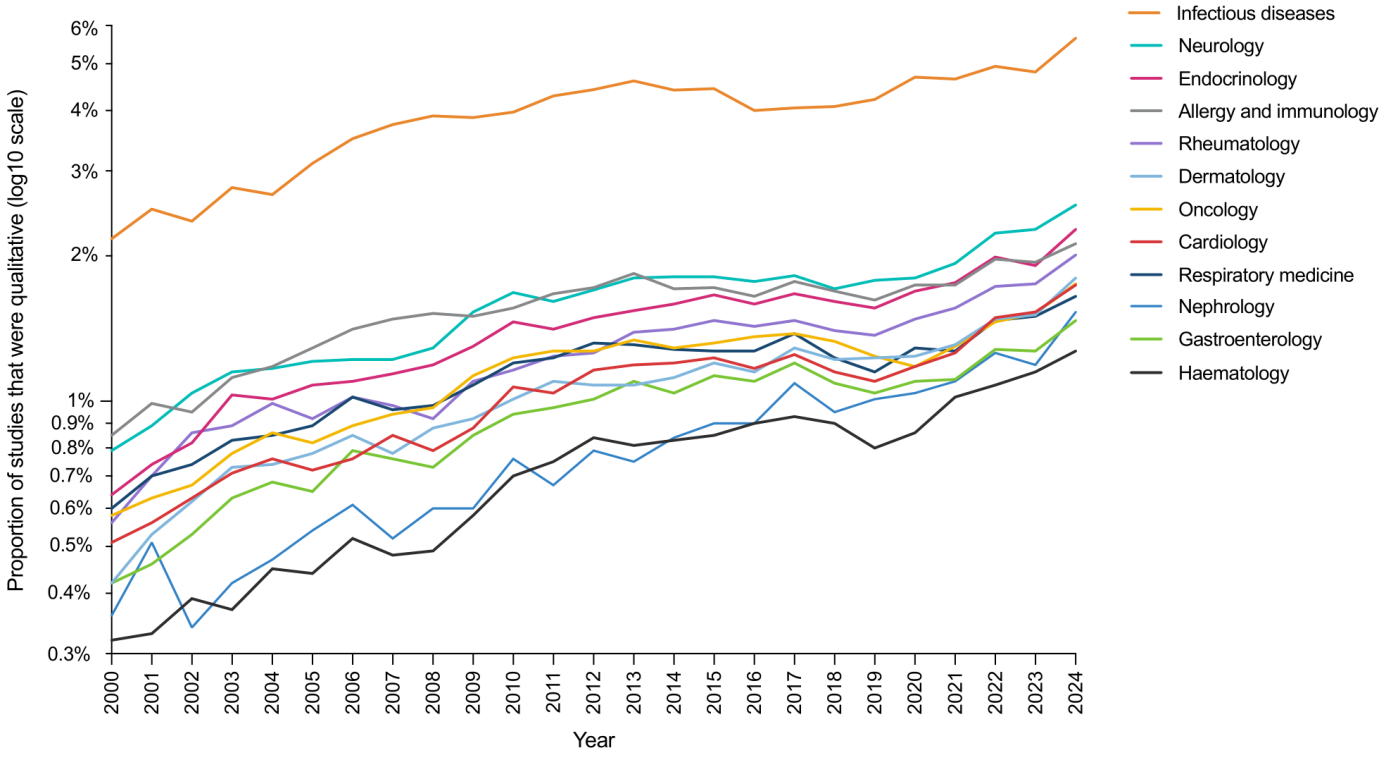


Figure 2 Proportion of qualitative studies in 12 medical subspecialties 2000–2024.

in the proportion of qualitative studies over the 25-year period varied significantly across the medical subspecialties (p<0.001, online supplemental table 9).

Adherence to reporting standards

Qualitative methods used in sampled studies

As the subspecialties with the highest and lowest number of qualitative studies, respectively, neurology and nephrology were selected to compare adherence to reporting standards. Of the 100 qualitative studies assessed in each of these two subspecialties, 84% (84/100) of neurology and 86% (86/100) of nephrology studies used only qualitative methods, while the rest employed mixed methods with a qualitative component. Data collection methods for the qualitative components of both qualitative and mixed-methods studies were similar across the 100 sampled studies in each subspecialty, with around half using semi-structured interviews (online supplemental table 10).

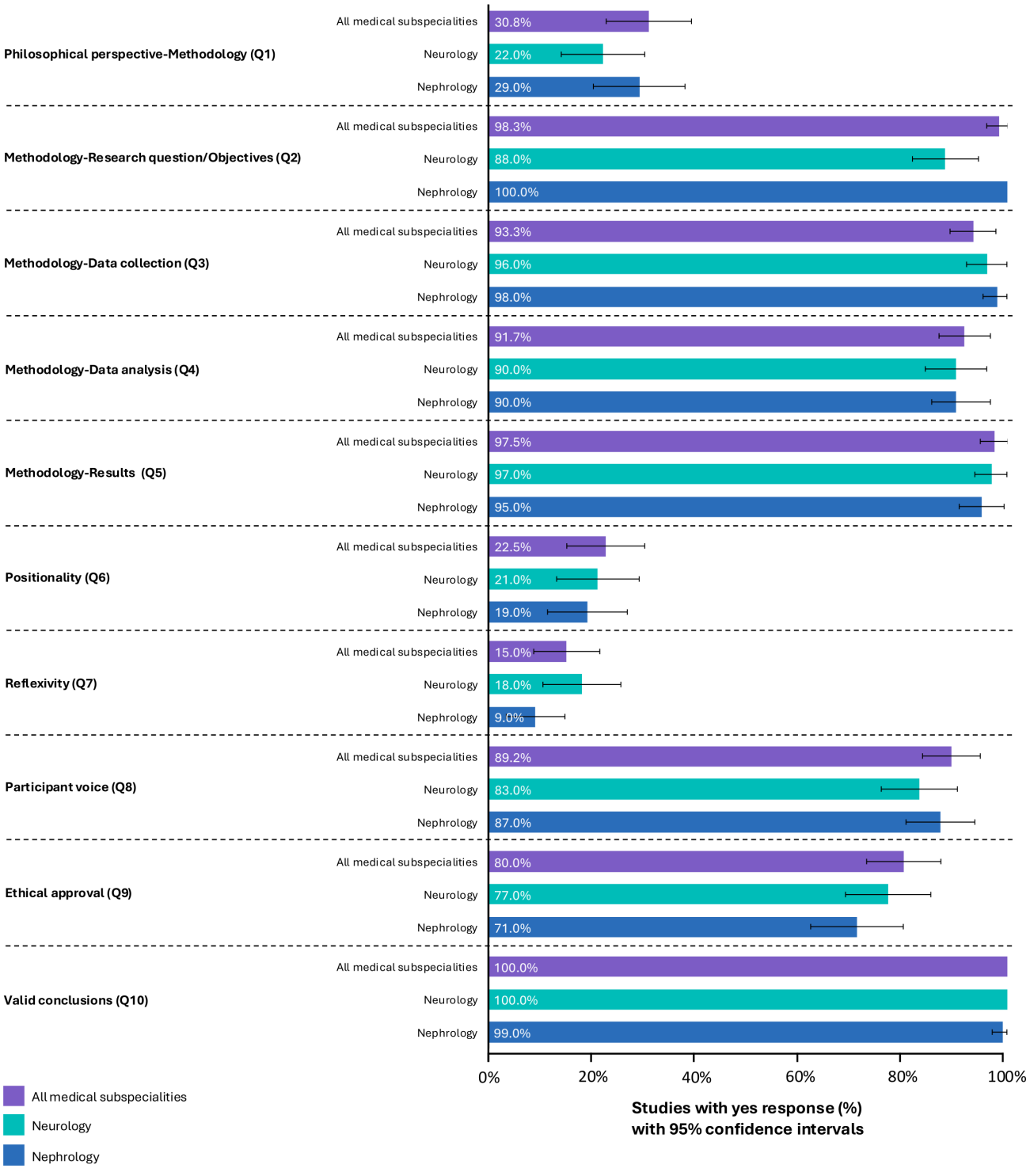
Adherence to reporting standards of sampled studies

Most studies in both subspecialties demonstrated strong methodological coherence, with clear alignment between their chosen methodology and each component of the research process—research aims, data collection, analysis and interpretation (Q2–Q5). The patterns observed in the medical subspecialty with the highest (neurology) and the lowest (nephrology) number of qualitative studies were consistent with the stratified sample across all subspecialties. A notable proportion of studies in both neurology and nephrology did not explicitly state their philosophical perspective, with 78% and 71% omitting this information (Q1), mirroring the findings from the stratified sample across all subspecialties. Researchers' reflexivity and positionality was also less consistently reported. Only 21% of neurology studies and 19% of nephrology studies reported the researchers' awareness of how their background and identity might influence their research (positionality) (Q6). Furthermore, only 18% of neurology studies and 9% of nephrology studies reported the researchers' awareness of how their biases might affect their research (reflexivity) (Q7). This was similar in the stratified sample across all subspecialties. Full assessment of adherence to reporting standards for both the subspecialty comparisons and the stratified sample across all subspecialties is presented in figure 3 and online supplemental table 11.

DISCUSSION

Summary of findings

Between 2000 and 2024, 715 471 qualitative studies were published across 12 medical subspecialties, representing 1.36% of all studies (52 620 042). Neurology and oncology had the largest number of qualitative studies (116 835 and 106 360). Infectious diseases contributed a lower absolute number (59 947), but had the highest proportion of qualitative studies (4.07%). Conversely, nephrology and haematology had the lowest number of qualitative studies (14 510 and 28 198) and lowest proportions (0.90% and 0.81%). The proportion of qualitative research increased across all subspecialties, with their relative positions remaining largely stable over time. The proportion of qualitative studies increased from 0.64%



Q1. Is there congruity between the stated philosophical perspective and the research methodology?
Q2. Is there congruity between the research methodology and the research question or objectives?
Q3. Is there congruity between the research methodology and the methods used to collect data?
Q4. Is there congruity between the research methodology and the representation and analysis of data?
Q5. Is there congruity between the research methodology and interpretation of results?
Q6. Is there a statement locating the researcher culturally or theoretically?
Q7. Is the influence of the researcher on the research, and vice-versa, addressed?
Q8. Are participants, and their voices, adequately represented?
Q9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?
Q10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

Figure 3 Adherence to reporting standards of qualitative studies in a sample of all medical subspecialties compared with the subspecialties with the highest (neurology) and lowest (nephrology) number of qualitative studies.

(6052/945 008) in 2000 to 1.95% (56 909/2 919 825) in 2024. Adherence to reporting standards was similar across subspecialties, with good methodological coherence but frequent under-reporting of philosophical perspectives, positionality and reflexivity.

Findings in the context of other research

Our findings build on earlier bibliometric analyses that showed qualitative research remains under-represented in the broader literature. Gagliardi and Dobrow reported that 0.0–0.6% of empirical research articles were qualitative studies in the 10 top ranked general medical journals, with proportions increasing from 0.22% in 1999 to 0.44% in 2008.[7] Similarly, McKibbon and Gadd found that 0.6% of all articles in 170 core clinical journals in 2000 were qualitative studies.[8] Because these studies focused on selected journals, their findings are not necessarily generalisable to activity within medical subspecialties. Their short time frames also preclude observation of longer-term trends and do not include recent studies, which our review addresses.

Qualitative research appears to be more established in other specialties such as primary care. Sidhu *et al* reported that approximately one-quarter of submissions to the *British Journal of General Practice* used qualitative methods, with a similar acceptance rate to quantitative methods[28]—substantially higher than the 1.6% we observed in 2017 across hospital-based medical subspecialties.

To our knowledge, no prior studies have systematically compared published qualitative research across medical subspecialties. Similar heterogeneity between subspecialties has been observed in bibliometric analyses of RCTs, but they did not propose potential explanations.[11 12] The differences we observed in qualitative research publications between subspecialties are unlikely to reflect a lack of relevance, as all of these fields involve patient experiences, communication challenges and complex decision-making where qualitative research is valuable. Rather, differences in uptake may reflect epistemic cultures, clinical context, professional norms and infrastructure.

Epistemic cultures shape which forms of knowledge are prioritised and which research questions are considered legitimate.[29] Subspecialties such as nephrology and haematology have historically focused on biomarkers, laboratory values and other quantifiable endpoints, reinforcing norms where quantitative methodologies are regarded as the most rigorous and clinically impactful.[30] In contrast, neurology may have adopted qualitative methods more readily because many neurological conditions are complex, subjective and significantly affect daily functioning, which can be difficult to capture quantitatively. Similarly, infectious diseases often involve psychosocial and behavioural complexities that lend themselves more readily to qualitative enquiry.[31]

Adoption of qualitative methods is further influenced by research infrastructure and collaborative networks.[32 33] Limited expertise, mentorship and institutional support in some subspecialties make conducting qualitative research harder.[34] In addition, journal cultures and a shortage of reviewers with qualitative methods experience may further reinforce the dominance of quantitative methods by reducing opportunities for qualitative research to be published.[35 36]

Although methodological congruence, participant representation and ethical conduct were typically well reported, philosophical perspectives and researcher influence (positionality and reflexivity) were frequently omitted.[37 38] Philosophical perspectives reflect the belief system guiding a researcher's worldview and how they conduct research.[39] Positionality involves researchers acknowledging their assumptions about the research topic, contexts and participants.[40 41] Reflexivity encourages critical examination and addressing of these assumptions.[42 43] Similarly to our study, Walsh *et al* found poor reporting of positionality and reflexivity in nursing journals, with only 33.4% and 19.1% reporting positionality and reflexivity, respectively.[44] In our review, adherence to reporting standards did not differ substantially between subspecialties with high and low qualitative research outputs, suggesting that under-reporting of these aspects is widespread rather than confined to less experienced subspecialties. These omissions may reflect either shortcomings in the research itself or publishing constraints, such as limits on manuscript length or word count.

Implications

Our review demonstrates that qualitative research across medical subspecialties has increased over the past 25 years, but it still represents only a small fraction of the published studies. Adoption is uneven across medical subspecialties, highlighting important gaps and missed opportunities for qualitative inquiry.

Where qualitative research has been conducted in under-represented subspecialties, it has generated valuable insights that directly influence care. In nephrology, qualitative studies exploring decision-making at end-stage kidney disease revealed communication biases and patients' perceptions of limited choice[45–47] leading to improvements in information-delivery, guidance and shared decision-making.[48] In haematology, qualitative research into 'watch and wait' uncovered hidden emotional distress and unmet informational needs for those with chronic blood cancers, prompting greater integration of psychosocial support.[49–51] These examples highlight the added value of qualitative research and potential consequences of its absence.

Despite such contributions, qualitative research remains undervalued by many journals and funders. Past editorial policies in high-impact journals, such as *The British Medical Journal*, have reiterated misconceptions about the lack of practical value and lower citation rates, despite evidence to the contrary.[52] To address this, action is needed by journals, funders and researchers. Journals should expand reviewer and editorial expertise in qualitative methods, encourage qualitative and mixed-methods submissions and allocate publication space for

high-quality studies. Funders should support qualitative and mixed-methods designs, particularly in medical subspecialties where uptake remains low. Researchers can help normalise qualitative evidence by integrating it into study designs and adhering to reporting guidelines to strengthen credibility. Without making these changes, we risk reinforcing an overly narrow evidence base. As care continues to become more complex and patient-centred is increasingly prioritised, qualitative research is essential for understanding decision-making, communication and the realities of care delivery. Supporting wider integration of qualitative research is therefore not simply an issue of academic balance, but a requirement for more responsive and evidence-informed healthcare.

CONCLUSIONS

Qualitative research is under-represented across medical subspecialties but has increased steadily over time, with notable variation in adoption between subspecialties. Adherence to reporting standards is generally high for methodological alignment, inclusion of participants' voices and ethical conduct. However, epistemological foundations and researcher influence, both critical to rigorous qualitative research, are under-reported.

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Contributors Author contributions are reported in line with the Contributor Role Taxonomy (CRediT). MG: data curation, formal analysis, investigation, project administration, visualisation, writing—original draft, writing—review and editing and guarantor. AS: methodology, writing—review and editing. LL: methodology, writing—review and editing. AO'C: supervision, writing—review and editing. JF: conceptualisation, supervision, writing—review and editing.

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Patient consent for publication Not applicable.

Ethics approval Not applicable.

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