Qualitative research: Reaching the *truths* of osteopathy that other methodologies cannot reach

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OSEAN Open Forum- 'teaching the soft skills', Vienna, Austria 21st -22nd April 2016

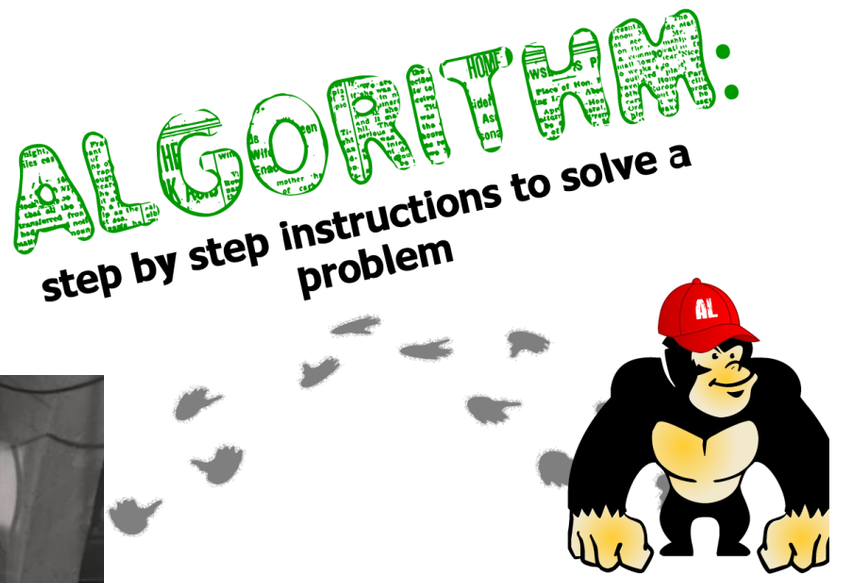
Workshop aims

- Explore shifting views of EBP
- Qualitative research and EBP
- To give you an introduction to qualitative research methods
- Critical appraisal of qualitative research
- Transferable skills of qualitative research to developing *softer* skills for practice
- Experience from the BSO research department
- Top tips for supervisors

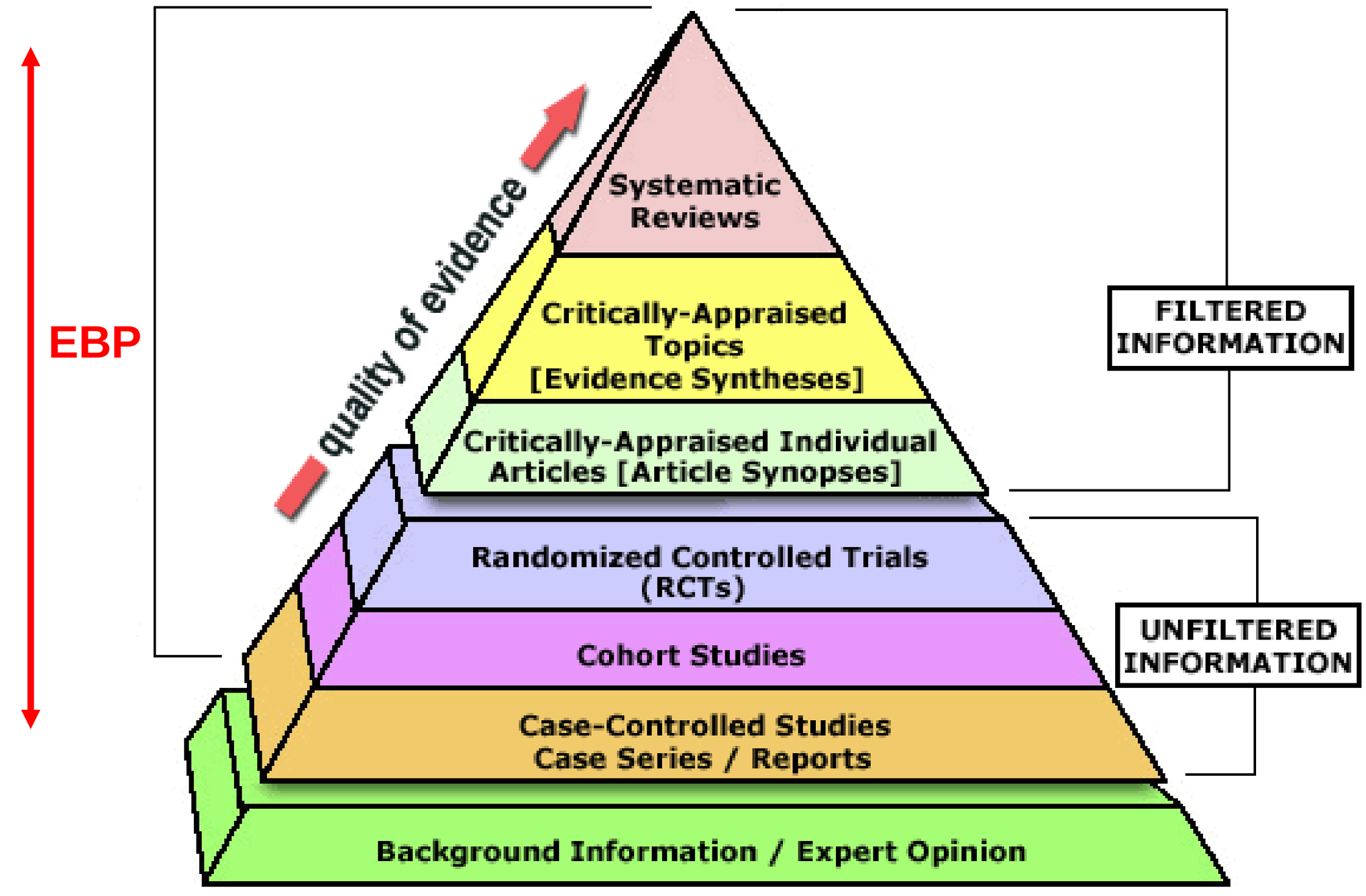
My Perspective

- Practicing osteopath
- Senior lecturer at the BSO
- Mainly quantitative undergrad/postgrad
- PhD employed grounded theory to explore osteopaths' clinical decision making and conceptions of practice.
- Interested in practitioners'/osteopaths' beliefs and clinical reasoning.
- Personal and professional frustrations

Evidence-based practice (EBP)- just misunderstood?



Enduring image of EBP?



Evidence-based Practice

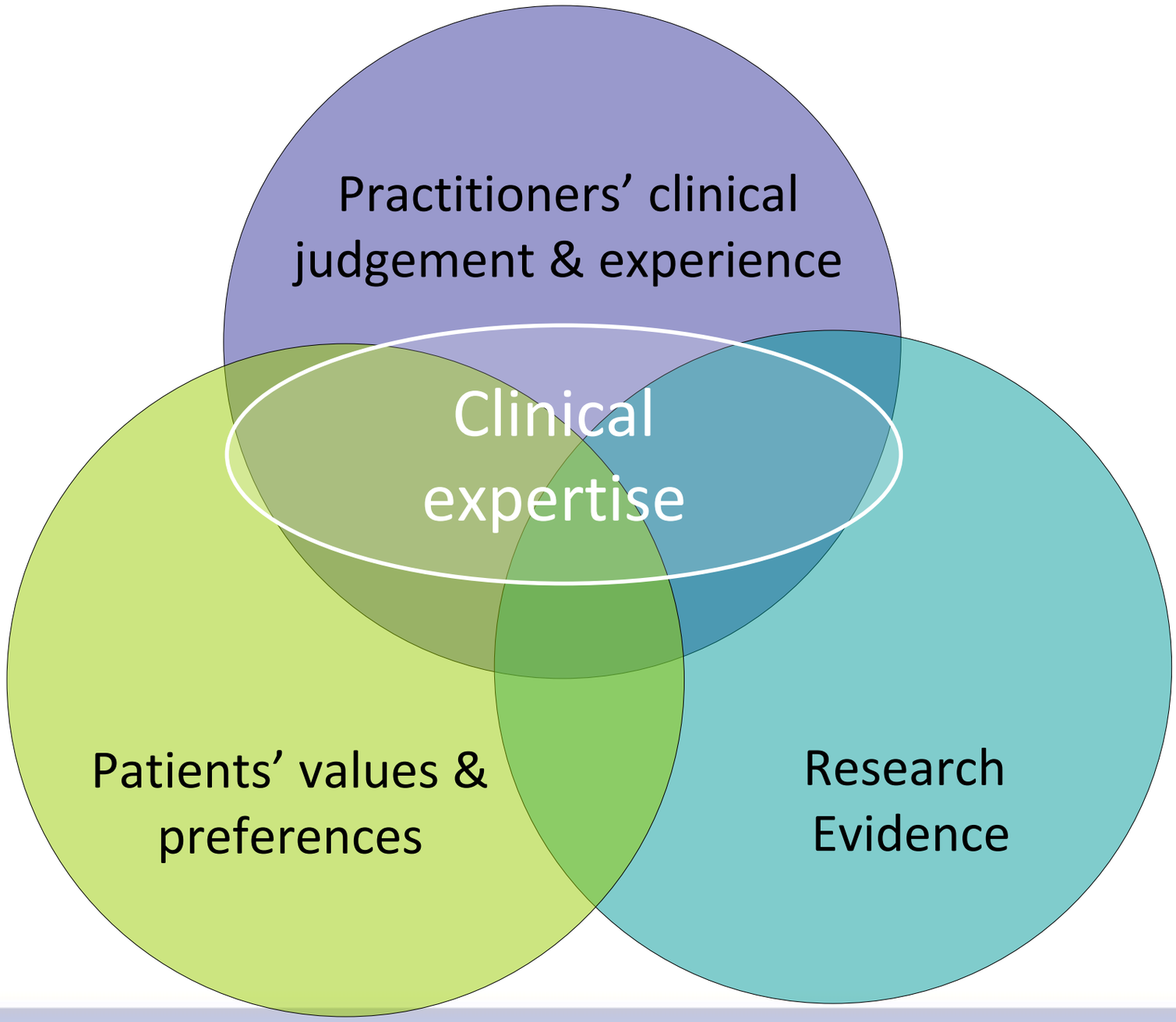
“the integration of best research evidence with clinical expertise and patient values"

(Sackett et al, 2000)

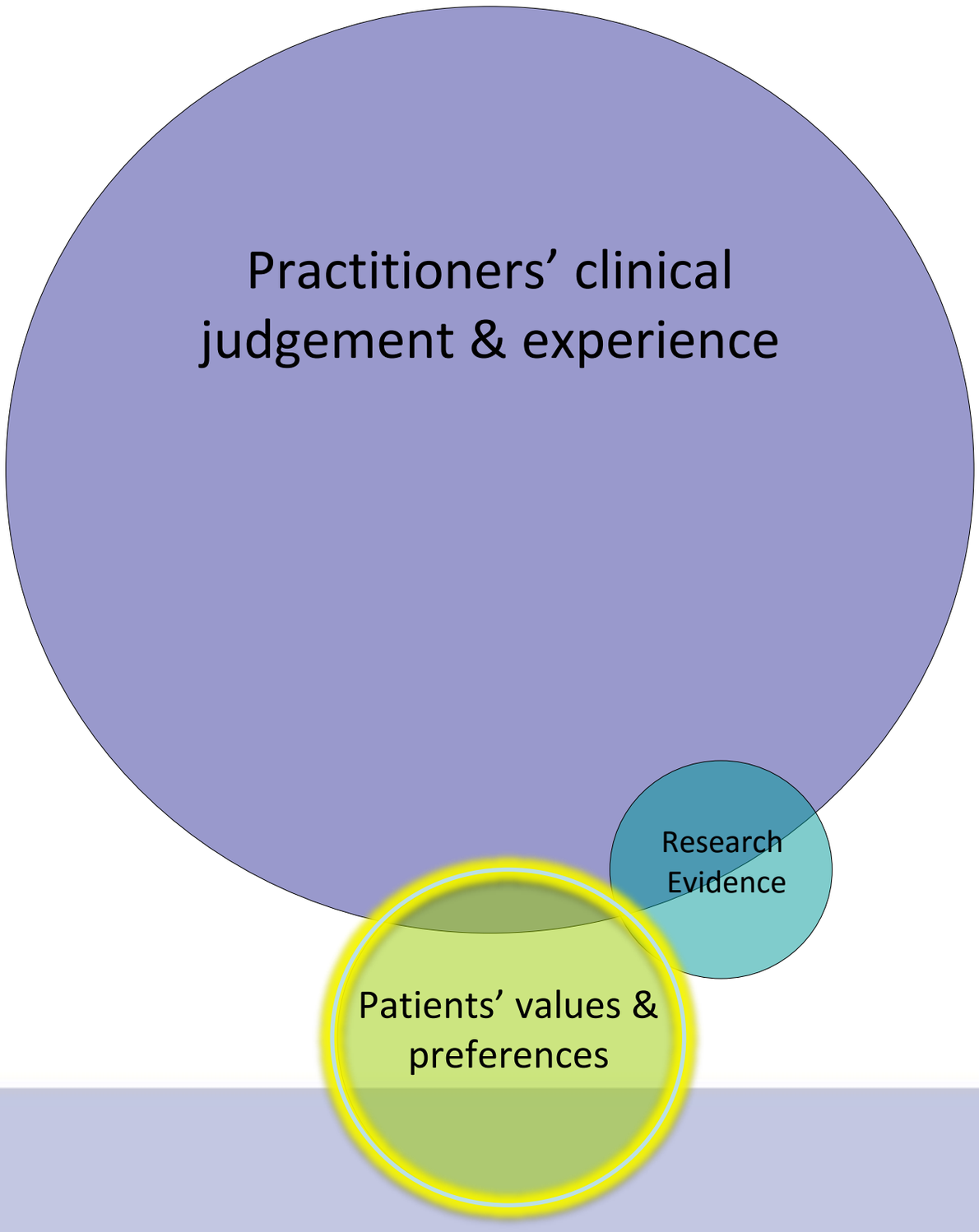
Evidence Based Practice

Resonates with qualitative research on expertise in physical and manual therapy

e.g. Thomson et al 2014; Petty et al 2011;Edwards 2004; Jensen et al 2000



Current Practice?



Some fear this is the direction of EBP

Real evidence-based practice

- Real EBP asks, "*what is the best course of action for this patient, in these circumstances, at this point in their illness or condition*?" (Greenhalgh et al 2014)

- "*Which evidence is most likely going to inform the multitude of decisions within this therapeutic interaction*?" (Kerry 2015).


BMJ

BMJ 2014;348:g3725 doi: 10.1136/bmj.g3725 (Published 13 June 2014) Page 1 of 7

ANALYSIS

ESSAY

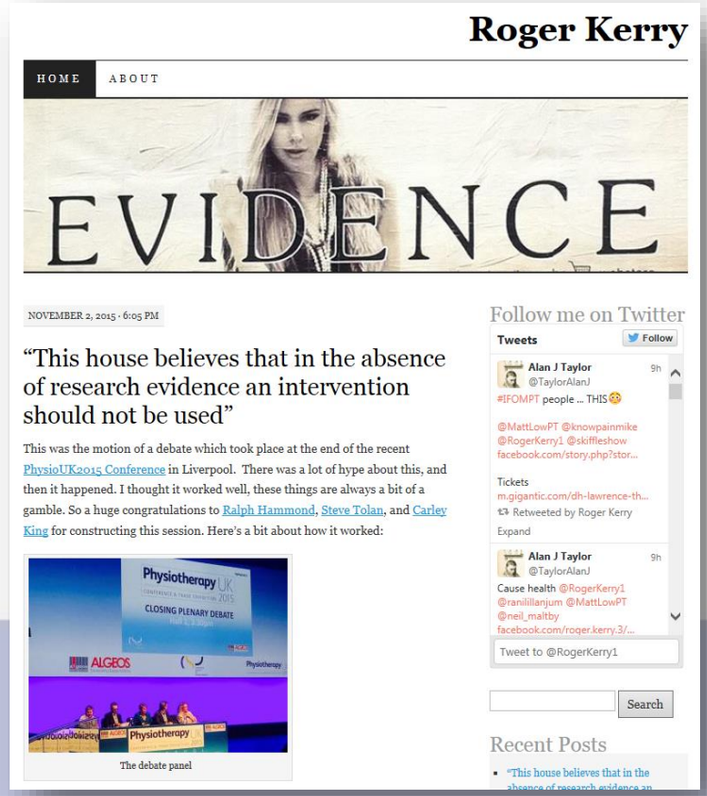
Evidence based medicine: a movement in crisis?

OPEN ACCESS

Trisha Greenhalgh and colleagues argue that, although evidence based medicine has had many benefits, it has also had some negative unintended consequences. They offer a preliminary agenda for the movement's renaissance, refocusing on providing useable evidence that can be combined with context and professional expertise so that individual patients get optimal treatment

Trisha Greenhalgh *dean for research impact*[1], Jeremy Howick *senior research fellow*[2], Neal Maskrey *professor of evidence informed decision making*[3], for the Evidence Based Medicine Renaissance Group

[1]Barts and the London School of Medicine and Dentistry, London E1 2AB, UK; [2]Centre for Evidence-Based Medicine, University of Oxford, Oxford OX2 6NW, UK; [3]Keele University, Staffs ST5 5BG, UK


Roger Kerry

HOME ABOUT

EVIDENCE

NOVEMBER 2, 2015 · 6:05 PM

"This house believes that in the absence of research evidence an intervention should not be used"

This was the motion of a debate which took place at the end of the recent PhysioUK2015 Conference in Liverpool. There was a lot of hype about this, and then it happened. I thought it worked well, these things are always a bit of a gamble. So a huge congratulations to Ralph Hammond, Steve Tolan, and Carley King for constructing this session. Here's a bit about how it worked:

The debate panel

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Recent Posts

- "This house believes that in the absence of research evidence an

- Is reflexive, active and patient-centred
- Addresses a range of clinical questions/problems
- Therefore, involves the construction, application and integration of different sources of knowledge/evidence.

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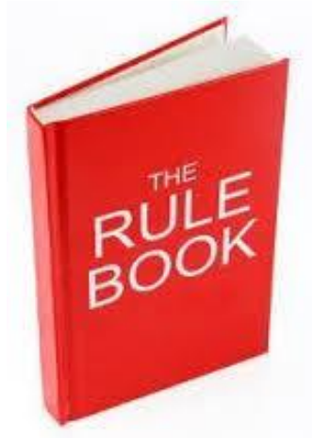
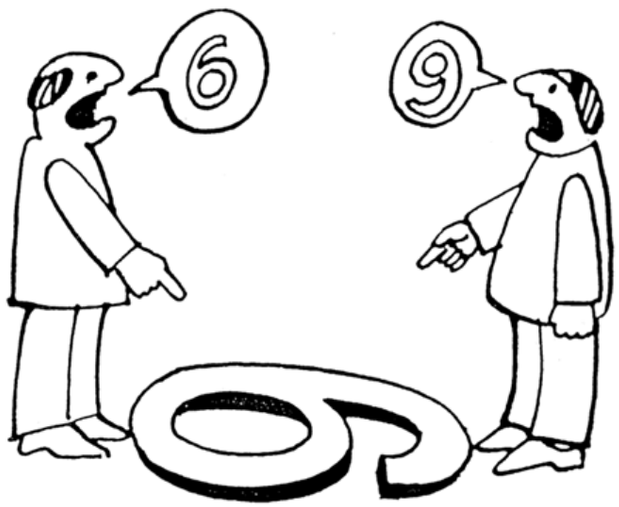
What is qualitative research?



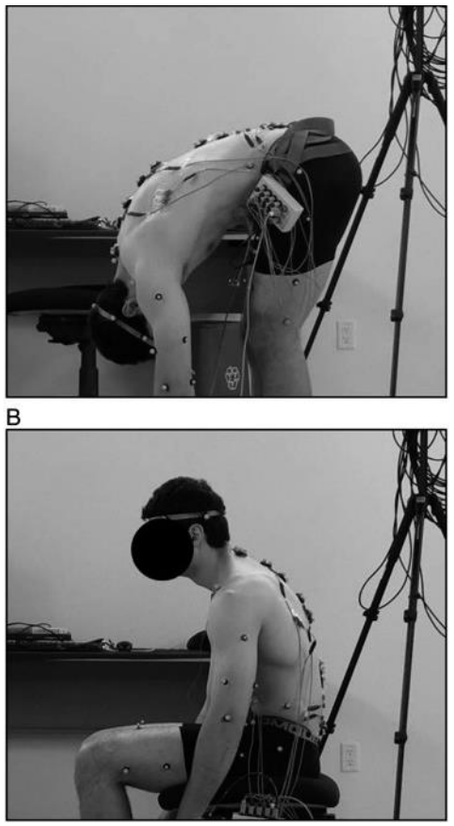
- Particular assumptions about knowledge, truth and reality.
- Build in-depth, rich, contextual understanding and/or theory (predominantly induction)
- Asks an open question (not deductively test a hypothesis/prediction).
- Data (spoken or written word) is interpreted rather than measured.
- Findings are not generalisable (but may be transferable).
- Researcher's position: participants *and* researcher actively co-construct reality and ensuing data.



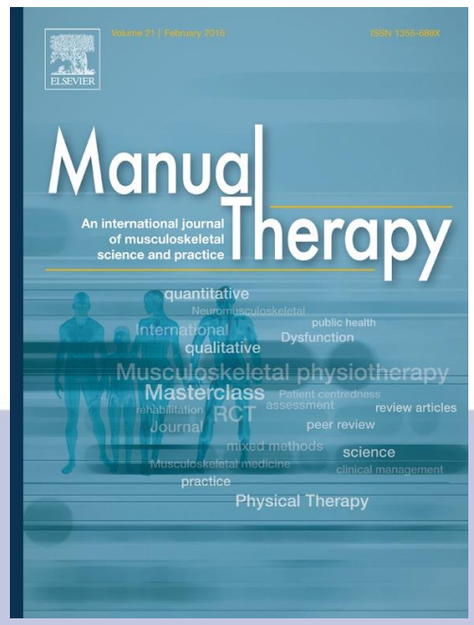
Petty, N. J., O. P. Thomson and G. Stew (2012). Ready for a paradigm shift? Part 1: Introducing the philosophy of qualitative research. Manual Therapy 17(4): 267-274.

Qualitative research and manual therapy

- In UK and throughout the world, manual therapy research has predominantly focused on quantitative research studies.



- e.g. Last 16 years to December 2011, *Manual Therapy Journal* has published 475 original articles and only ten (2.1%) used a qualitative research approach (Petty et al 2013).



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A Paradigm Shift...?

- Value that qualitative approaches can add to the knowledge bases of a range of manual therapy professions has been highlighted, e.g. in MSK physiotherapy (Petty et al 2013; Grant 2005; Shepard et al 1997), chiropractic (Adams, 2008) and osteopathy (Thomson et al 2011; 2014).

- The types of knowledge and evidence we recognise and value will be influenced by the way in which we view, or conceive, our own model of practice.

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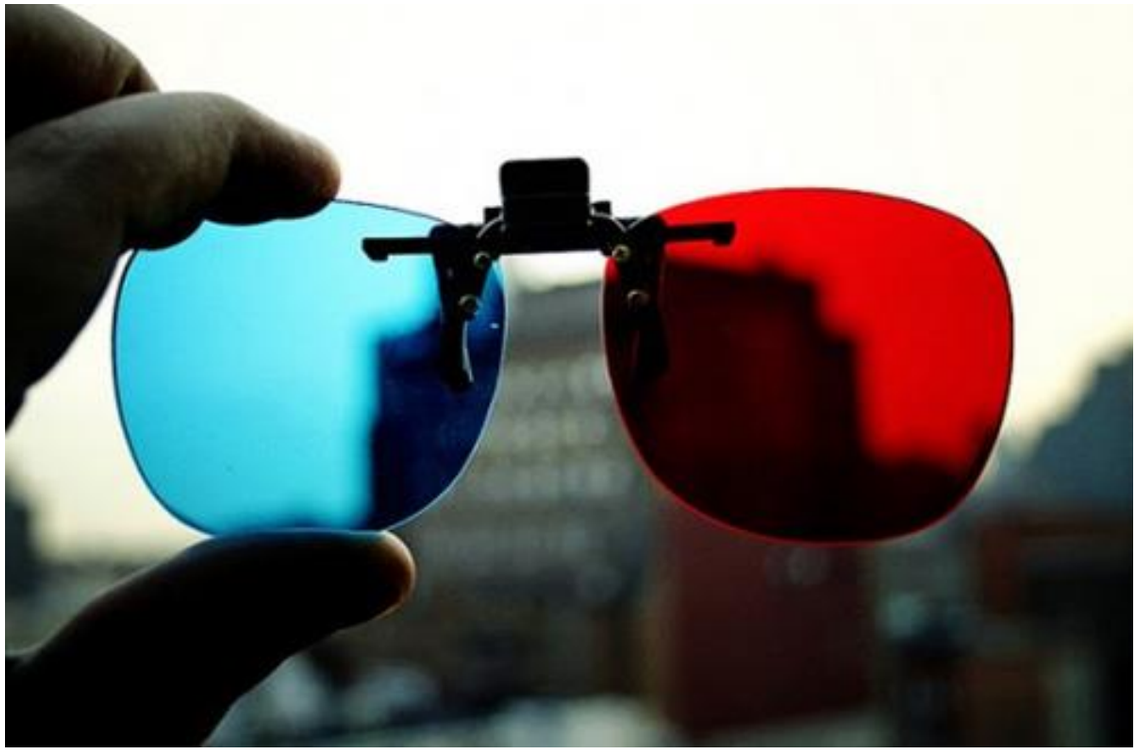
Conception of practice

How we view the nature of our practice and the different aspects of our clinical work such as knowledge, skills, activities, and decision-making.



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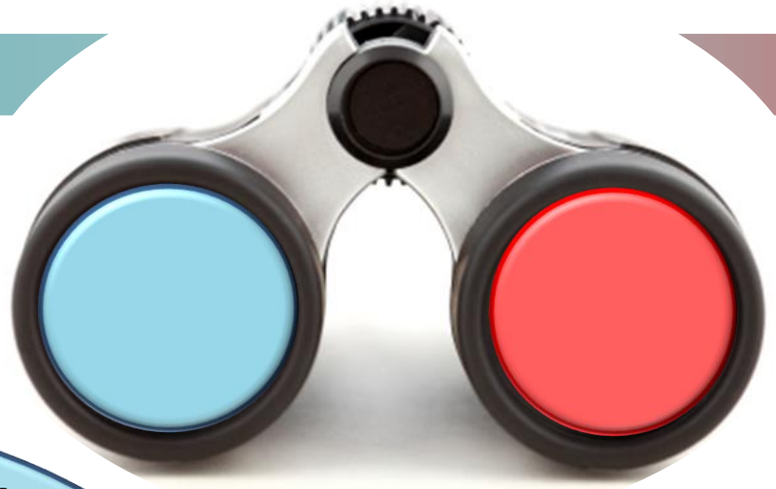
Two opposing views……

Conception of practice

Technical rationality



Professional artistry

Application of value-free skills & knowledge

Practice is linear and mechanistic

Knowledge and skills separate from practice

Problems are predictable and straightforward

Analyses cause-effect relationships

Context specific judgements

Practice is creative and flexible

Knowledge and skills inseparable from practice

Problems are unpredictable, complex and ambiguous

Interprets, contextualises, understands

(Schön, 1987; Fish and Coles, 1998)

For example, manual therapy and LBP…?

Manual therapy is 'orthodox' and mainstream
(e.g. NICE clinical guidelines, GCC, GOsC, HCP)

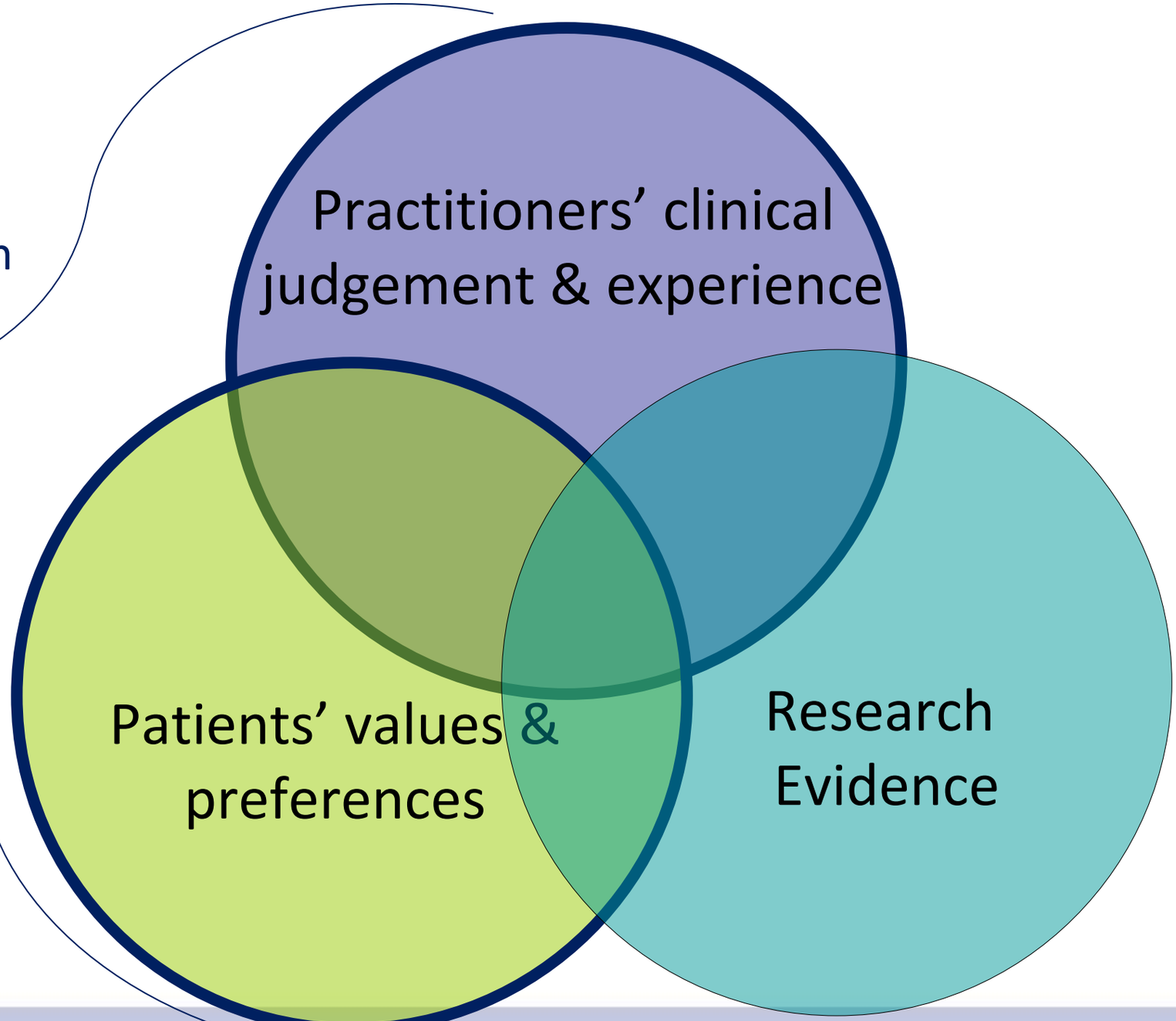
Lots of practitioners 'doing it' and lots patients 'using it'

Yet RCT outcomes are modest and disputed

So what's going on…?

What's going on...?

Opportunities for qualitative research



Technical rationality

Professional artistry

- Effectiveness/efficiency of manual therapy.
- Reliability/validity of examination techniques.
- Epidemiology.
- Biological mechanisms.
- Predict/risk assessment of bio, psych and social factors amongst specific patient groups.

Mixed Methods

- Experience of practitioners (clinical reasoning, expertise),
- Lived-experience of patients.
- Nature and development of therapeutic relationships
- How examination techniques are conceptualised, interpreted and applied.
- How biological theories are conceptualised by practitioners
- How Illness and pain beliefs are constructed

Qualitative research questions

What are the social processes involved?

How do practitioners conceptualise…?

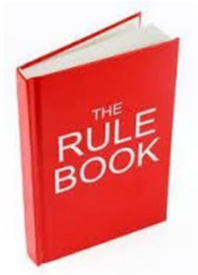
What are practitioners' attitudes and beliefs?

How do patients experience…?

Why don't practitioners follow clinical guidelines?

What therapeutic relationships develop?

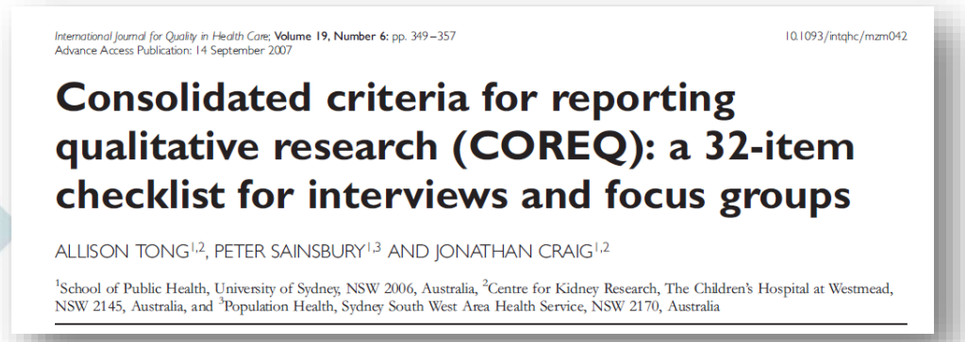
What is good qualitative research?



Not straightforward!…'criteriology debate' since 1990s (Symon and Cassell 2012)

Some strategies to enhance *trustworthiness* (Guba and Lincoln, 1987)

- Reflexivity
- Member checking
- Peer-debriefing
- Audit trail
- Thick descriptions

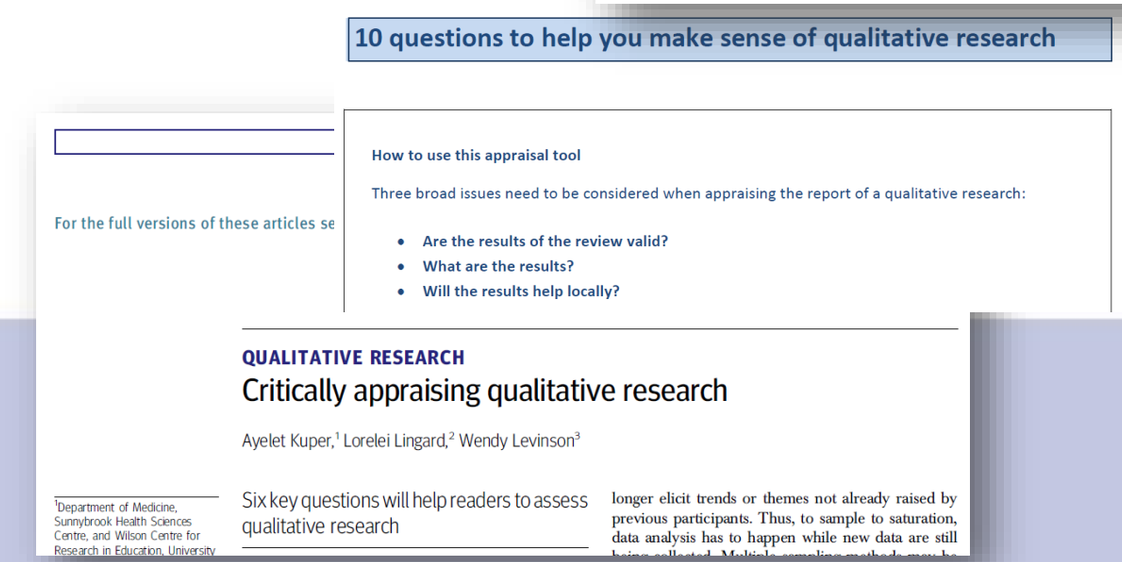

International Journal for Quality in Health Care; **Volume 19, Number 6:** pp. 349–357
Advance Access Publication: 14 September 2007

10.1093/intqhc/mzm042

Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups

ALLISON TONG[1,2], PETER SAINSBURY[1,3] AND JONATHAN CRAIG[1,2]

[1]School of Public Health, University of Sydney, NSW 2006, Australia, [2]Centre for Kidney Research, The Children's Hospital at Westmead, NSW 2145, Australia, and [3]Population Health, Sydney South West Area Health Service, NSW 2170, Australia


10 questions to help you make sense of qualitative research

For the full versions of these articles se

How to use this appraisal tool

Three broad issues need to be considered when appraising the report of a qualitative research:

- **Are the results of the review valid?**
- **What are the results?**
- **Will the results help locally?**

QUALITATIVE RESEARCH

Critically appraising qualitative research

Ayelet Kuper,[1] Lorelei Lingard,[2] Wendy Levinson[3]

[1]Department of Medicine, Sunnybrook Health Sciences Centre, and Wilson Centre for Research in Education, University

Six key questions will help readers to assess qualitative research

longer elicit trends or themes not already raised by previous participants. Thus, to sample to saturation, data analysis has to happen while new data are still

Published appraisal guidelines

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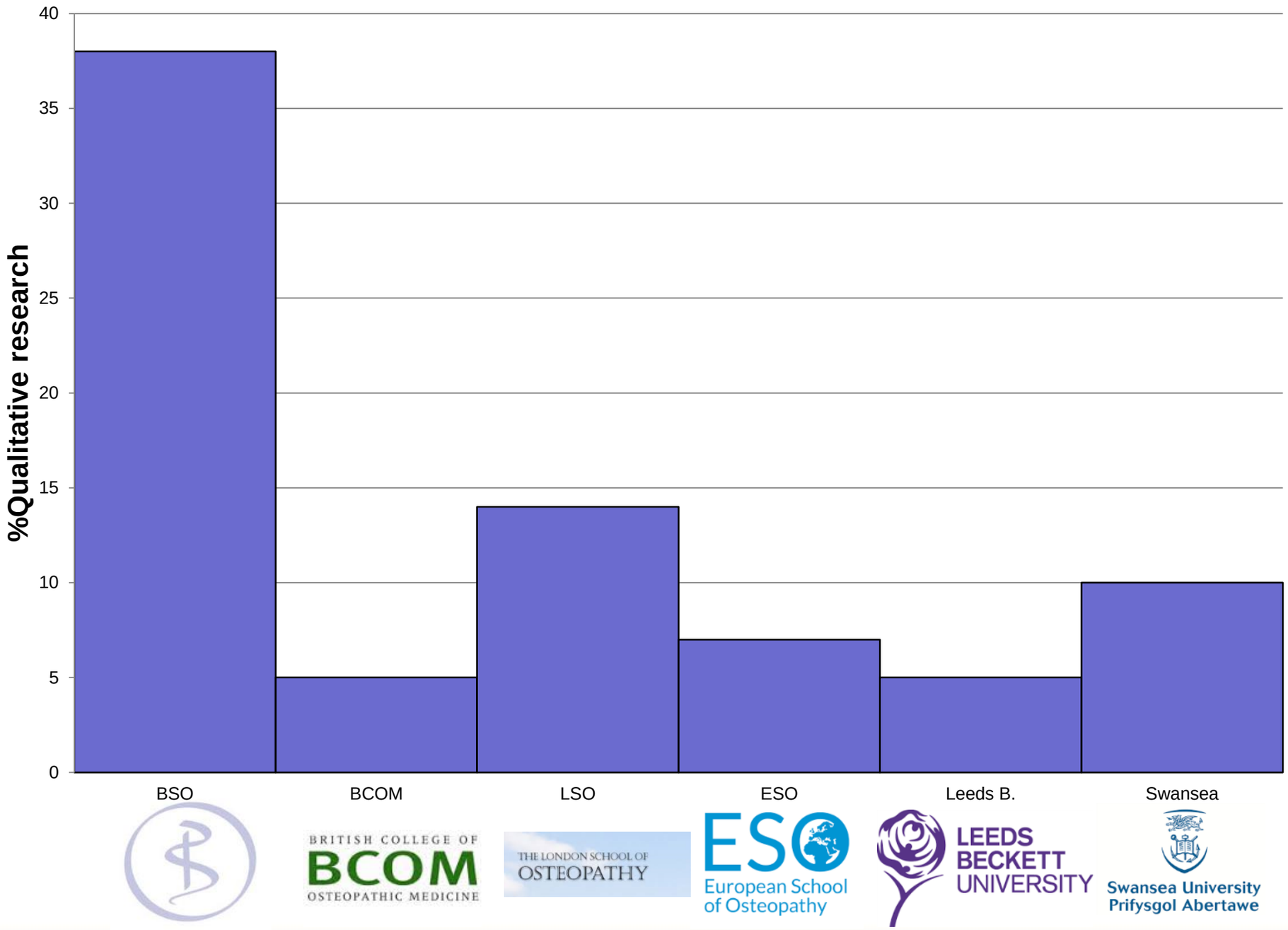
Qualitative research and osteopathic education

Underrepresentation of qualitative research in undergraduate research in some UK OEIs



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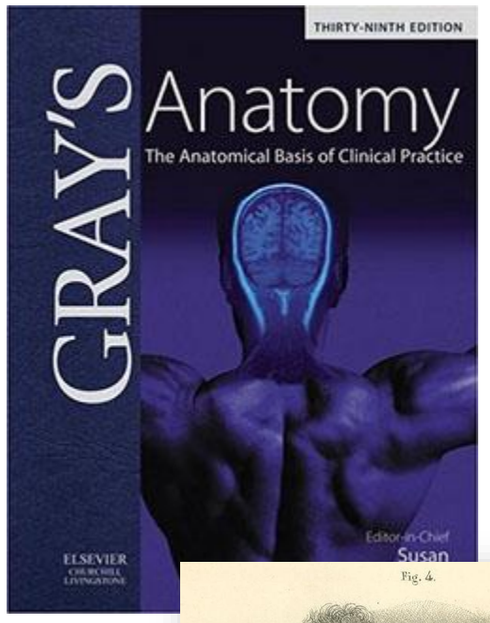
Opportunities of qualitative Research…just a few..

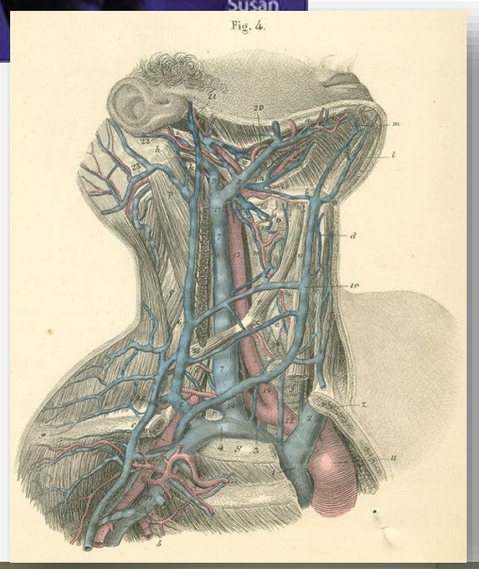
- Current model of EBP insufficient (Greenhalgh et al 2014).
- Qualitative research provides rich and deep knowledge.
- Can act as a contextual envelope for findings from quantitative studies (many RCTs now have a qualitative component).
- Represents the different types of knowledge used in practice.
- **Lends itself to understand the multiple facets and complexities of the human side of practice (patients, practitioners.**

Soft or Hard skills

Soft v Hard

- Soft skills does not = unscientific
- Osteopathy tends to focus on technical ‘hard’ skills and emphasises ‘hard’ sciences.
- Research suggests importance softer aspects of care (e.g. PS factors, therapeutic relationship)





Soft skills

Soft skills

Communication (listening, sharing ideas, views & perspectives, *constructing* a case history)

Developing therapeutic relationships

Appreciate & embrace multiplicity of interpretations based on different perspectives.

Data interpretation

Data analysis

Critical awareness of own beliefs, knowledge and perspective

Transferable skills of qualitative research to clinical practice

Data collection

Data analysis

Data interpretation

Reflexivity

Qualitative research skills

Clinical skills & expertise

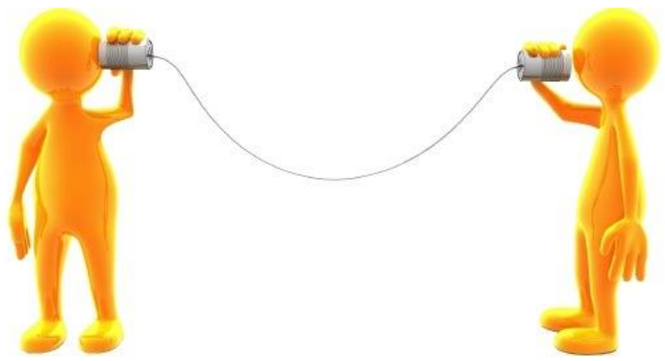
(e.g GOsC OPS 2012, Petty 2015)

Soft Skill 1: Communication

- Data collection in qualitative research
- Listening and co-constructing rich and detailed narratives
- Exploring taken for granted assumptions and meanings local to the person.
- Develop a relationship which is trustful, non-judgmental and participatory.

Soft Skill 1: Communication

- Develop a deep and contextual understanding of the personal meaning of participants.
- Assume that there are multiple meanings which are constructed by people while they interact with the world which they are interpreting.
- Individual illness experience



Soft Skill 2: Developing relationships

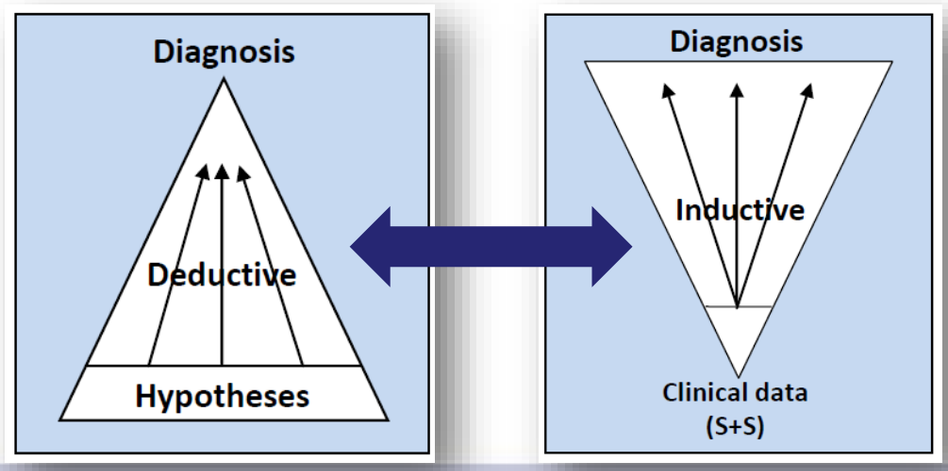
- Develop a relationship which is trustful, non-judgmental and participatory.
- Relationship with participants during interviews is interactive; both members of the relationship ‘give and take’ from each other, and knowledge (data) is constructed.
- Neutralise relationship and power imbalances

Soft Skill 3: Appreciate and embrace multiplicity of perspectives

- Different world views
- No one perspective trumps another
- The researcher has their own perspective on the world and data
- A research study grounded in the different perspectives of participants makes for rounded and sophisticated understanding of social phenomena

Soft Skill 4: Data analysis

- Systematic, yet flexible/creative
- Constantly comparison of data/participants noting difference and similarities and relationships between data.
- Moving between hypothesis generation (inductive reasoning) and testing (deductive reasoning)- components of *diagnostic reasoning* (Thomson et al 2014).
- ‘Fly above’ and abstract from the data to ‘see what’s going on’.



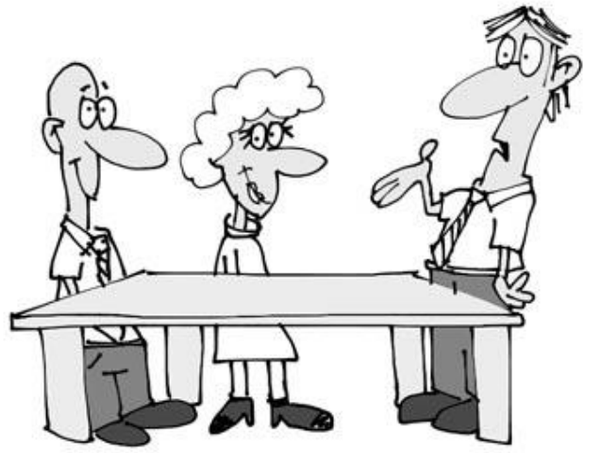
Soft Skill 5: Data interpretation

- Meaning of data is actively co-constructed.
- Generation, acquisition and interpretation of cues as part of clinical reasoning.
- Appreciate and embrace multiplicity of interpretations based on different perspectives.
- Recognise own clinical gaze/lens

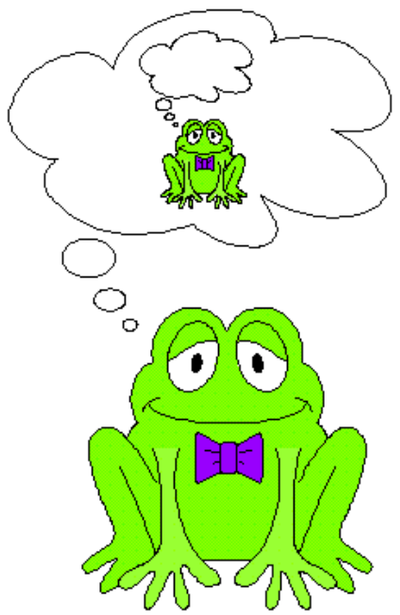
The curse that afflicts abstract painting

Soft Skill 6: Critical awareness of own beliefs (reflexivity)

- Critically reflecting on own biases, views and assumptions and how these may have influenced data collection and analysis.
- Well developed metacognitive skills are a characteristics of clinical expertise (Thomson et al, 2014; Jensen, et al 2001)
- Being *aware of*, *comfortable with* and *managing* uncertainty.
- Qualitative research is value-laden



"WE KNEW THAT ALREADY! SEEMS LIKE WE DIDN'T NEED TO DO THE RESEARCH AFTER ALL!"



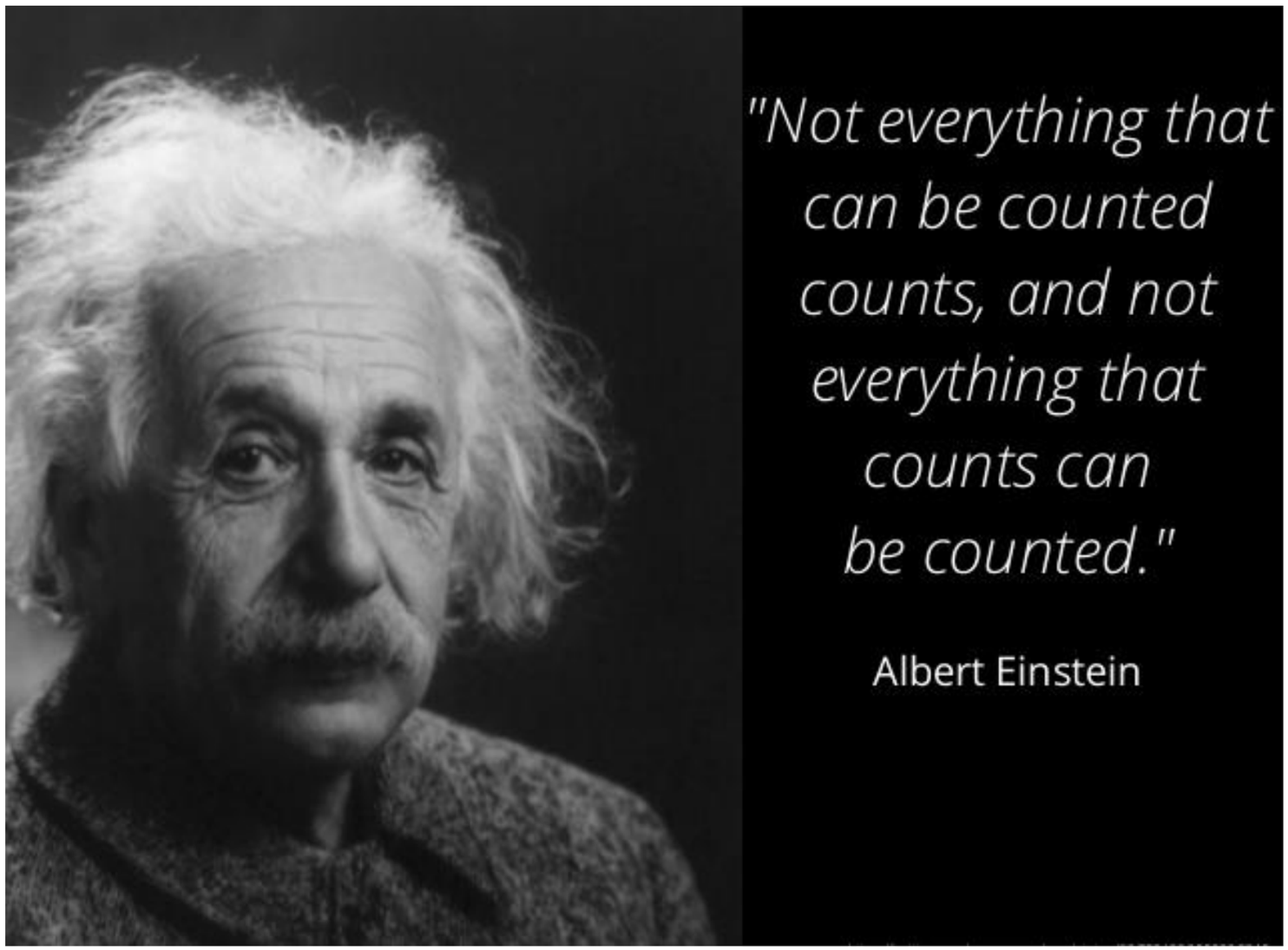
Experience from the BSO research department

- Interviews often used
- Grounded theory used as a framework for analysis
- Usually 8-12 participants
- Theory not built- rather description with some conceptual explanation
- 5000 words (+/- 10%)
- Theoretical saturation/sufficiency rarely reached

Supervisor tips...

- Reassure students that they are producing ***an*** understanding not ***the*** understanding.
- Remove insecurities which can be distraction/barrier to creating a theory.
- Facilitate creativity in analysis
- Trust in *own* interpretation of data
- Promote benefits of insider status.
- Need to help get over the ‘doing it right anxiety’ as this stifles analysis, creativity and abstraction (Heath, 2004)

Thank you


"Not everything that can be counted counts, and not everything that counts can be counted."
Albert Einstein