SYNTHESISING QUALITATIVE RESEARCH FINDINGS: WHAT ARE THEY, WHERE ARE THEY AND WHAT SHOULD I DO WITH THEM? ESRC METHODS FESTIVAL 2016

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OUTLINE OF THE WORKSHOP

- WHAT IS SYSTEMATIC REVIEW AND EVIDENCE SYNTHESIS?
- WHAT ARE THE METHODS FOR QUALITATIVE EVIDENCE SYNTHESIS?
- FACILITATE GROUP WORK IN WHICH PARTICIPANTS WILL WORK IN SMALL GROUPS TO:
  - IDENTIFY AND CATEGORISE DIFFERENT TYPES OF FINDINGS IN RESEARCH REPORTS;
  - THINK ABOUT HOW TO UNDERTAKE A THEMATIC SYNTHESIS OR A META-ETHNOGRAPHY.
- UNDERSTAND DIFFERENCE BETWEEN KEY METHODS
- WHAT IS META-THEORY?
- HOW TO THINK ABOUT CONFIDENCE IN SYNTHESIS FINDINGS

WORKSHOP FORMAT 11:15-12:45

Time	Topic	Format
11:15-11:25	What is systematic review?	Presentation
11:25-11.45	What do qualitative findings look like & where do you find them?	Presentation
11:45-12	Look at example papers & identify types of finding	Small group work
12-12:10	Feedback	Whole group
12.10-12:20	What do I do with the findings once I have found them?	Presentation
12:20-12:30	Using findings from example papers, how could you synthesise them?	Whole group discussion
12:30-12:45	Other synthesis methods Confidence in finidings	Whole group

WHAT ARE SYSTEMATIC REVIEWS?

SYSTEMATIC REVIEWS:

- USE STRUCTURED APPROACHES TO IDENTIFYING, INCLUDING, QUALITY APPRAISING AND SYNTHESISING RESEARCH EVIDENCE ABOUT A GIVEN PHENOMENON
- TRY TO GIVE CLEAR DESCRIPTIONS OF WHAT WAS DONE AND WHY
- EMERGED FORM EVIDENCE BASED PRACTICE AND POLICY MAKING

SYSTEMATIC REVIEWS OF QUALITATIVE RESEARCH

WHY SYNTHESISE QUALITATIVE RESEARCH?

- STRATEGIC
- LESS WASTEFUL
- CREATE MORE POWERFUL EXPLANATIONS, HIGHER ORDER CONCEPTUALISATION
- BROADER, MORE ENCOMPASSING THEORIES (MORE TRANSFERABLE)
- BELIEF THAT IT "WILL YIELD TRUTHS THAT ARE BETTER, MORE SOCIALLY RELEVANT, OR MORE COMPLETE" (PATERSON ET AL, 2001)
- ENHANCE TRANSFERABILITY OF FINDINGS
- "INVOKES SOME DEGREE OF CONCEPTUAL INNOVATION OF THE PARTS AS A MEANS OF CREATING THE WHOLE" (STRIKE & POSNER, CITED BY NOBLIT AND HARE)

Try: http://www.wordle.net/

METHODOLOGICAL STUDY

- WE SEARCHED FOR METHODOLOGICAL PAPERS CONCERNING THE SYNTHESIS OF CONCEPTS OR THEORIES
  - PURPOSIVE, RATHER THAN SYSTEMATIC SEARCH
  - REFERENCE ‘CHASING’
  - GOOGLE SCHOLAR SEARCH
  - HANDSEARCHING KEY JOURNALS
- 203 PAPERS RETRIEVED
- 9 DISTINCT METHODS FOR SYNTHESIS

METHODS FOR SYNTHESIS IDENTIFIED

- META-NARRATIVE SYNTHESIS
- CRITICAL INTERPRETIVE SYNTHESIS
- META-STUDY
- META-ETHNOGRAPHY
- GROUNDED THEORY
- THEMATIC SYNTHESIS
- FRAMEWORK SYNTHESIS
- ECOLOGICAL TRIANGULATION

MANY METHODS: SIMILAR OR DIFFERENT?

- EXAMINED THE METHODS ACROSS DIFFERENT DIMENSIONS:
  - EPISTEMOLOGY
  - APPROACH TO QUALITY ASSESSMENT
  - ATTITUDES TOWARDS PROBLEMATIZING THE LITERATURE
  - USE OF REVIEW QUESTION
  - HOW SIMILAR / DIFFERENT THE INCLUDED STUDIES WERE
  - CHARACTERISTICS OF THE SYNTHETIC PRODUCT
- FOUND THEY FELL INTO TWO BROAD CAMPS: ‘IDEALIST’ AND ‘REALIST’

‘REALIST’ APPROACHES

PURPOSE

- TO ANSWER A POLICY RELEVANT QUESTION

METHODS

- QUALITATIVE/ QUANTITATIVE DATA ANALYSED WITH QUALITATIVE/ QUANTITATIVE METHODS
- SEARCHING LINEAR OR ITERATIVE
- QUALITY ASSESSMENT OF STUDY METHODS

PRODUCT

- DIRECTLY APPLICABLE TO POLICY AND PRACTICE DECISIONS

‘IDEALIST’ APPROACHES

PURPOSE

- TO EXPLORE AND CONSTRUCT CONCEPTS FROM THE DATA
- FOR GENERATING THEORY

METHODS

- QUALITATIVE DATA ANALYSED WITH QUALITATIVE METHODS
- SEARCHING ITERATIVE
- QUALITATIVE ASSESSMENT OF STUDY CO*NTENT* > *METHOD*

PRODUCT

- COMPLEX, REQUIRING FURTHER INTERPRETATION BEFORE BEING USED FOR POLICY OR PRACTICE

CONCLUSIONS

- OPERATIONALLY, MANY METHODS ARE VERY SIMILAR
- UNDERLYING PRINCIPLES DIFFER
- PRODUCT DIFFERS IN TERMS OF THE AMOUNT OF ADDITIONAL INTERPRETATION REQUIRED. THIS MAY REFLECT…

- BARNETT-PAGE E, THOMAS J (2009) METHODS FOR THE SYNTHESIS OF QUALITATIVE RESEARCH: A CRITICAL REVIEW. *BMC MEDICAL RESEARCH METHODOLOGY*, 9:59. DOI:10.1186/1471-2288-9-59. (HTTP://WWW.BIOMEDCENTRAL.COM/1471-2288/9/59)

CONFIGURATION & AGGREGATION

- NEW (ISH) WORK IN SRS HAS ARGUED THAT THE QUALITATIVE / QUANTITATIVE BINARY DIVIDE CONCEALS MORE THAN IT REVEALS
- SUGGESTS A BETTER HEURISTIC IS AGGREGATE / CONFIGURE
  - VOILS CI, SANDELOWSKI M, BARROSO J, HASSELBLAD V: MAKING SENSE OF QUALITATIVE AND QUANTITATIVE FINDINGS IN MIXED RESEARCH SYNTHESIS STUDIES. FIELD METHODS 2008, 20:3–25.
  - SANDELOWSKI M. VOILS CJ, LEEMAN J, CRANDLEE JL (2011) MAPPING THE MIXED METHODS-MIXED RESEARCH SYNTHESIS TERRAIN *JOURNAL OF MIXED METHODS RESEARCH*
  - GOUGH D, OLIVER S, THOMAS J (2012) AN INTRODUCTION TO SYSTEMATIC REVIEWS. LONDON: SAGE
  - GOUGH D; THOMAS J; OLIVER S (2012) CLARIFYING DIFFERENCES BETWEEN REVIEW DESIGNS AND METHODS. *SYSTEMATIC REVIEWS*. 1(28)

AGGREGATION IN REVIEWS

AGGREGATION REFERS TO 'ADDING UP' (AGGREGATING) FINDINGS FROM PRIMARY STUDIES TO ANSWER A REVIEW QUESTION…

… TO INDICATE THE DIRECTION OR SIZE OF EFFECT

… AND OUR DEGREE OF CONFIDENCE IN THAT FINDING

GOUGH D; THOMAS J; OLIVER S (2012) CLARIFYING DIFFERENCES BETWEEN REVIEW DESIGNS AND METHODS. *SYSTEMATIC REVIEWS*. 1(28)

CONFIGURATION IN REVIEWS

CONFIGURATION INVOLVES THE ARRANGEMENT (CONFIGURATION) OF THE FINDINGS OF PRIMARY STUDIES TO ANSWER THE REVIEW QUESTION….

… TO OFFER A MEANINGFUL PICTURE OF WHAT RESEARCH IS TELLING US

… ACROSS A POTENTIALLY WIDE AREA OF RESEARCH

Methods of evidence synthesis

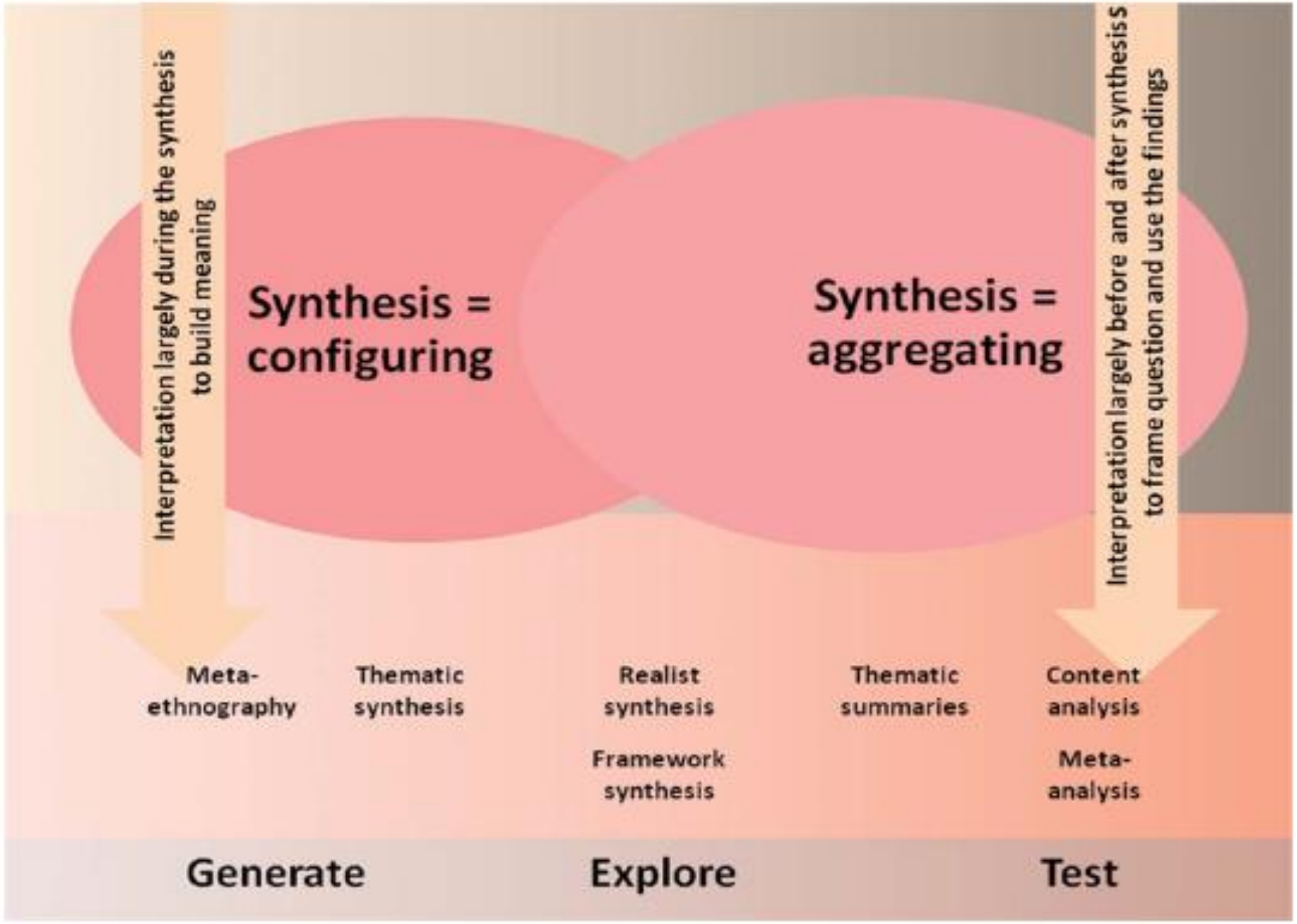
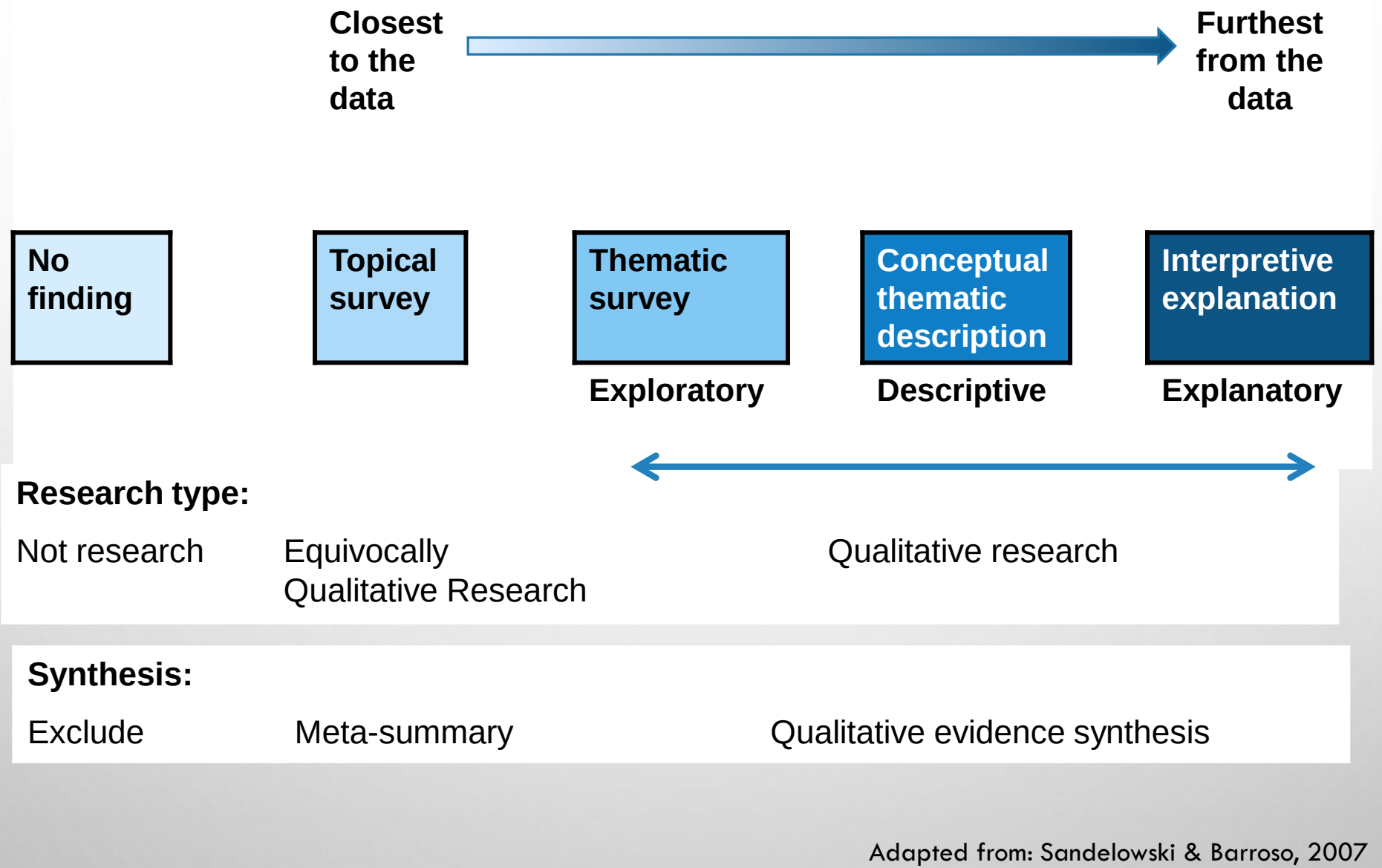


Figure 1. Methodological continuum of synthesis approaches and methods.
Source: Adapted from Thomas *et al*. (2012).



Adapted from: Sandelowski & Barroso, 2007

CHOOSING A METHOD

- EXPERIENCE
- TIME & RESOURCES
- PURPOSE OF REVIEW
- AUDIENCE AND PURPOSE
- TYPE OF EVIDENCE AVAILABLE

WHAT DOES QUALITATIVE DATA LOOK LIKE?

Member of sta
them … when t
and stuff … you
ask them, 'Woul
outside for a lit
for some of the
them down. It c
outside and
whatever was a

Member of staff – "When I take residents out into the garden, especially those from the dementia care unit who don't speak, they make a deep sigh, as if they are at peace."

WHAT DO FINDINGS FROM QUALITATIVE RESEARCH EVIDENCE LOOK LIKE?

HOW DO WE MAKE SENSE OF THE WORLD? (LEVELS OF INTERPRETATION)

- 1ST ORDER CONSTRUCTS :
  - EVERYDAY WAYS OF MAKING SENSE OF OUR WORLD (SEEN AS PARTICIPANT QUOTES AND DESCRIPTIVE THEMES)

- 2ND ORDER CONSTRUCTS:
  - SOCIAL SCIENCE RESEARCHERS' INTERPRETATIONS OF THIS "COMMON SENSE WORLD" TO ACADEMIC CONCEPTS AND THEORIES

- 3RD ORDER CONSTRUCTS?
  - REVIEWERS' INTERPRETATIONS OF THE RESEARCHERS' INTERPRETATIONS.

(AFTER SCHULTZ)

CVD PREVENTION PROGRAMMES

Quote (1st order)	Researchers' interpretations (2nd order)	Reviewers' interpretation (3rd order)
"Pamphlets involve a lot of reading…food sampling gives them the opportunity to feel relaxed and ask questions."	Practical demonstrations have more impact than provision of written information.	Personalised support, allowing relationships to develop & facilitating questioning, may have more impact.
"Sue was great, she had lots of information and advice."	Programme "champions" allow personalised information about the interventions to be disseminated.	

TYPES OF FINDINGS FROM QUALITATIVE RESEARCH (AND REVIEWS)

- DESCRIPTION OF A PHENOMENON
- DEFINITION OF A NEW CONCEPT
- CREATION OF A NEW TYPOLOGY
- DESCRIPTION OF PROCESSES
- EXPLANATIONS OR THEORIES
- DEVELOPMENT OF STRATEGIES

WHAT DOES THIS LOOK LIKE?

- TEXT (QUOTES, AUTHOR'S ANALYSIS)
- TABLES (CLASSIFICATIONS, SUMMARY OF THEMES)
- CONCEPTUAL FIGURES
- IMAGES (PHOTOGRAPHS, ARTWORK)

LOOKING FOR FINDINGS IN A PAPER

A Socially Excluded Space: Restrictions on Access to Health Care for Older Women in Rural Bangladesh

Qualitative Health Research
20(9) 1192–1201

DOI: 10.1177/1049732310370695
http://qhr.sagepub.com
SAGE

Abul Hossen[1] and Anne Westhues[2]

Abstract

This study was an exploration of the experiences of 17 women, age 60 or more years, from Bangladesh. The women were asked about decision-making processes with respect to their access to health care and whether they perceived that there were differences based on age and sex in the way a household responds to an illness episode. The overall theme that characterized their experiences was "being in a socially excluded space." The themes that explained this perception of social exclusion included gender- and age-based social practices, gender- and class-based economic practices, religious beliefs that restricted the mobility of women, and social constructions of health and illness that led the women to avoid seeking health care. We conclude that the Bangladesh constitutional guarantee that disparities will be eliminated in access to health care between rich and poor, men and women, rural and urban residents, and younger and older citizens has not yet been realized.

Finally, saturation occurs when there is ongoing replication of data covering the emerging essential thematic elements of the phenomenon under study (Woodgate, Ateah, & Secco, 2008). In this study, the redundancy of data became evident after hearing the narratives of 8 participants.

Findings

The analysis of the interviews provided a deep understanding of the older rural women's perceptions of restrictions on their access to health care when they are sick, and the mechanism by which these processes work. The overarching or core theme that emerged to capture the essence of being an older woman seeking health care in rural Bangladesh was *being in a socially excluded space*. Being in a socially excluded space was defined by social practices that assumed an inferior role for older women within the family and less access to family resources than other family members; exclusion from the opportunity to participate in the wage economy outside the home; and exclusion from the broader community through the restrictions on mobility outside the home and contact with men who are not family members that are associated with the religious practice of purdah. The women interviewed also talked about the stigma associated with some illnesses and their inclination to avoid this stigma, which meant that they did not go for medical care when they were ill. These themes are developed below, and quotes provided to support the analysis.

Exclusionary Social Practices

Older women's health is treated as the least important in the family. In general, the women interviewed reported that the health of an older adult woman is treated as less important within the family than that of the rest of the family. They felt that limited attention was given to them during their sickness compared to the attention given to other members of the family. They identified both age and gender as factors that influence health care seeking, with younger people being given priority for health care within the family. Participants agreed that children with any illness were prioritized for treatment because of the common view that "children have not begun their life, but the elderly have almost lived theirs." For a typical family, the order of priority for seeking health care was: baby boy, baby girl, father, grandfather, mother, and then grandmother.

Husbands were more likely to pay for medical care for themselves and their children than for their wives. This attitude was inculcated through socialization to children, with the result that they also privileged older adult men over women. As one participant who had a heart problem said, "In our *shomaj* [society] women never get priority. My husband and I are both suffering from diabetes. My son brings medicine for my husband but he does not care for me. Actually, my name is not on the priority list." Most participants who were suffering from some type of illness perceived that they were unsupported in their illness. For example, one participant commented, "Because we are senior and women our sickness gets limited attention within the family. However, when my husband gets sick everybody becomes *chintitoto* [concerned] and brings *oshodpathha* [medicine and special food]. But they ignore my problems."

Others decide for you. When asked about how decisions were made within the family with respect to accessing health care, the women interviewed said that they informed someone in the family when they were sick. They usually discussed the sickness with their husbands first, or if the husband was deceased, with the eldest son. Participants explained that even if husbands did not accompany them to the health care providers, they played an important role in decision making for health care. In the words of one woman, "In case of any *ashukh Bishukh* [illness], the first person I talk with is my husband, because he knows who he can talk with for advice and also controls the money." Another participant stated,

> In case of any sickness, I talk with my family members first because without the family's permission I cannot see a doctor. It is not easy. You need money, you need somebody to accompany you, you also need to manage your daily chores before you go.

Demonstrating the relationship between decision-making processes and religious beliefs, one participant explained,

> My husband makes the decision but my *Bhasur* [husband's senior brother] is interested in where I go and what to do. If he learns that I have gone to the hospital, he gets mad. He says I am trying to destroy the *shomman* [image] of the family, because the family has a long reputation about purdah [women's seclusion in the home].

The needs of other household members come first. Women also reported being reluctant to disrupt the household by taking time from their domestic chores to seek treatment or be admitted to hospital. These women were socialized not to complain about illnesses or pain, and to continue working for the welfare of their families even when quite ill. Explaining how this affected access to health care, one participant said, "After my daughter died her two children came to me. It is my responsibility to take care of them. I cannot go to hospital and leave them alone." Another participant said, "I find it difficult to have time for myself. I don't want to wait for four hours in the hospital and be absent from housework."

Exclusionary Economic Practices

Work is at home, not in the wage economy. Although this is beginning to change, women in Bangladesh traditionally did not have direct access to means of production such as land. They had access to land only through their male guardians, their male children, or their spouses, and did not work outside the home. All participants in the study followed this traditional pattern and hence earned little or no income. Because they had no income of their own, the threshold for defining a need for health care tended to be high for them. They identified this economic barrier to health care access with comments such as, "Since men are involved in income-earning activities, they should have priority in getting treatment." Several participants made observations such as the following: "If we had a job, we could earn money and spend it on our health." This shows that they understood that it was not only family poverty that created a barrier to health care for women, but their exclusion from having sources of income over which they had control.

Being poor. Family poverty and lack of savings because of the cost of day-to-day living were common reasons given for not seeking health care. The influence of poverty on health-seeking behaviors was explained by several participants, who described how they prioritized the health needs of other household members over their own. A family situation of debt and limited resources led many women to remain silent about their condition. As one participant explained, "Money is the biggest problem for us. I try not to think about it, but it seems to always be there, over my head."

The cost of medications was often mentioned as a barrier to getting help. Even if free care was available at the health center, medicines were not always free. Participants reported that it was common for medicine to be out of stock at the health center, so it became necessary to pay for it at the drug store. As one participant observed, "In hospital you might get a prescription if doctors are available, but where will you get medicine? The difficult thing is, although you have a prescription, there is no money to buy it. This is expensive." Another participant explained, "The only thing you might get from hospital is a prescription or at best two tablets. They will tell you to buy the medicine. I don't have money." Another explained that money might be available for medications initially, but if the need for them continued, the family could not afford it:

> I have been suffering from an eye problem for five years and taking medicines, but recently I stopped. I am now tired of taking medicine, it never works. So I would really like to go to another doctor but due to my husband's financial condition, I cannot.

Exclusionary Religious Beliefs

Restricted mobility. Purdah is an important religious practice that restricts the mobility of women members of Bangladeshi society. A strong tradition of purdah acts to seclude women within their homes. It is unacceptable for women to go to a health center without an escort, for example. One participant explained, "If I go to hospital by myself, it might destroy the *shomman* [image] of the family in the community." In a more extreme interpretation of purdah, another participant said, "You cannot go outside of the house since this is not allowed by *Shariah* [Islamic law]. At this age I should not disobey the *Bidhan* [code] of Islam."

Restrictions on contact with men outside the family. In rural Bangladesh, ideologies of purity and shame remain so important to the status of women that Muslim female patients cannot speak directly to male doctors. Instead, husbands or sons explain the women's health concerns to the doctor on their behalf (Rozario, 1995). Illustrating this point, one participant said, "A man seeing a woman's body not only leads to sins of the wife but also of the husband and the family. Totally against our religion, you see, and that is why we do prefer a lady doctor." Another said,

> I feel *lojja* [shame] to talk to a male doctor about *mayali* [female] problems. Male doctors do not understand some *mayali ashukh* [female diseases]. You can talk about *mathabetha* [headache] to a male doctor, but how can you show your *book* [breast] to a male doctor?

Many participants said they preferred women health care providers because of greater comfort talking to them compared to men physicians. One participant said she preferred a woman provider because "she is my kind," and because it would be easier to share problems with a woman. Three others said that they believed that a woman doctor had a better understanding of their problems: "If I tell a male doctor that I have a *mashiker gondogole* [menstrual problem], he does not know what it is to have a menstrual problem. He will not understand me directly." This applied particularly to "women's problems," probably because they thought that a doctor who had shared or would share the experiences of menstruation, pregnancy,

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Second order interpretations/constructs: how researchers interpret people's experiences

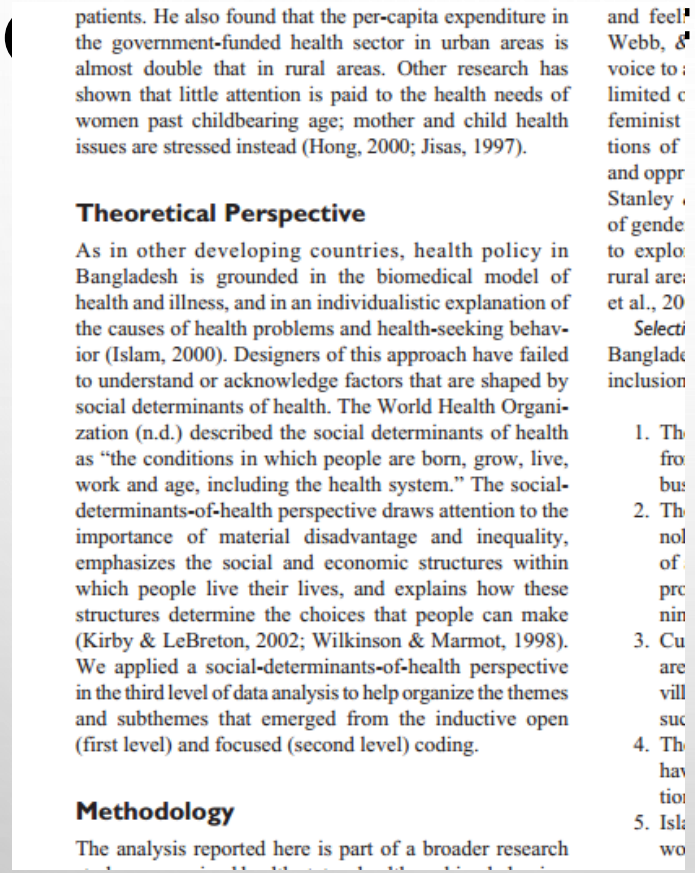
First order interpretations/constructs : how people make sense of their experiences

and not suffer. This is our *kismet* [destiny].

Stigma associated with some illnesses. Considerable stigma was associated with diseases of the sexual organs, especially sexually transmitted diseases. Participants who thought they might have these diagnoses were very concerned about the consequences of detection and the possibility of being ostracized by their family and community.

Use of existing theory in qualitative research analysis:
Stigma (Goffman, 1963)
A well developed theory about how identity and acceptability are socially managed and constrained

SOMETIMES IMPORTANT INFORMATION RELATED TO THE FINDIN INDINGS SECTION!



patients. He also found that the per-capita expenditure in the government-funded health sector in urban areas is almost double that in rural areas. Other research has shown that little attention is paid to the health needs of women past childbearing age; mother and child health issues are stressed instead (Hong, 2000; Jisas, 1997).

Theoretical Perspective

As in other developing countries, health policy in Bangladesh is grounded in the biomedical model of health and illness, and in an individualistic explanation of the causes of health problems and health-seeking behavior (Islam, 2000). Designers of this approach have failed to understand or acknowledge factors that are shaped by social determinants of health. The World Health Organization (n.d.) described the social determinants of health as "the conditions in which people are born, grow, live, work and age, including the health system." The social-determinants-of-health perspective draws attention to the importance of material disadvantage and inequality, emphasizes the social and economic structures within which people live their lives, and explains how these structures determine the choices that people can make (Kirby & LeBreton, 2002; Wilkinson & Marmot, 1998). We applied a social-determinants-of-health perspective in the third level of data analysis to help organize the themes and subthemes that emerged from the inductive open (first level) and focused (second level) coding.

Methodology

The analysis reported here is part of a broader research

Found between the Introduction and the Methodology sections

Found in the Discussion section:

age routine preventive health practices and attention to symptoms in their early stages.

Our findings suggest that the constitutional guarantee that the state will adopt effective measures to reduce disparities in access to health care between rich and poor, men and women, rural and urban residents, and younger and older citizens has not yet been realized for the older women in this study. Bangladesh has had a series of policies in place since 1995 that promote the goals of poverty reduction and greater gender equity (Pal, 2001). The National Action Plan for Advancement of Women (BMOHFW, 2005b) sets out strategies to achieve the commitments Bangladesh has made to the Beijing Platform for Action

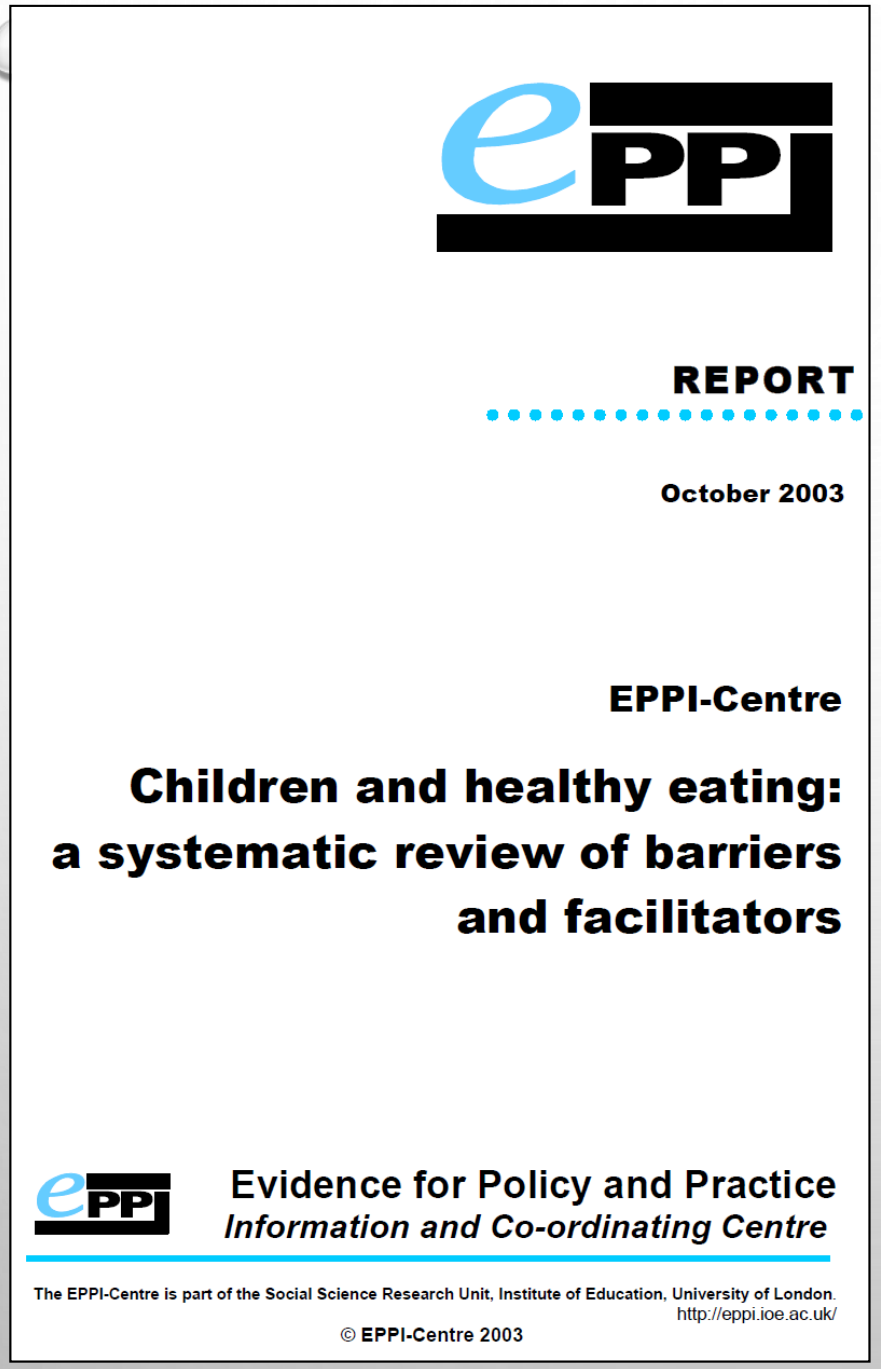
EXERCISE

- WHAT FINDINGS ARE THERE IN THE PAPER THAT YOU HAVE?
  - FIND EXAMPLES OF
    - 1ST ORDER CONSTRUCTS
    - 2ND ORDER CONSTRUCTS
    - HOW ARE THEY PRESENTED?
    - WHERE ARE THEY FOUND?

EXAMPLES OF SYNTHESIS I: THEMATIC SYNTHESIS

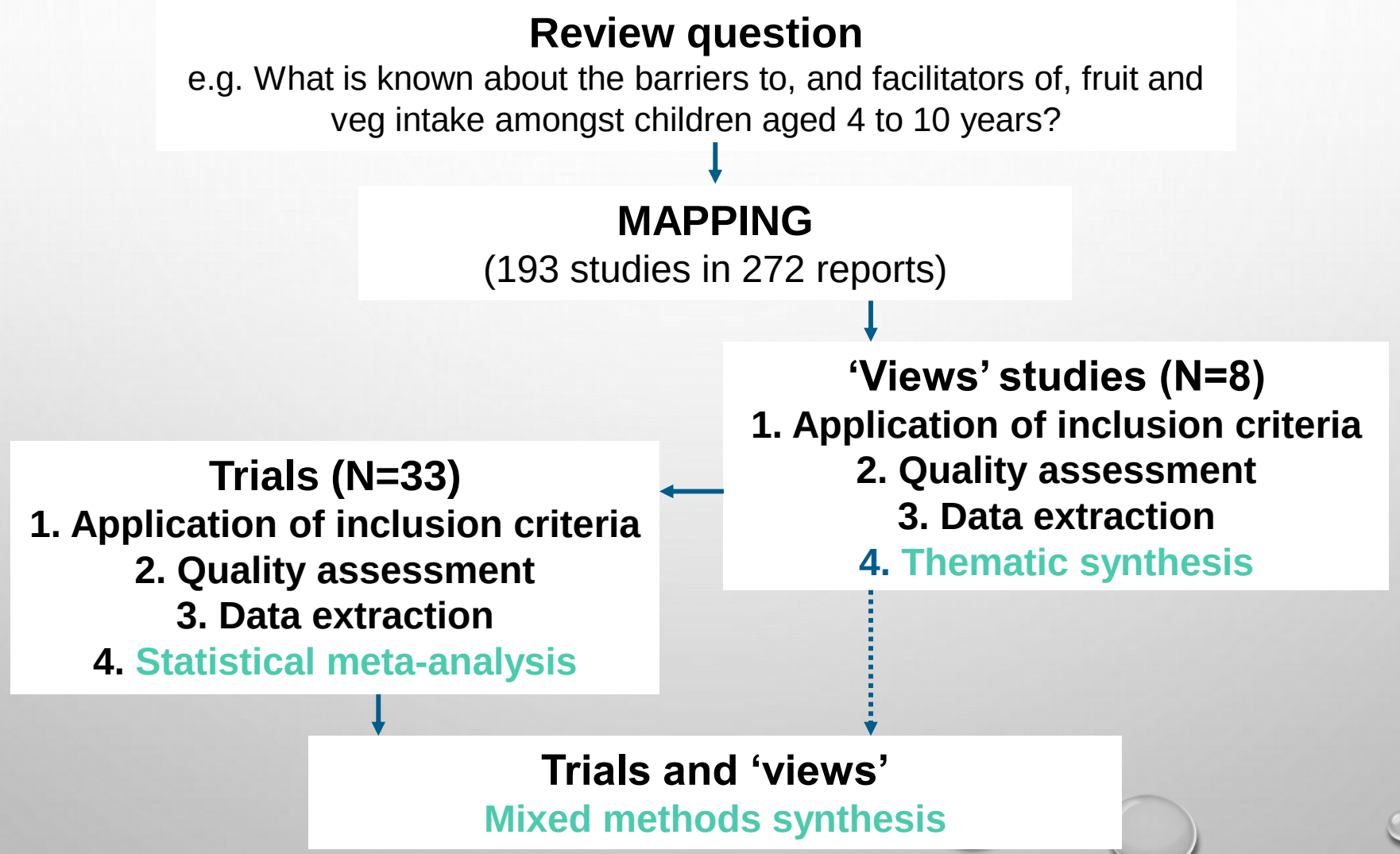
ORIGINS

- ECHOES THEMATIC ANALYSIS IN PRIMARY QUALITATIVE RESEARCH
- MAY USE LINE BY LINE CODING OR EXTRACT THEMES BEFORE CODING
- CODES OFTEN DESCRIPTIVE, BUT MAY BUILD UP TO BE MORE CONCEPTUAL



http://eppi.ioe.ac.uk/EPPIWebContent/hp/reports/healthy_eating02/Final_report_web.pdf

THEMATIC SYNTHESIS PART OF A MIXED METHODS REVIEW



THREE ANALYTIC STEPS DESCRIBED IN THEMATIC SYNTHESIS

1. THE CODING OF TEXT 'LINE-BY-LINE‘ (DATA DRIVEN CODES);
2. THE DEVELOPMENT OF 'DESCRIPTIVE THEMES'; AND
3. THE GENERATION OF 'ANALYTICAL THEMES‘ (THEORY DRIVEN CODES).

SYNTHESIS APPROACH

- FINDINGS OF EACH STUDY EXAMINED IN TURN, EACH SENTENCE OR PARAGRAPH ASSIGNED A DESCRIPTIVE CODE – "LINE BY LINE CODING" (E.G. CHILDREN PREFER FRUIT TO VEGETABLES) (IN NVIVO) 36 INITIAL CODES.
- SIMILARITIES AND DIFFERENCES BETWEEN CODES SOUGHT TO GROUP THEM INTO A HIERARCHICAL TREE STRUCTURE.
- NEW CODES WERE CREATED TO CAPTURE THE MEANING OF GROUPS OF INITIAL CODES. 13 DESCRIPTIVE THEMES.
- A NARRATIVE SUMMARY OF THE FINDINGS ACROSS THE STUDIES ORGANIZED BY THESE 13 DESCRIPTIVE THEMES WAS THEN WRITTEN.

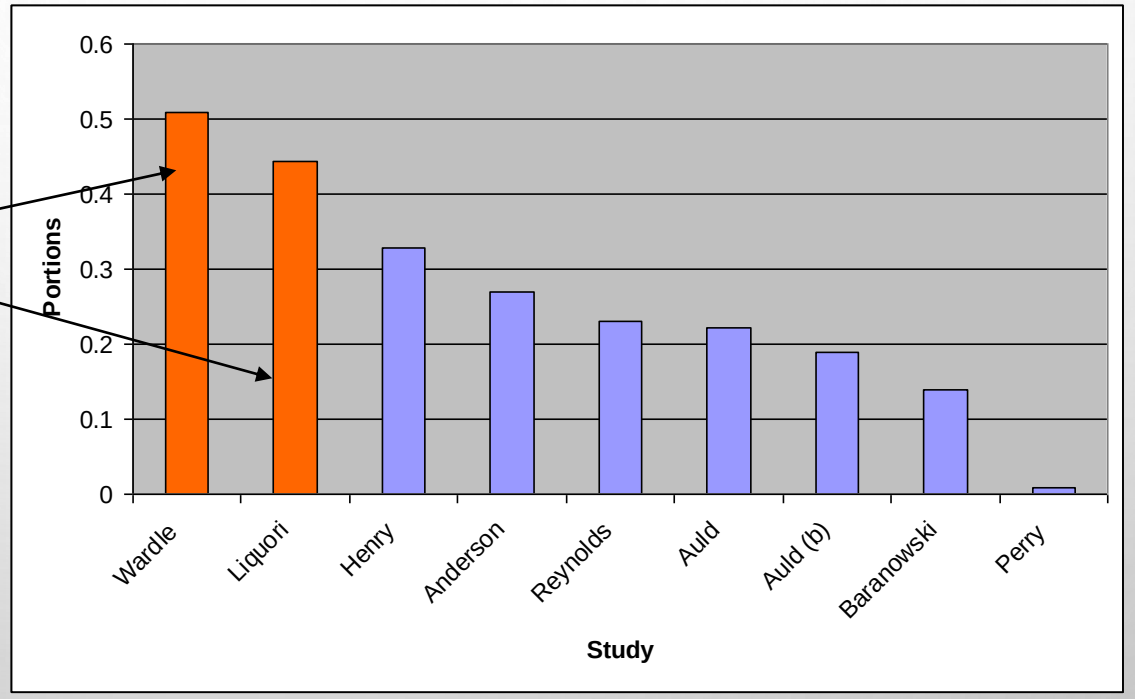
FINDINGS FROM QUALITATIVE SYNTHESIS 'DROVE' MM SYNTHESIS

Children's views	Outcome evaluations	
Recommendation for interventions	**Good quality**	**Other**
Do not promote fruit and vegetables in the same way	No soundly evaluated interventions	No other interventions identified
Brand fruit and vegetables as an 'exciting' or child-relevant product, as well as a 'tasty' one	5 soundly evaluated interventions identified	5 other interventions
Reduce health emphasis in messages to promote fruit and vegetables particularly those which concern future health	5 soundly evaluated interventions identified	6 other interventions identified

QUALITATIVE SYNTHESIS FORMED THE BASIS OF QUANTITATIVE SUB-GROUP ANALYSIS

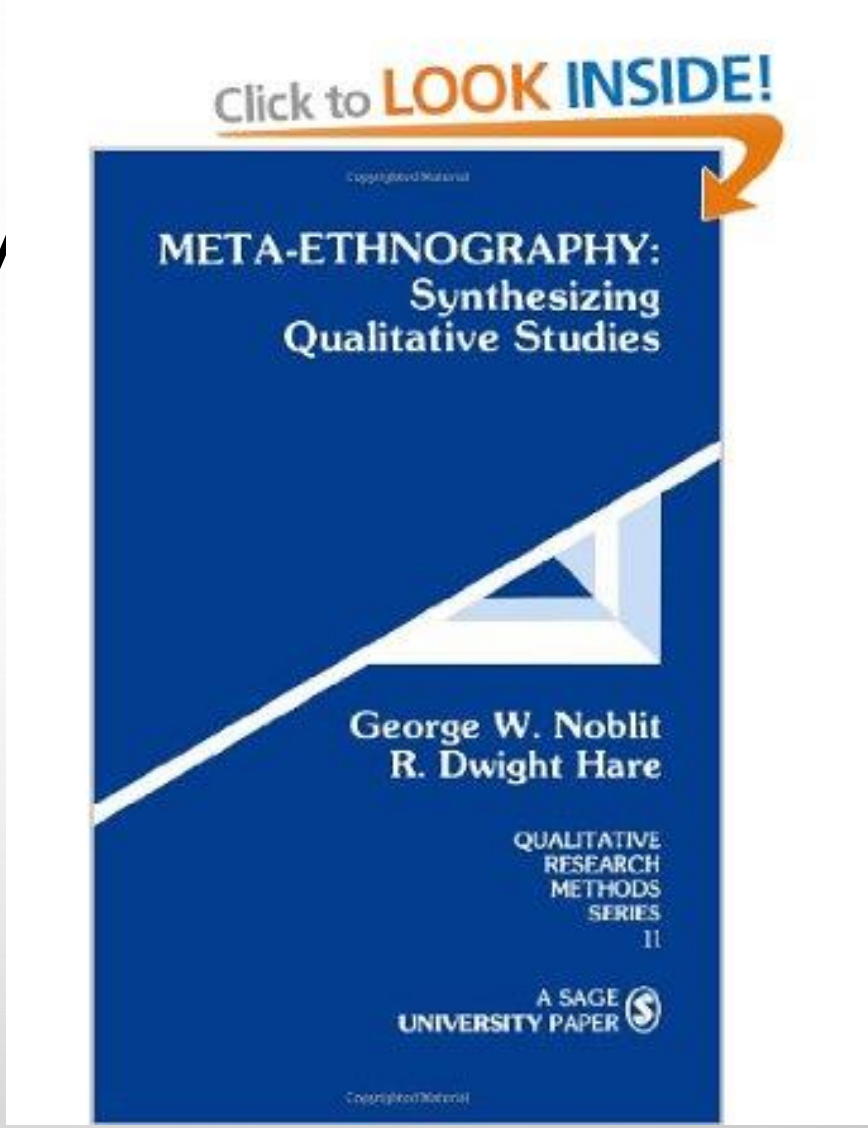
Increase (standardised portions per day) in vegetable intake across trials

Little or no emphasis on health messages



EXAMPLES OF SYNTHESIS II: META-ETHNOGRAPHY

KEY TEXT FROM



Original research

Using meta ethnography to synthesise qualitative research: a worked example

Nicky Britten, Rona Campbell[1], Catherine Pope[1], Jenny Donovan[1], Myfanwy Morgan[2], Roisin Pill[3]

Department of General Practice and Primary Care, King's College, London; [1]Department of Social Medicine, University of Bristol; [2]Department of Public Health Sciences, King's College, London; [3]Department of General Practice, University of Wales College of Medicine, Cardiff, UK

***Objectives*: To demonstrate the benefits of applying meta ethnography to the synthesis of qualitative research, by means of a worked example.**

***Methods*: Four papers about lay meanings of medicines were arbitrarily chosen. Noblit and Hare's seven-step process for conducting a meta ethnography was employed: getting started; deciding what is relevant to the initial interest; reading the studies; determining how the studies are related; translating the studies into one another; synthesising translations; and expressing the synthesis.**

***Results*: Six key concepts were identified: adherence/compliance; self-regulation; aversion; alternative coping strategies; sanctions; and selective disclosure. Four second-order interpretations (derived from the chosen papers) were identified, on the basis of which four third-order interpretations (based on the key concepts and second-order interpretations) were constructed. These were all linked together in a line of argument that accounts for patients' medicine-taking behaviour and communication with health professionals in different settings. Third-order interpretations were developed which were not only consistent with the original results but also extended beyond them.**

***Conclusions*: It is possible to use meta ethnography to synthesise the results of qualitative research. The worked example has produced middle-range theories in the form of hypotheses that could be tested by other researchers.**

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Introduction

stemological reasons. Computerised literature searches are likely to miss much qualitative research that is

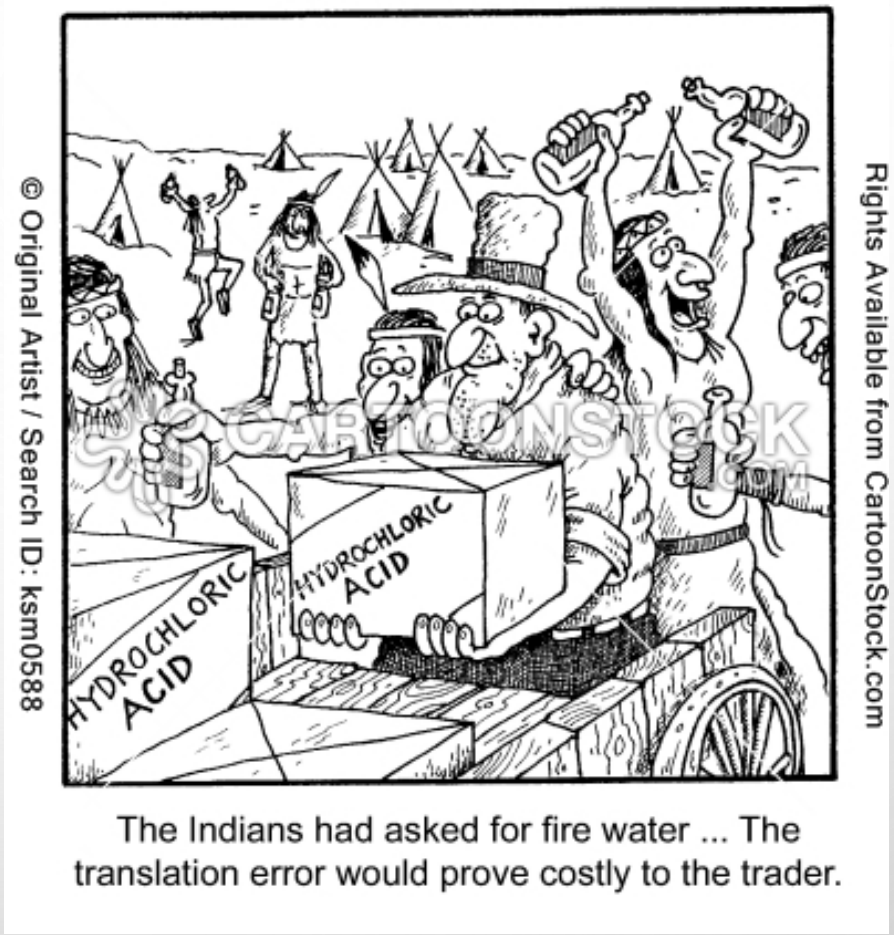
DEFINITION OF SYNTHESIS IS EXPLICITLY INTERPRETATIVE

ACTIVITY OR THE PRODUCT OF ACTIVITY WHERE SOME SET OF PARTS IS COMBINED OR INTEGRATED INTO A WHOLE…

(SYNTHESIS) INVOLVES SOME DEGREE OF CONCEPTUAL INNOVATION, OR EMPLOYMENT OF CONCEPTS NOT FOUND IN THE CHARACTERIZATION OF THE PARTS AS A MEANS OF CREATING THE WHOLE

STRIKE & POSNER (1983) QUOTED IN NOBLIT & HARE (1988)

TRANSLATION IS AT THE CONCEPTUAL LEVEL



The Indians had asked for fire water ... The translation error would prove costly to the trader.

TRANSLATION TYPES I:

- RECIPROCAL TRANSLATION
  - "IN AN ITERATIVE FASHION, EACH STUDY IS TRANSLATED INTO THE TERMS OF THE OTHERS AND VICE VERSA"
  - "ATTENTION TO WHICH METAPHORS, THEMES, ORGANIZERS, ENABLE US TO FULLY RENDER THE ACCOUNT IN A REDUCED FORM."

RECIPROCAL TRANSLATION

- SIMILAR TO CONSTANT COMPARISON
- LOOK FOR OVERLAP, SIMILARITIES, CONTRADICTIONS
- ARE SOME CONCEPTS “BETTER”? (SCOPE, UTILITY, EXPLANATORY POWER).
- REVIEWER INTERPRETATION CRUCIAL (THIRD ORDER CONSTRUCTS/ CONCEPTS/THEORY)
- DIFFERENT WAYS OF JUXTAPOSING CONCEPTS (TABULATION, MIND MAPS, COLOUR CODING, SHORT TEXT DESCRIPTIONS)

TRANSLATION TYPES II:

- REFUTATIONAL TRANSLATION
  - "A SPECIFIC FORM OF INTERPRETATION"
  - OPPOSITIONAL/ COUNTER ARGUMENT FINDINGS
  - SPECIFIC SEARCH FOR METAPHORS, THEMES, AND CONCEPTS THAT OPPOSE/ REFUTE EMERGING PATTERNS.

TRANSLATION TYPES III:

- LINE OF ARGUMENT
  - "WHAT CAN WE SAY ABOUT THE WHOLE?" (P. 62)
  - DEVELOPMENT OF A NEW MODEL, THEORY OR UNDERSTANDING THROUGH THE SYNTHESIS

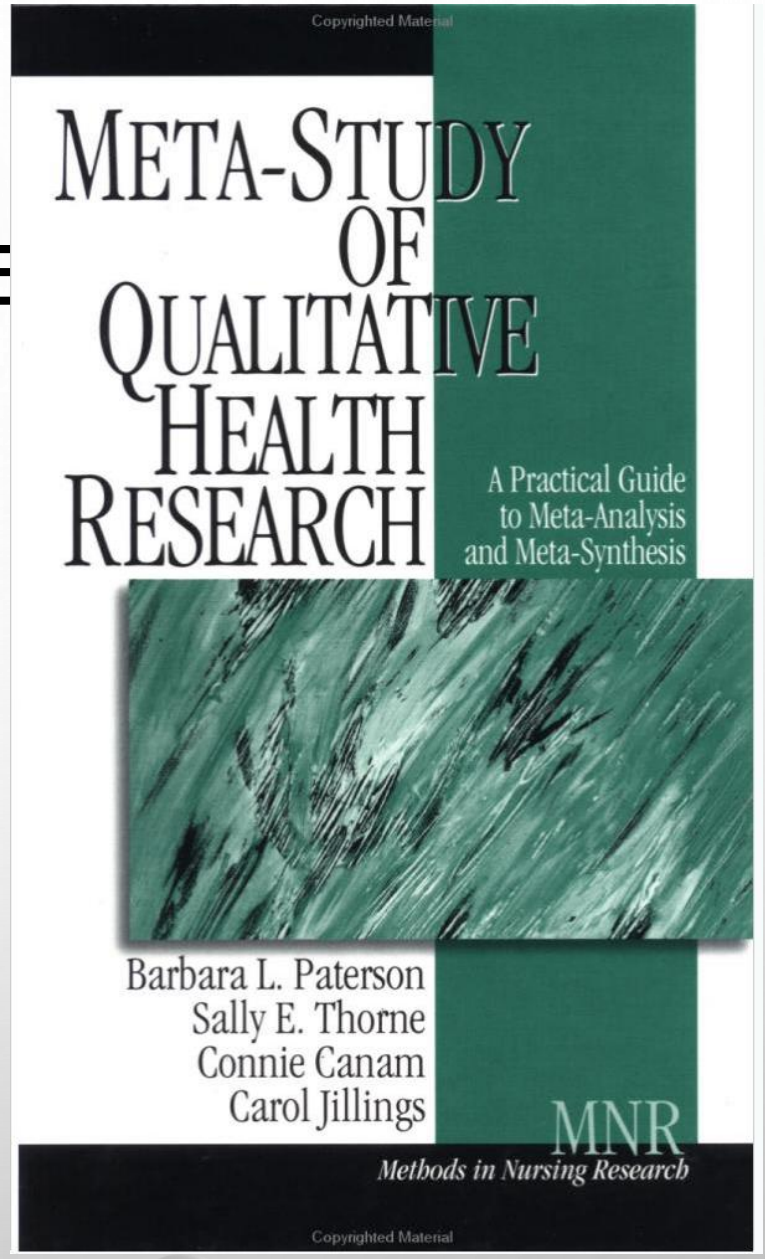
EXERCISE

- HOW WOULD YOU THINK ABOUT SYNTHESIS FOR THE TEXTS YOU HAVE READ?

OTHER APPROACHE

META STUDY

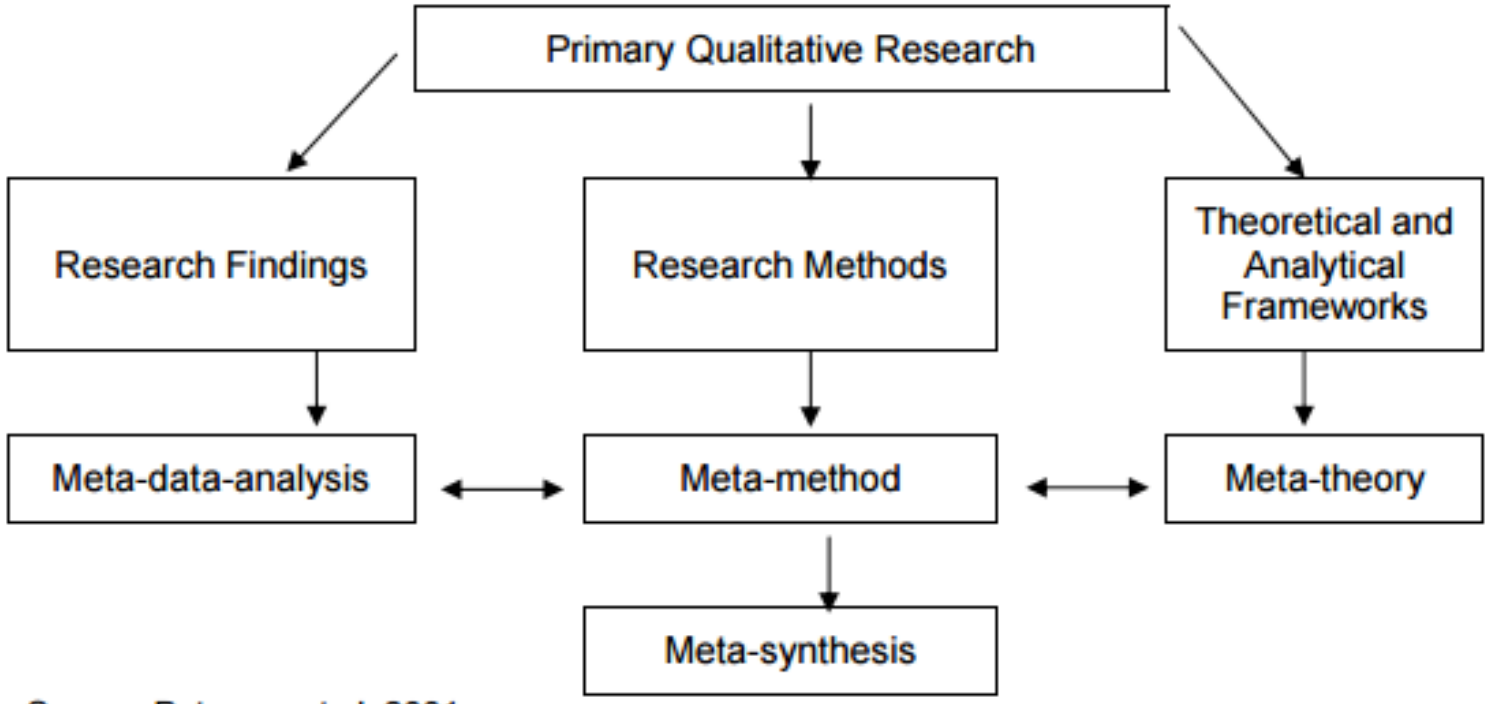
(PATERSON ET AL 2001)



A RESEARCH APPROACH INVOLVING THE ANALYSIS OF THEORY, METHODS AND FINDINGS IN QUALITATIVE RESEARCH AND THE SYNTHESIS OF THESE INSIGHTS INTO NEW WAYS OF THINKING ABOUT PHENOMENON [WHICH] CREATES A MECHANISM BY WHICH THE NATURE OF INTERPRETATION IS EXPOSED AND THE MEANINGS, THAT EXTEND WELL BEYOND THOSE PRESENTED IN THE AVAILABLE BODY OF KNOWLEDGE, CAN BE GENERATED. AS SUCH IT OFFERS A CRITICAL, HISTORICAL AND THEORETICAL ANALYTIC APPROACH TO MAKING SENSE OF QUALITATIVE DERIVED KNOWLEDGE.

(PP.1-2)

Figure 1: Components of meta-study



Source: Paterson et al, 2001

GENERATING NEW UNDERSTANDINGS

- CRITICAL INTERPRETATION OF EXISTING RESEARCH TO CREATE “NEW AND MORE COMPLETE UNDERSTANDINGS OF THE PHENOMENON UNDER STUDY”
- ARTICULATING A THEORETICAL FRAMEWORK TO INFORM DIRECTION OF THE STUDY IS KEY
- FINDINGS ARE UNDERSTOOD AS CONSTRUCTED THROUGH THE INTERACTIONS OF THEORY AND METHOD.

THIS ANALYTIC PROCESS ALLOWED US TO SHIFT OUR INTERPRETATION FROM ASSUMING THAT THE SIMILARITIES BETWEEN STUDIES STRENGTHENED THEIR COLLECTIVE TRUTH TOWARD RECOGNISING THE POSSIBILITY OF A SYSTEMATIC INFLUENCE OF THE ONE KIND OF THEORIZING ON THE GENERATION OF FINDINGS

(RITZER 1991)

Methods of evidence synthesis

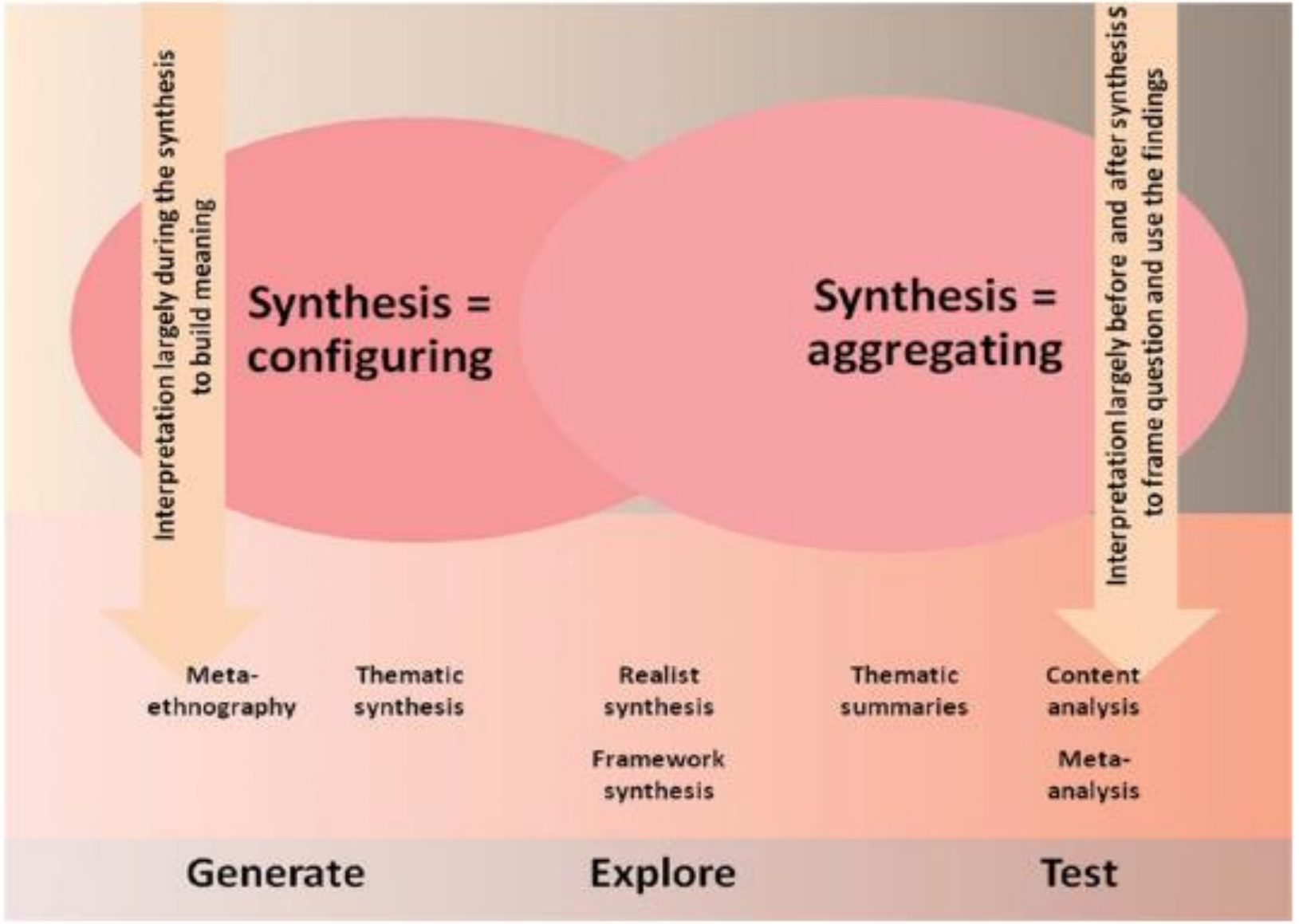


Figure 1. Methodological continuum of synthesis approaches and methods.
Source: Adapted from Thomas *et al*. (2012).

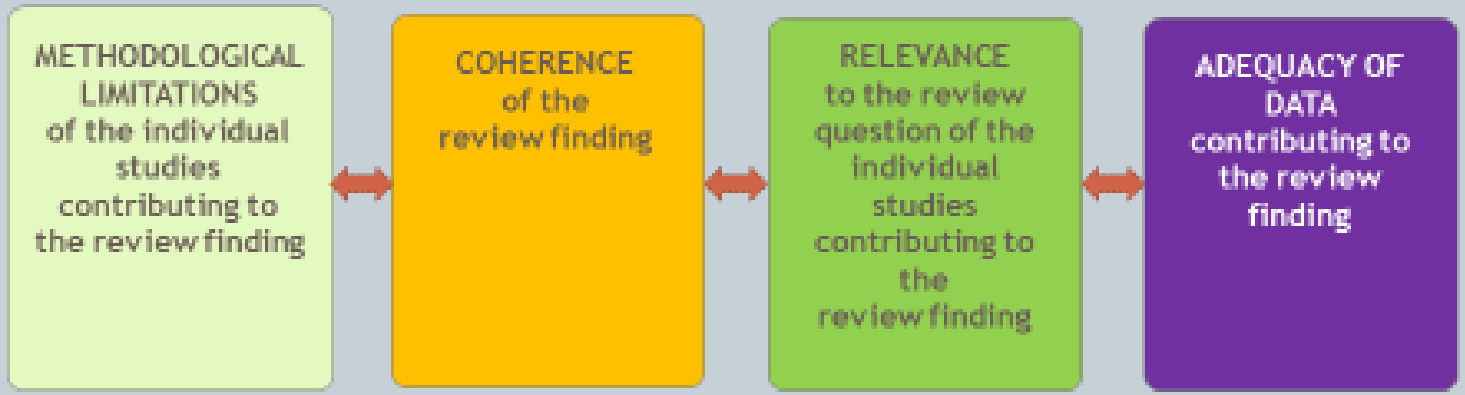
HOW MUCH CONFIDENCE CAN WE HAVE IN QES FINDINGS?

- POLICY MAKERS WANT TO KNOW WHETHER IT IS WISE TO MAKE DECISIONS BASED ON THE EVIDENCE.
- DECISIONS ABOUT THIS SHOULD BE TRANSPARENT
- QUANTITATIVE META-ANALYSES USE AN EXISTING SYSTEM – GRADE.

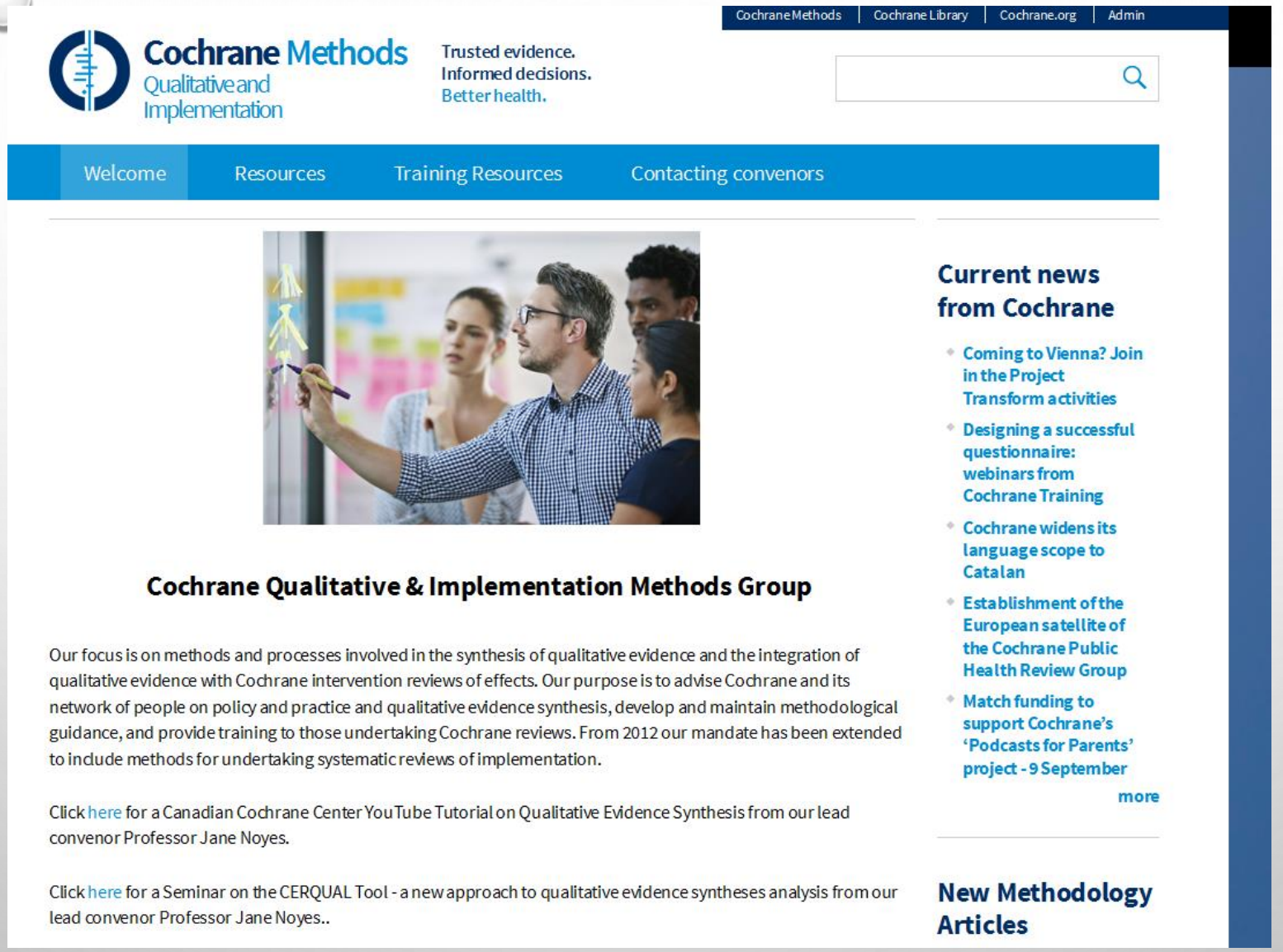
The CERQual approach

Overall aim of the system:
To assess how much confidence we have in the evidence for the review finding

This is based on an assessment of



http://qim.cochrane.org/



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