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

- Thomson et al 2014;
- Petty et al 2011;
- Edwards 2004;
- Jensen et al 2000
Current Practice?

Practitioners’ clinical judgement & experience

Patients’ values & preferences

Research Evidence
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).

- 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.
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.

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).
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.
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.

Two opposing views......
Conception of practice

Technical rationality

Application of value-free skills & knowledge
Practice is linear and mechanistic
Problems are predictable and straightforward
Knowledge and skills separate from practice
Analyses cause-effect relationships

Context specific judgements
Practice is creative and flexible
Problems are unpredictable, complex and ambiguous
Knowledge and skills inseparable from practice
Interprets, contextualises, understands

Professional artistry

(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...?

- Practitioners’ clinical judgement & experience
- Patients’ values & preferences
- Research Evidence

Opportunities for qualitative research
Technical rationality

- 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.

Professional artistry

- 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

Quantitative research

Qualitative research

Mixed Methods
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

Published appraisal guidelines
Qualitative research and osteopathic education
Underrepresentation of qualitative research in undergraduate research in some UK OEIs
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)

Data interpretation

Developing therapeutic relationships

Data analysis

Appreciate & embrace multiplicity of interpretations based on different perspectives.

Critical awareness of own beliefs, knowledge and perspective
Transferable skills of qualitative research to clinical practice

- Qualitative research skills
  - Reflexivity
  - Data collection
  - Data analysis
  - Data interpretation

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
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 characteristic of clinical expertise (Thomson et al, 2014; Jensen, et al 2001)
- Being aware of, comfortable with and managing uncertainty.
- Qualitative research is value-laden
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