

# 09-30 Data Presentation

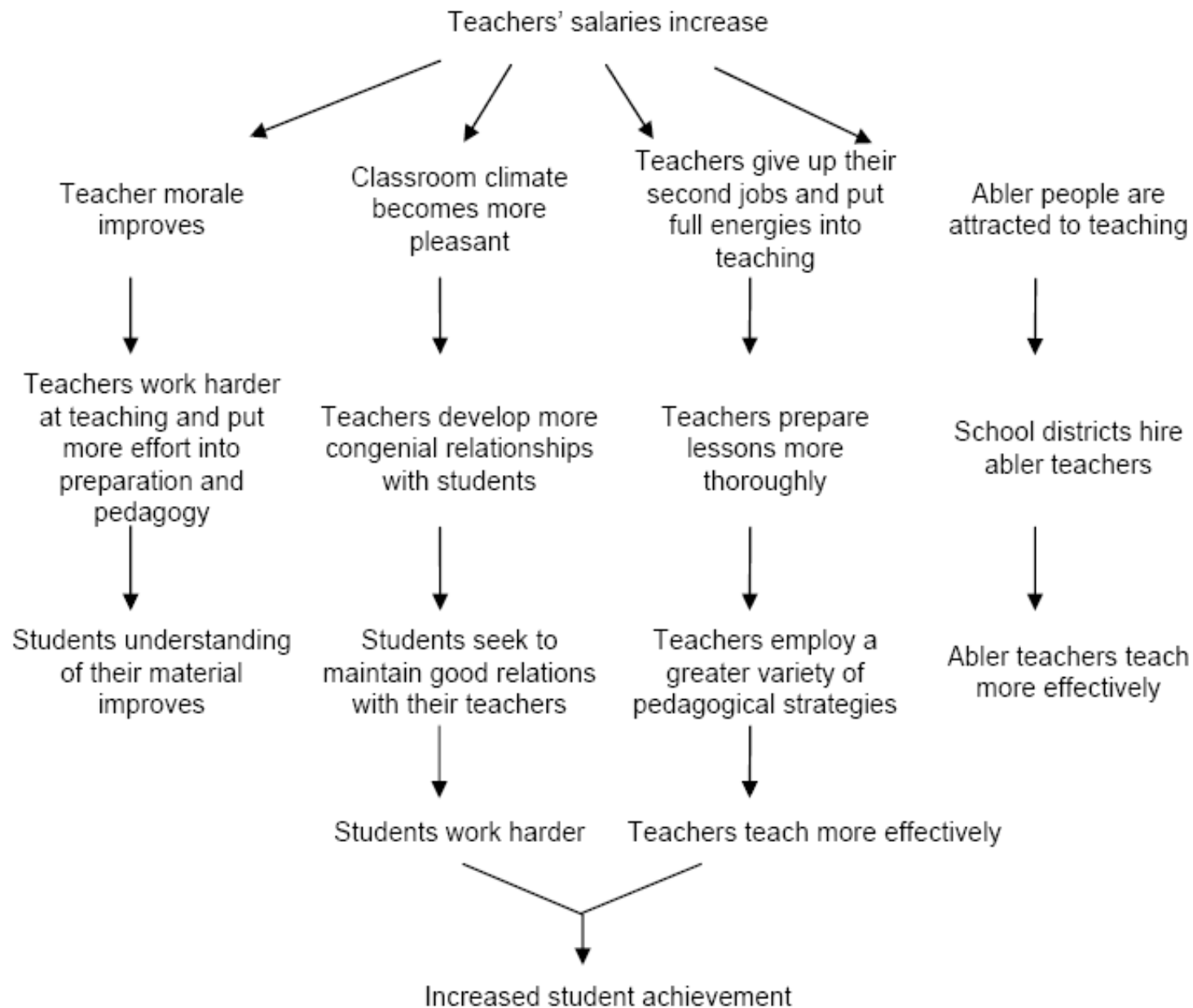
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# Four purposes for data presentation

- **Formative** – to aid conduct of review and insights from findings
- **Summative** – as an output from the review process
- **Integrative** – bringing together quantitative and qualitative elements (*See Next Session*)
- **Audit** – to increase confidence in robustness

# Formative



**Figure 3. Example of a Programme Theory model: mechanisms by which higher teachers' pay may be linked to increased student achievement (from Weiss, 1998)**

Figure 9. Examples of idea webbing

a)

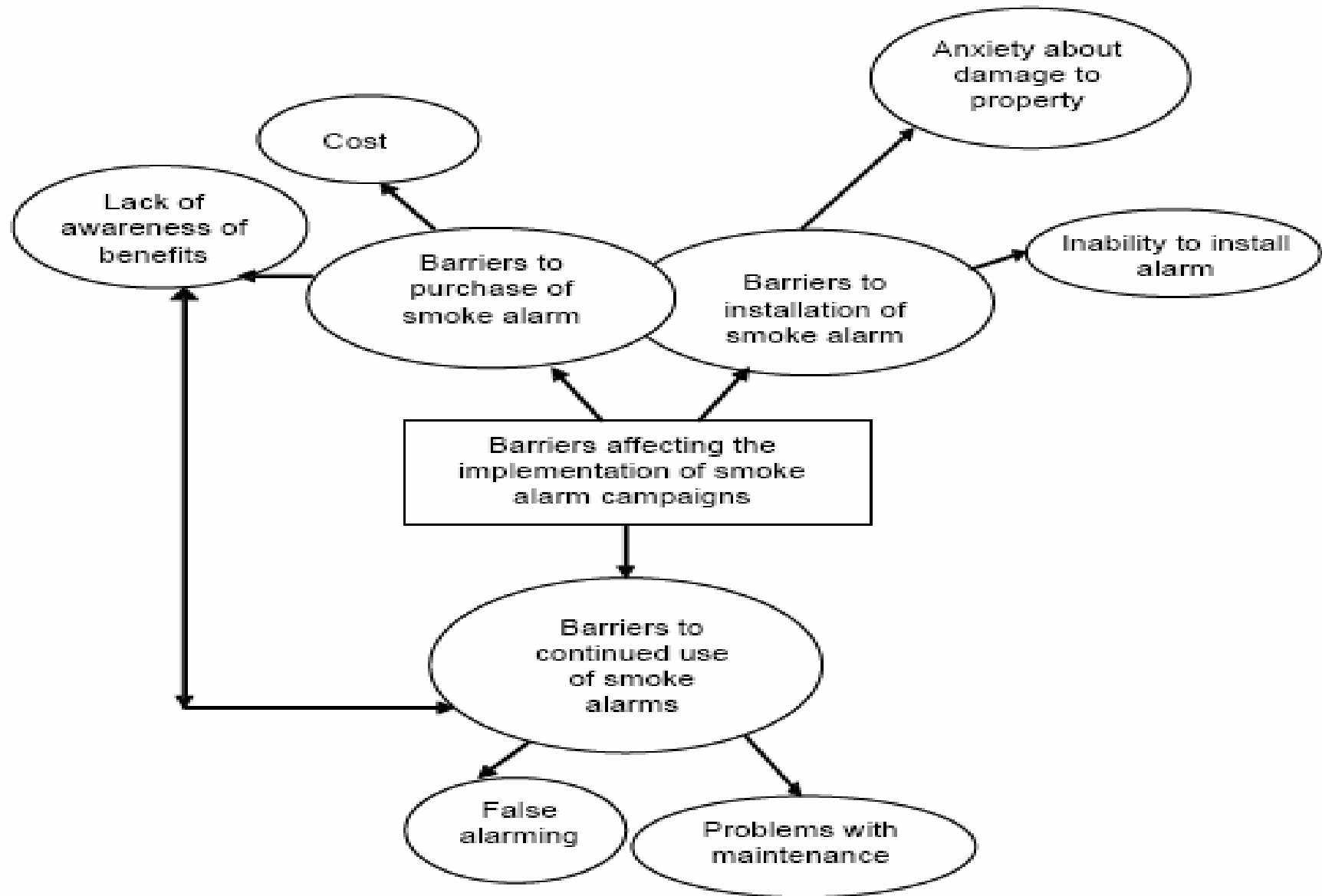
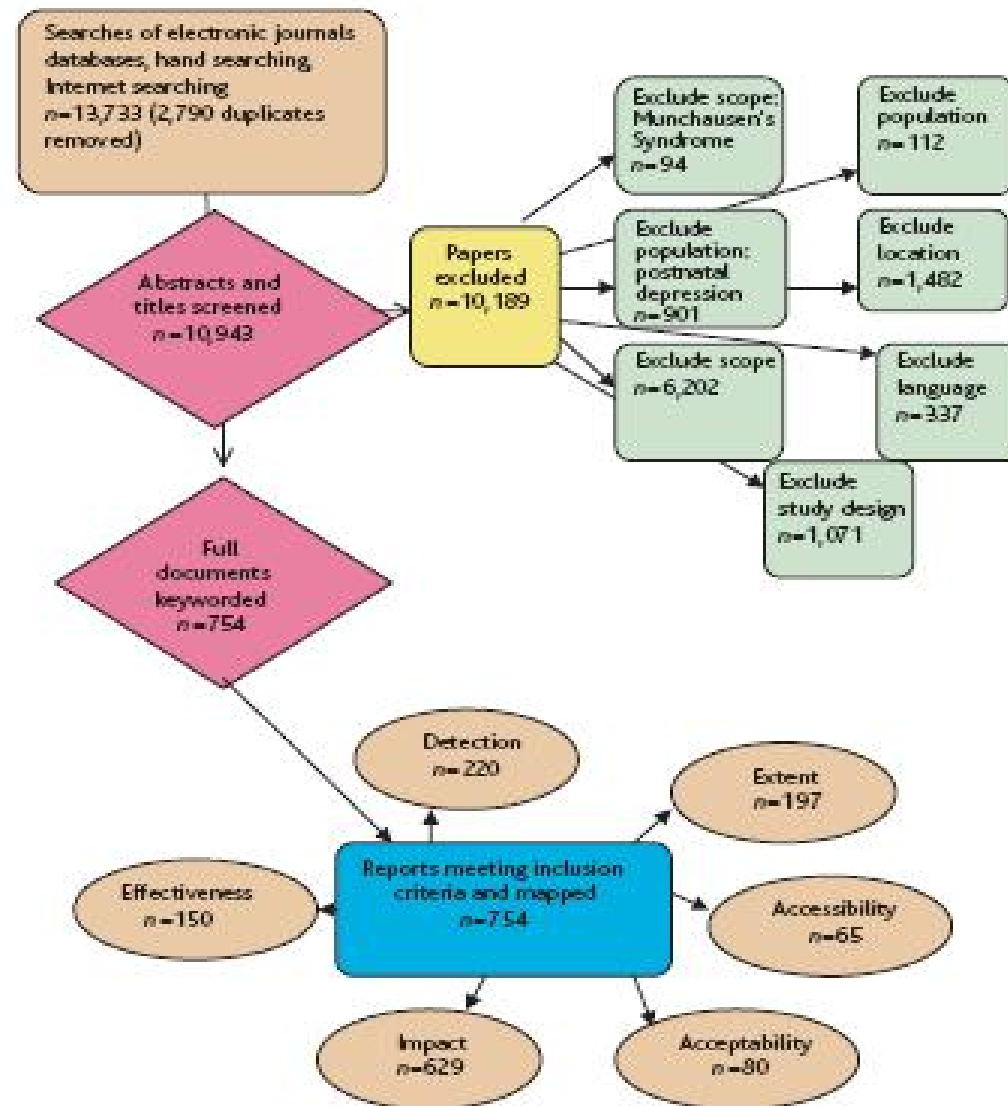


Figure 2 demonstrates the flow of literature through the systematic map.

Figure 2  
Flow of literature



Source: Adapted from EPPi-Centre (2004)

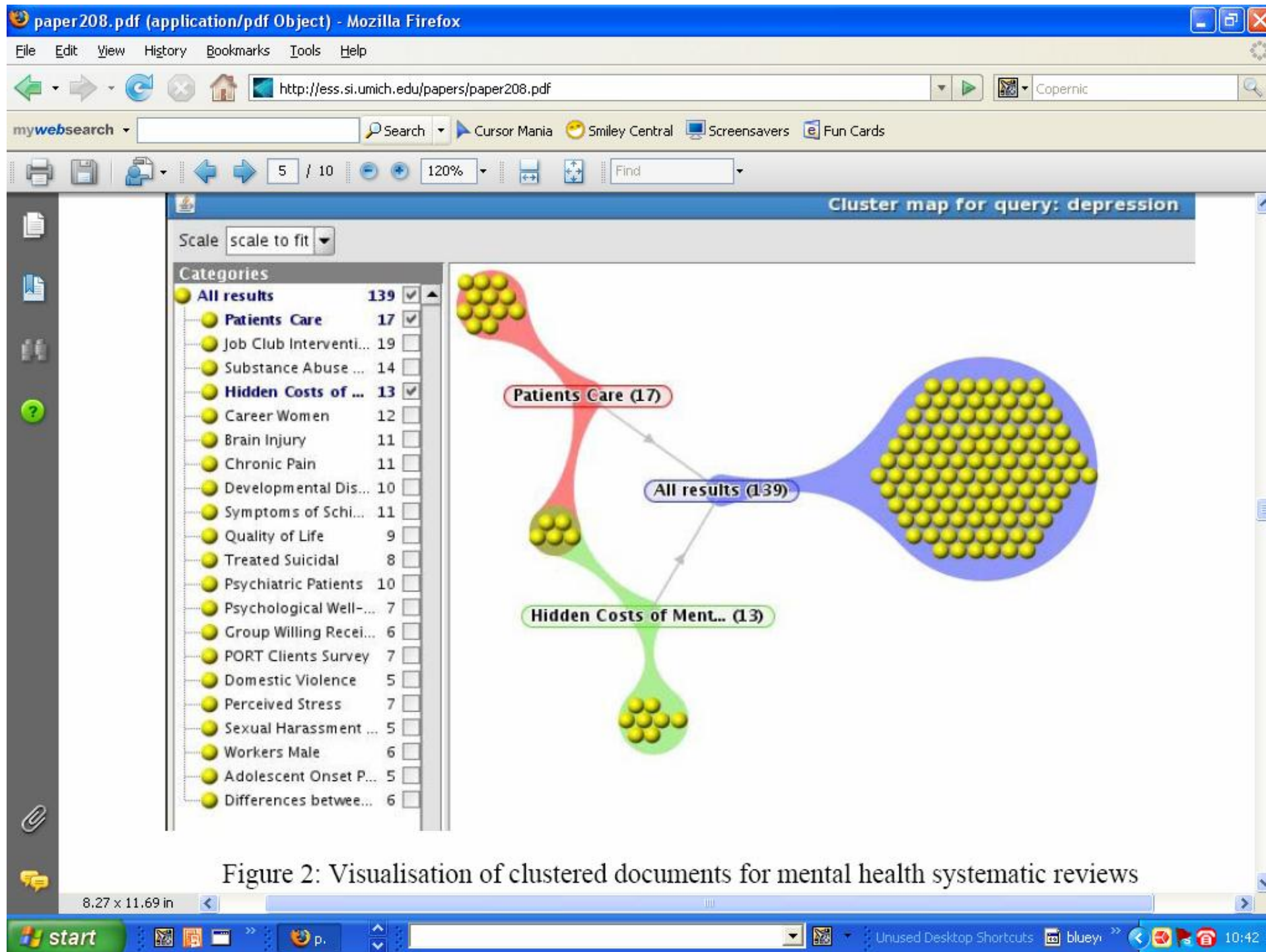
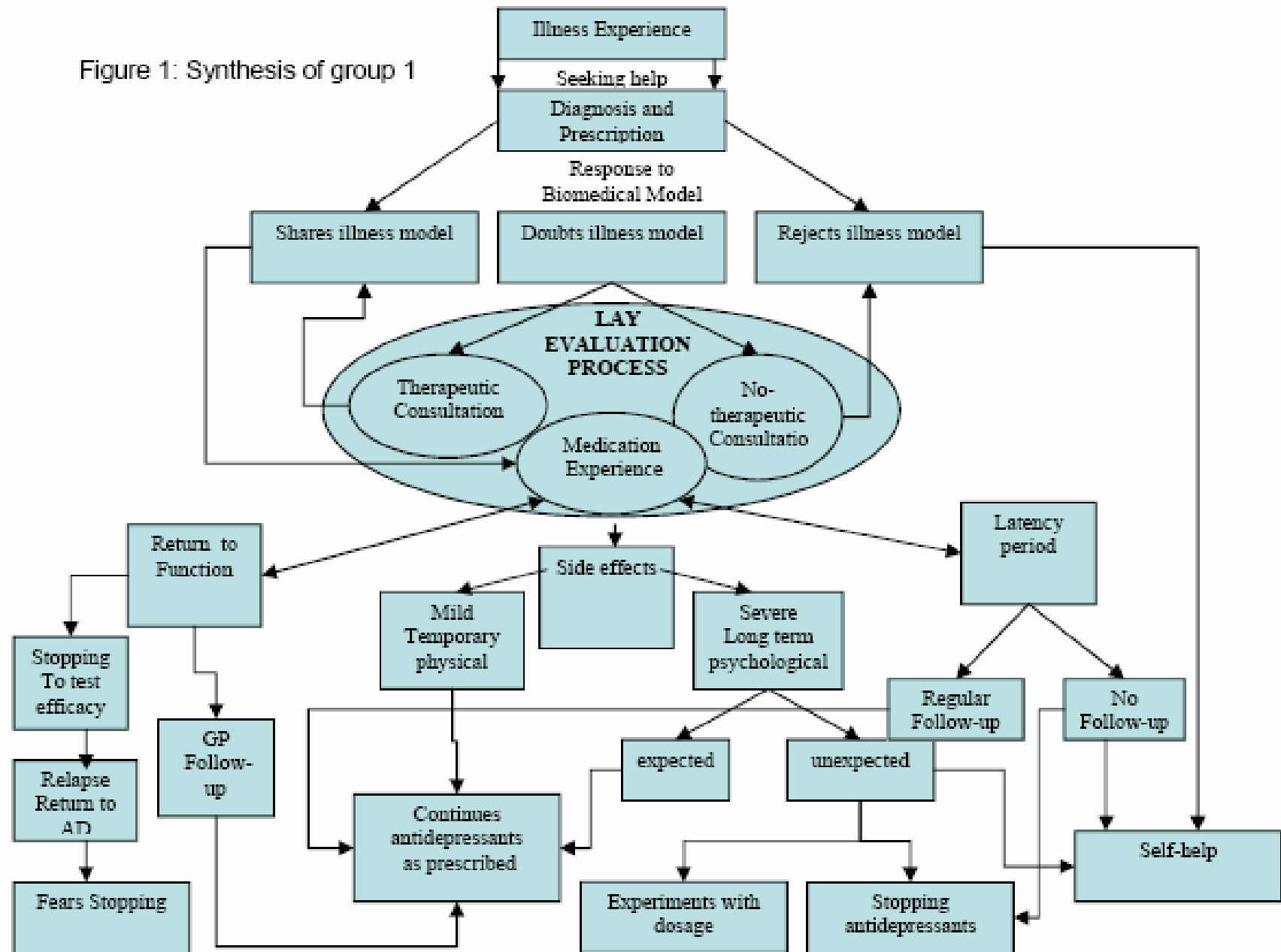


Figure 2: Visualisation of clustered documents for mental health systematic reviews

Figure 1: Synthesis of group 1





Inductive coding: diagrams - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Address [http://localhost:1933/EPPiReviewer/inductive\\_c\\_diagram.aspx](http://localhost:1933/EPPiReviewer/inductive_c_diagram.aspx)

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**EPPi-Reviewer 3.0** Inductive coding: diagrams [Help files](#)

Review details | Screening | Analyse | Enter / edit data | My account | Admin tools | Logout

List guidelines | Reviewers | Login details | Delete item | Inductive coding | Filter builder | Edit review | Web databases | Help | View item

Show all 42 items

Insert | Select code | Insert comment | Delete | Undo | Redo | Zoom in | Zoom out | Fit

```

graph TD
    A[Understandings of healthy eating] --> B[Healthy eating concepts]
    A --> C['Good' and 'bad' foods]
    A --> D[Health consequences]
    E[Provided foods] --> F[Foods in the school]
    E --> G[Foods in the home]
    F --> H[Factors further constraining limited choice]
    F --> I[School dinners as social occasion]
    G --> J[Breaking rules and asserting independence]
    G --> K[Parental influence and food rules]
    L[Chosen foods] --> M[Non-influencing factors]
    L --> N[Health benefits]
    L --> O[Roles and responsibilities]
    L --> P[Food preferences]
    L --> Q[Knowledge - behaviour gap]
    
```

Diagram name

Done Local intranet

# Line-by-line coding (Synthesis 2)

Inductive coding: code - Windows Internet Explorer  
http://localhost:1933/EPPIReviewer/inductive\_coding\_code.aspx

Inductive coding: code

EPPI-Reviewer 3.0 Inductive coding: code [Help files](#)

Review details | Screening | Analyse | Enter / edit data | My account | Admin tools | Logout

List guidelines | Reviewers | Login details | Delete item | Inductive coding | Filter builder | Edit review | Web databases | Help | View item

Show all 42 items

Coding text for item: *Dixey R; Sahota P; Atwal S; Turner A; (2001) Children talking about healthy eating: Data from focus groups with 300 9-11-year-olds* (click here to change item and/or text)

as a legitimate use of their money and thought parents should buy this.  
\*Children did not identify friends as an influence on their healthy eating

'Children were well aware of the pressures on them (to be healthy) and of the contradictions in their own behaviour, and knew that they did not always act on what they knew to be healthy: 'When they (the Apples project) come round, you think right, I'm going to get healthy now, but when you get home, you get something out of the fridge or something' (Boys, Year 6); 'At home I just nip into the biscuit tin.' (Boys, year 5)' p.74 - e.g. temptation 'All the things that are bad for you are nice, and all the things that are good for you are awful' (Boys, year 6) p.74 Problems with school dinners - 'But once you go down for the school dinners it's a different story, because you've got all your fattening foods' (Boys, Year 6) p.74 Some children reported throwing away foods they knew had been put in because they were 'good for you' and only ate the crisps and chocolate. Influence of advertising - reported keenness to emulate footballer Alan Shearer by eating at MacDonalds 'My brother says we have to go to there because Alan Shearer has been there.' (Girls, year 5) 'People thing 'I want to be like Alan Shearer so I better go to MacDonalds.' (Boys, year 6) Children said that adverts made them 'feel hungry' and were particularly

Text to code:

Create new code

- Understandings of healthy eating
- Influences on foods chosen
  - Provided foods
  - Chosen foods
    - Food preferences
    - Perceptions of health benefits
      - bad food = nice, good food = awful
    - Roles and responsibilities
    - Knowledge - behaviour gap
    - Non-influencing factors

Code selected text  
Remove this code from selected text  
Show text coded with this code  
Delete this code  
Add sub-code here  
Reports  
Properties...

You are logged in as: James Thomas  
Review: Children and Healthy Eating: A systematic review of barriers and facilitators  
Database: EPIC

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# Synthesis 2: Thematic analysis

1) Children don't see it as their role to be interested in health.

2) Children do not see future health consequences as personally relevant or credible.

3) Fruit, vegetables and confectionary have very different meanings for children.

4) Children actively seek ways to exercise their own choices with regard to foods.

5) Children value eating as a social occasion.

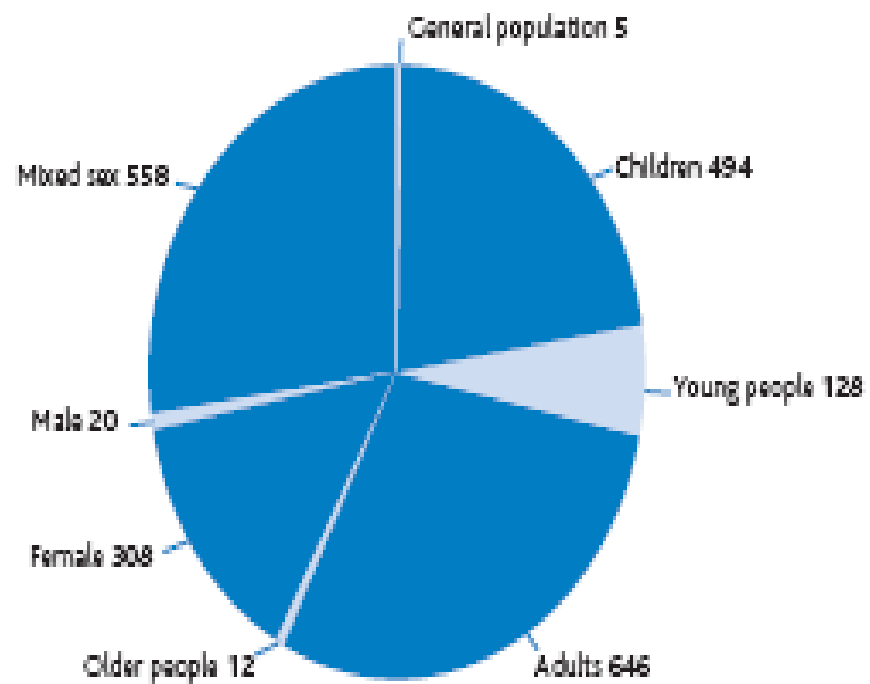
6) Children recognise contradiction between what is promoted and what is provided.

**Children consider taste, not health, to be a key influence on their food choice**

**Food labelled as healthy may lead children to reject them ('I don't like it so it must be healthy')**

**Buying healthy foods not seen as a legitimate use of their pocket money**

Figure 5  
Population breakdown in map



Note: Categories not mutually exclusive.

# Summative



# Temporal Profile

Table 1  
Temporal profile of reports (n = 42)

Year(s) data collected	References	Department of Health and Human Services Guidelines
Do not know	Misener & Sowell 1998	
Do not know	Fourney 1999	
Do not know	Richter <i>et al.</i> 2002	
Do not know	Douglass <i>et al.</i> 2003	
Do not know	Feigel 2003	
Do not know	Phillips <i>et al.</i> 2005	
1993–1995	Mostashari <i>et al.</i> 1998	No guidelines in place
1993–1996	Laine <i>et al.</i> 2000	No guidelines in place
1993–1996	Patama 2003	No guidelines in place
1993–1997	Turner <i>et al.</i> 2000	1993–1996: No guidelines 1997: Dual NRTI backbone + 1 PI
1993–2000	Stone <i>et al.</i> 2001	1993–1996: No guidelines 1997: Dual NRTI backbone + 1 PI 1998: Dual NRTI backbone + 1 or 2 PIs (EFZ added in Dec. 1998) 1999: Dual NRTI backbone (6 combos) + 1 or 2 PIs, or EFZ 2000: Dual NRTI backbone (4 combos) + 1 or 2 PIs, or EFZ
1994–1995	Siegel & Gorey 1997	No guidelines in place
1994–1996; 2000–2003	Schrimshaw <i>et al.</i> 2005	1994–1996: No guidelines in place 2000: Dual NRTI backbone (4 combos) + 1 or 2 PIs, or EFZ 2001–2002: EFZ, PI, or boosted PI + dual NRTI backbone 2003: EFZ + 3TC + (AZT or TDF or d4T) OR LPV/r + 3TC + (AZT or d4T)
1996–1997	Schuman <i>et al.</i> 2001	1996: No guidelines 1997: Dual NRTI backbone + 1 PI
1996–1997	Siegel <i>et al.</i> 2001	1996: No guidelines 1997: Dual NRTI backbone + 1 PI
1997	Mann 2001	Dual NRTI backbone + 1 PI
1997	Roberts & Mann 2000	Dual NRTI backbone + 1 PI
1997	Roberts & Mann 2003	Dual NRTI backbone + 1 PI
1997–1998	Ickovics <i>et al.</i> 2002	1997: Dual NRTI backbone + 1 PI 1998: Dual NRTI backbone + 1 or 2 PIs (EFZ added in Dec. 1998)
1997–1999	Jones <i>et al.</i> 2003	1997: Dual NRTI backbone + 1 PI 1998: Dual NRTI backbone + 1 or 2 PIs (EFZ added in Dec. 1998)
1997–2000	Sharpe <i>et al.</i> 2004	1997: Dual NRTI backbone + 1 PI 1998: Dual NRTI backbone + 1 or 2 PIs (EFZ added in Dec. 1998) 1999: Dual NRTI backbone (6 combos) + 1 or 2 PIs, or EFZ 2000: Dual NRTI backbone (4 combos) + 1 or 2 PIs, or EFZ
1998	Durante <i>et al.</i> 2003	Dual NRTI backbone + 1 or 2 PIs (EFZ added in Dec. 1998)
1998	Erlen <i>et al.</i> 2002	Dual NRTI backbone + 1 or 2 PIs (EFZ added in Dec. 1998)
1998–1999	Mellins <i>et al.</i> 2002	1998: Dual NRTI backbone + 1 or 2 PIs (EFZ added in Dec. 1998) 1999: Dual NRTI backbone + 1 or 2 PIs, or EFZ
1998–1999	Mellins <i>et al.</i> 2003	1998: Dual NRTI backbone + 1 or 2 PIs (EFZ added in Dec. 1998) 1999: Dual NRTI backbone + 1 or 2 PIs, or EFZ
1998–1999	Sowell <i>et al.</i> 2001a	1998: Dual NRTI backbone + 1 or 2 PIs (EFZ added in Dec. 1998)

Kane et al  
2007

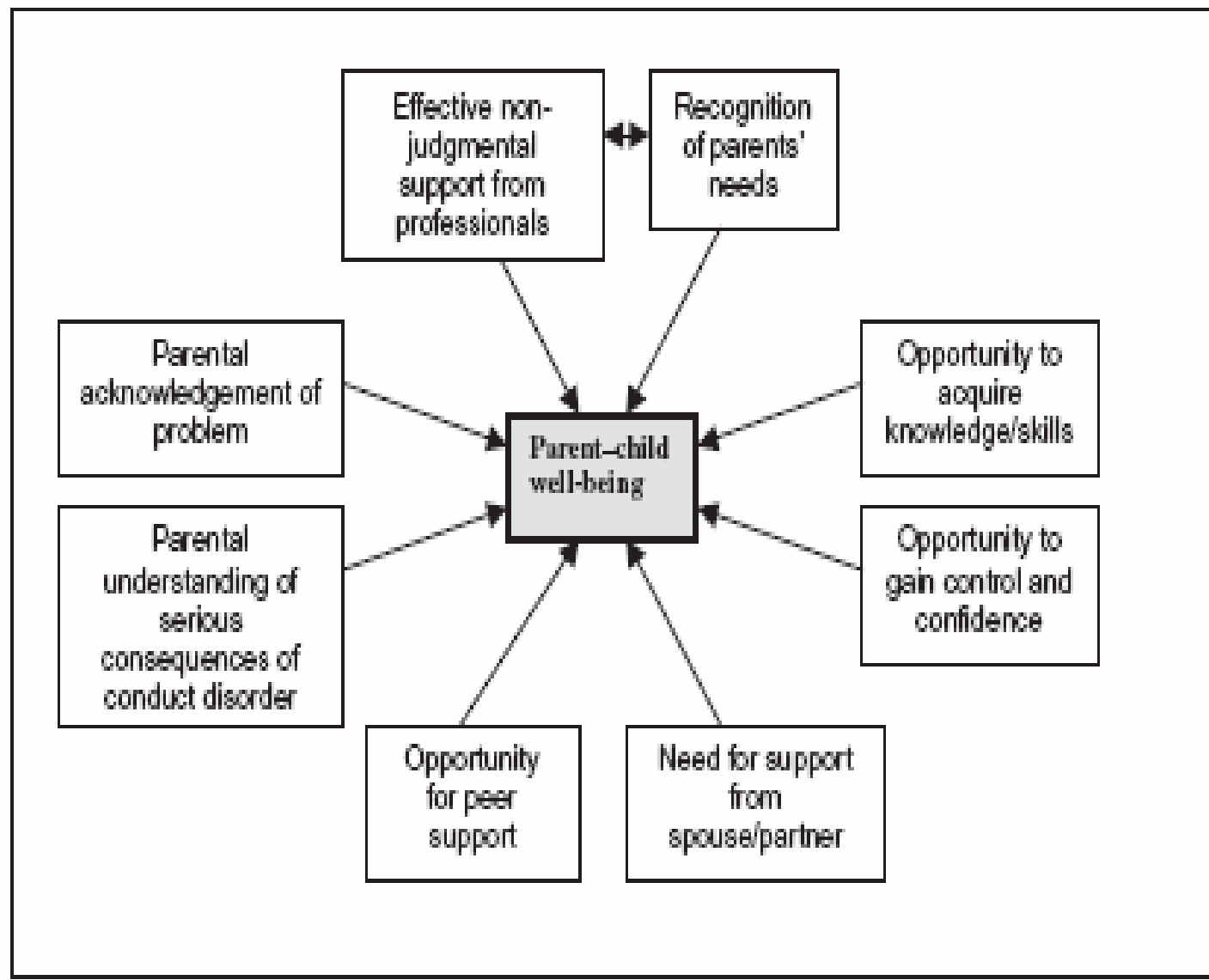






Figure 1. Line-of-argument synthesis: addressing parents' needs and promoting parent-child well-being.

Kylma 2005

<b>DESPAIR</b>	
<ul style="list-style-type: none"> <li>● Downward sub-process of despair refers to the destructive path of giving in to hopelessness</li> </ul>	<ul style="list-style-type: none"> <li>● Upward sub-process of despair refers to the constructive path leading towards hope</li> </ul>
 <b>CATEGORIES</b>	 <b>CATEGORIES</b>
<ul style="list-style-type: none"> <li>● Stopping and being stuck in the situation (III)</li> <li>● Losing grip and sinking into a narrowing existence (II,V,VI)</li> <li>● Focusing on impossibilities (IV)</li> <li>● Losing future perspective (II)</li> <li>● Questioning the possibility of hope (II)</li> </ul> <p style="text-align: center;">■</p>	<ul style="list-style-type: none"> <li>● Fighting against sinking (VI)</li> <li>● Fighting to rise up with a glimmer of hope (III, V)</li> </ul>
 <b>SUBCATEGORIES</b>	 <b>SUBCATEGORIES</b>
<ul style="list-style-type: none"> <li>● Experiencing distressing and stagnant inability (II-V) including panic (VI)</li> <li>● Living in exhaustive agony (II)</li> <li>● Being captive (II)</li> <li>● Experiencing lack of alternatives, means and resources (III, V)</li> <li>● Being stagnant (V)</li> <li>● Being alone (V)</li> <li>● Sinking down into narrowed existence (III) described as going down (II) and being unable to take hold of anything (VI),</li> <li>● A narrowing of the future towards the end (V) such as the narrowing of life (V), non-existence of positive factors upon which to build a future life (V), concealed dreams (V), future life having nothing to offer (V), approaching the end (V), existence of nothing after the end (V), having no grounds for life (V), and indifference in giving up and losing (III, IV) as well as acting destructively (VI)</li> </ul>	<ul style="list-style-type: none"> <li>● Understanding the situation (V)</li> <li>● Fighting back constructively against sinking (V, VI)</li> <li>● Rising up towards hope (V)</li> </ul>



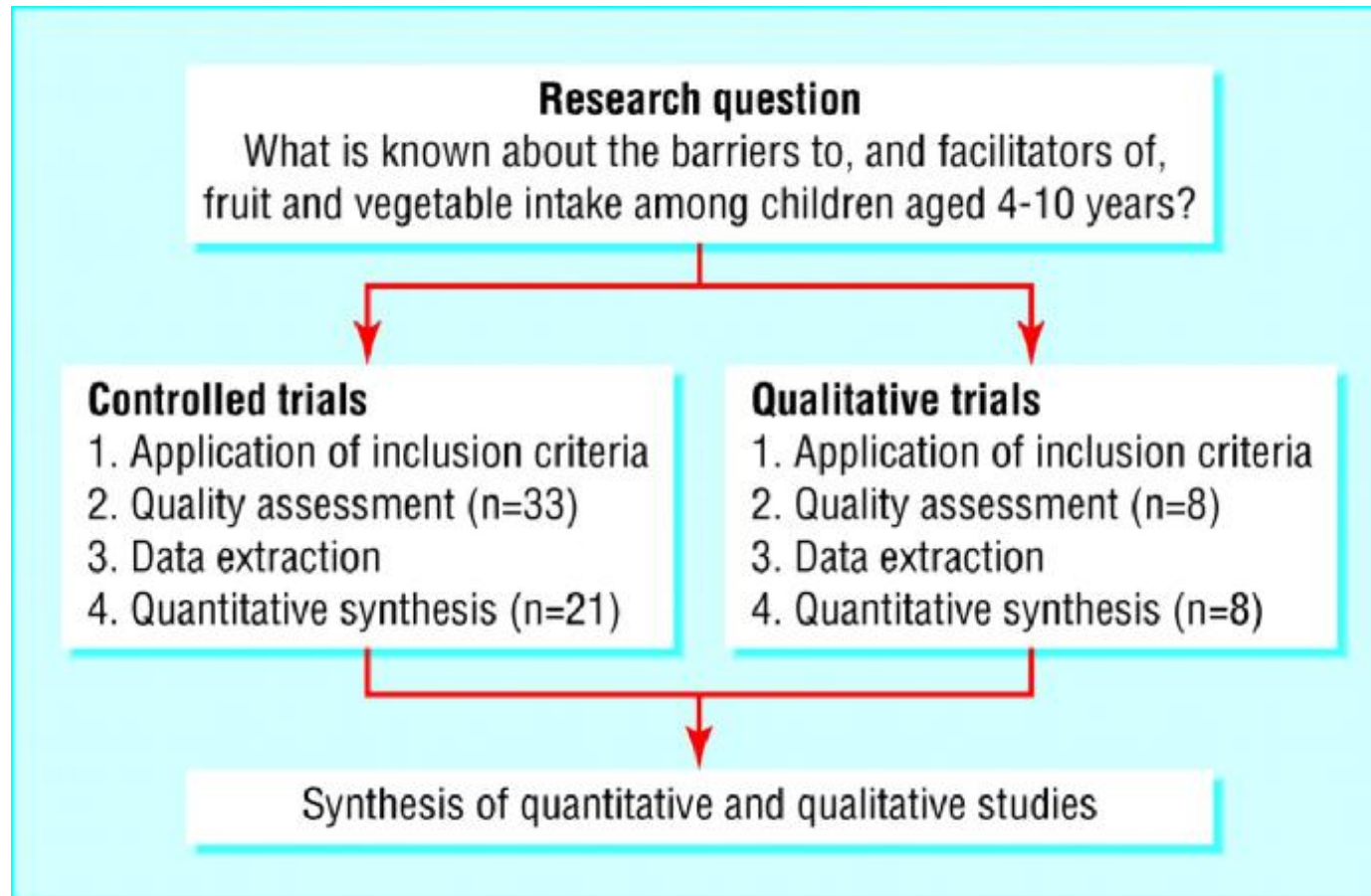
# Audit

# Transparency

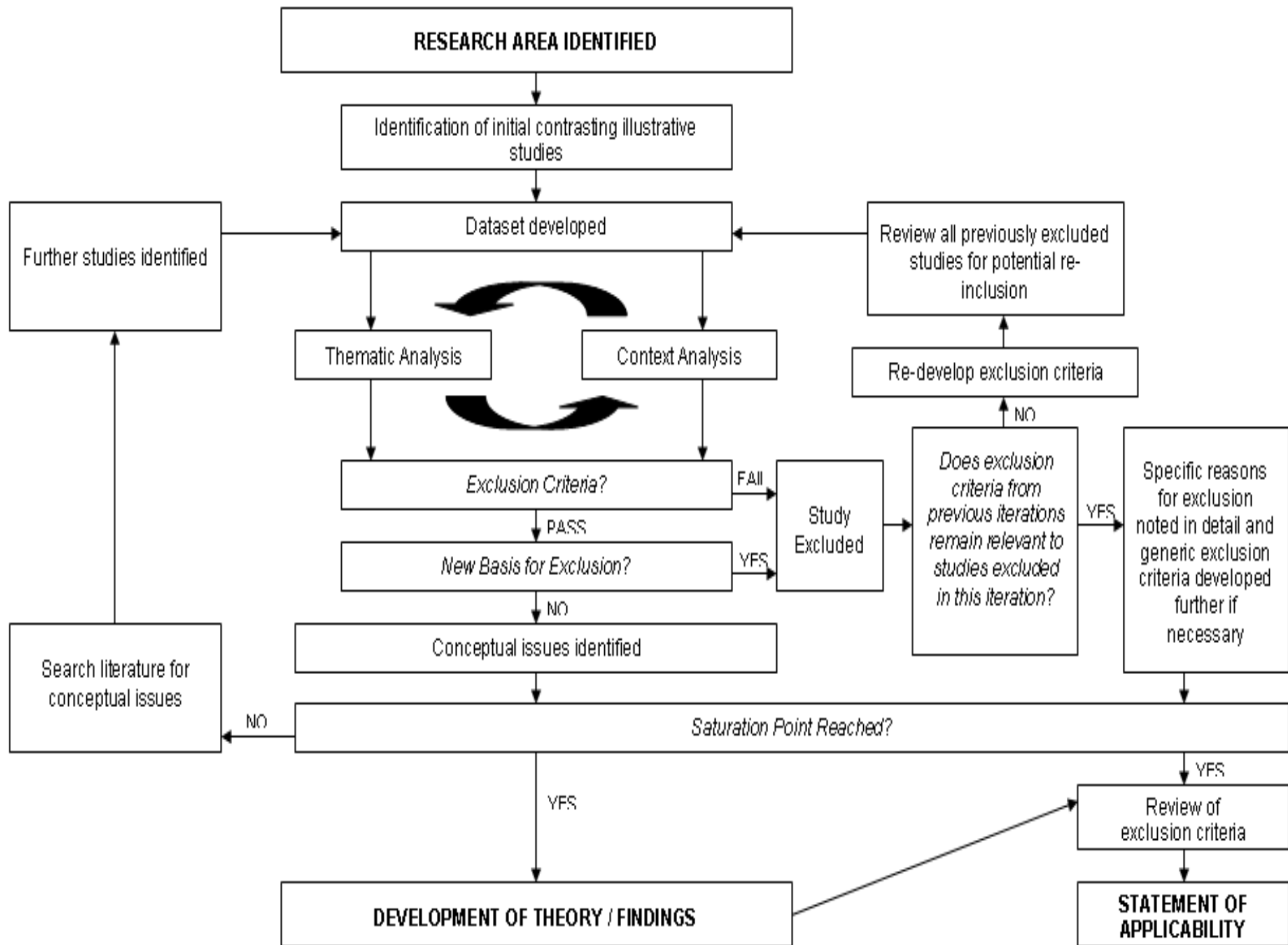
- ‘Given the involvement of the researcher in the research process, the question is not whether the data are biased, but to what extent has the researcher rendered transparent the processes by which data have been collected, analysed and presented’ (Popay et al, 1998, p. 348).

# Overall Process

**Fig 1 Stages of the review**



Thomas, J. et al. BMJ 2004;328:1010-1012



# Search Process

Table 1. Final search criteria and search terms using the SPICE(S) tool

Setting	Perspective	Intervention	Comparison	Evaluation	Social science method
<i>Depression</i>	<i>Patient View</i>	<i>Antidepressants</i>	<i>GP and Patient views</i>	<i>Anti-depressant use over time</i>	<u>Qualitative</u>
Depression; Depressive disorder; Depress\$.tw.	Attitude to health; Patient satisfaction; Patient\$ adj3 view\$; Patient care; Patient Compliance; Patient acceptance of health care; Patient participation; Treatment refusal; Patient preference	Antidepressive agents; Antidepress\$.tw	Physician-patient relations	Communication; Decision making; Consultation.tw.	Qualitative research; Qualitative.tw.; Qualitative adj research; Grounded adj theory; Ethnograph\$; Qualitative adj studies; Interview\$; Focus groups; Nursing research.tw.; nursing research/ or nursing evaluation research/ or exp nursing methodology research/ Field studies; Ethnonursing research; Field studies.tw.; Fieldwork.tw.

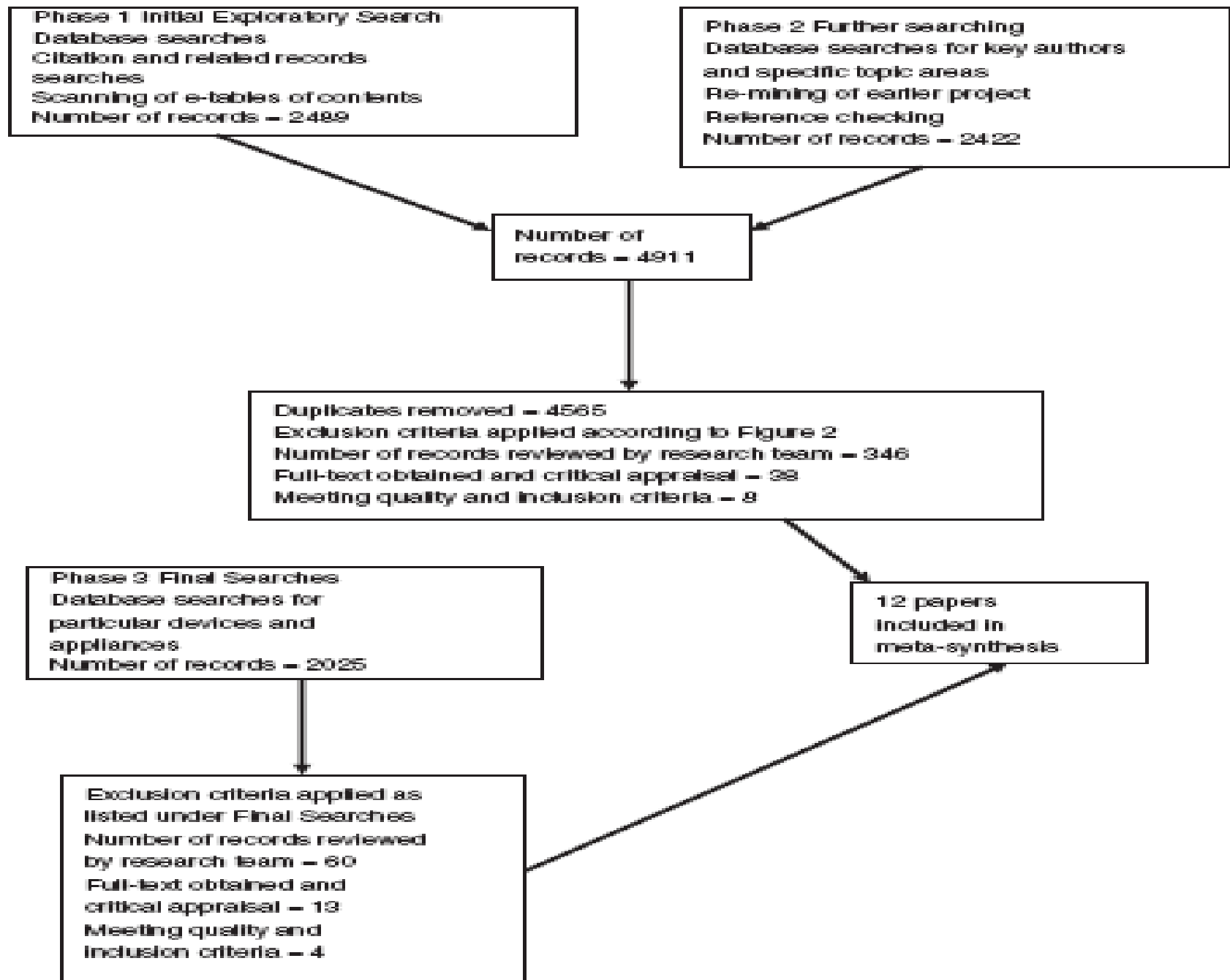


FIG. 2. Identification of relevant literature for inclusion in the meta-synthesis.



# Inclusion and Exclusion

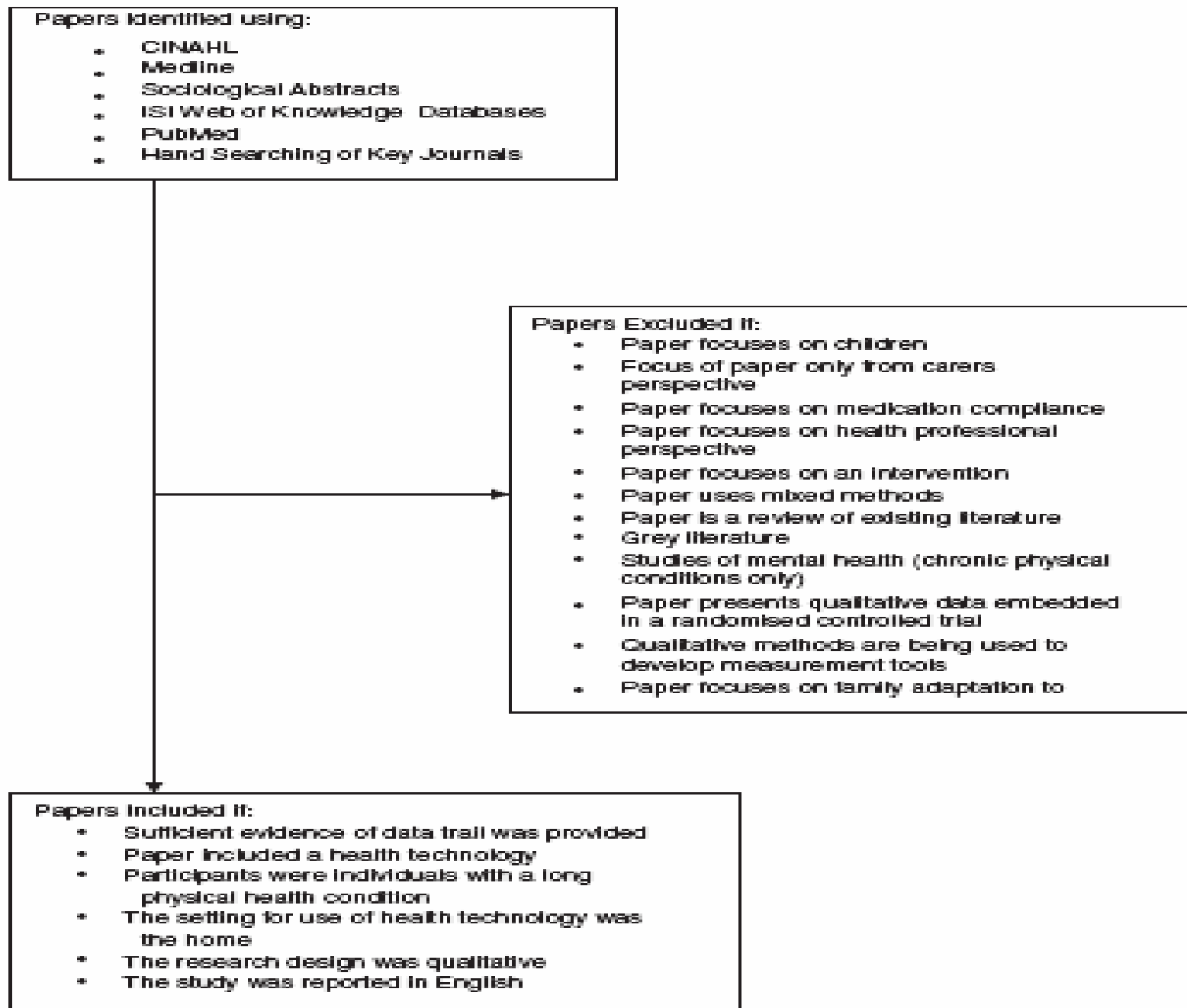
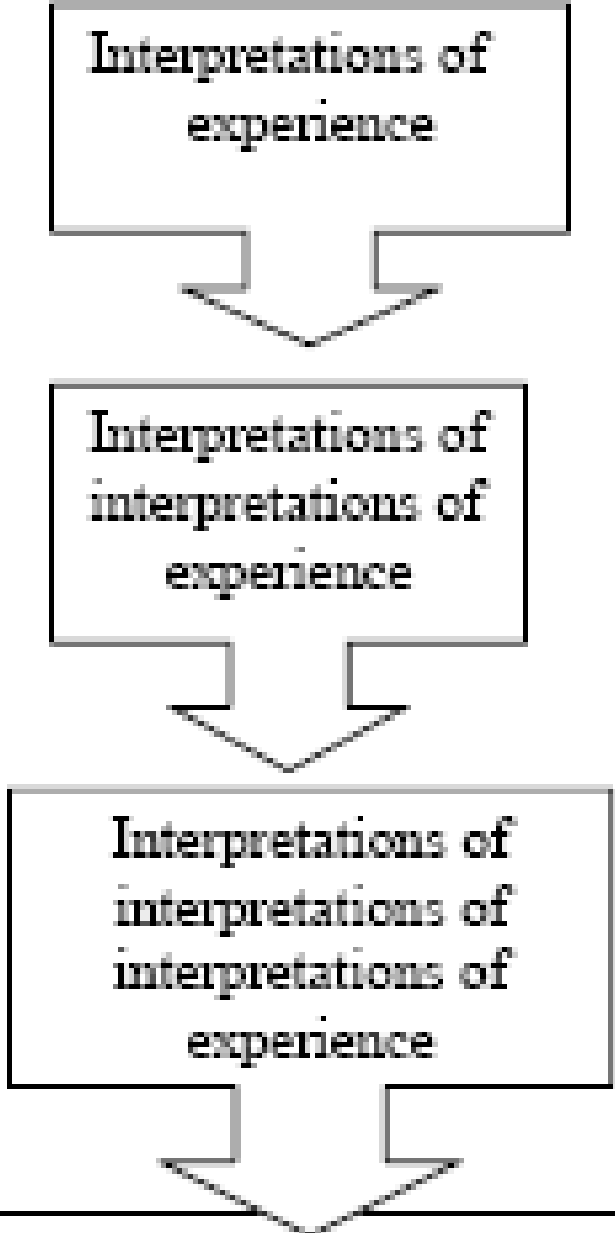


FIG. 1. Inclusion and exclusion criteria for synthesis of patient adaptation to health technologies.

# Synthesis Process

Table 4 – Definition of 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> order constructs, based on Noblit and Hare (1988)

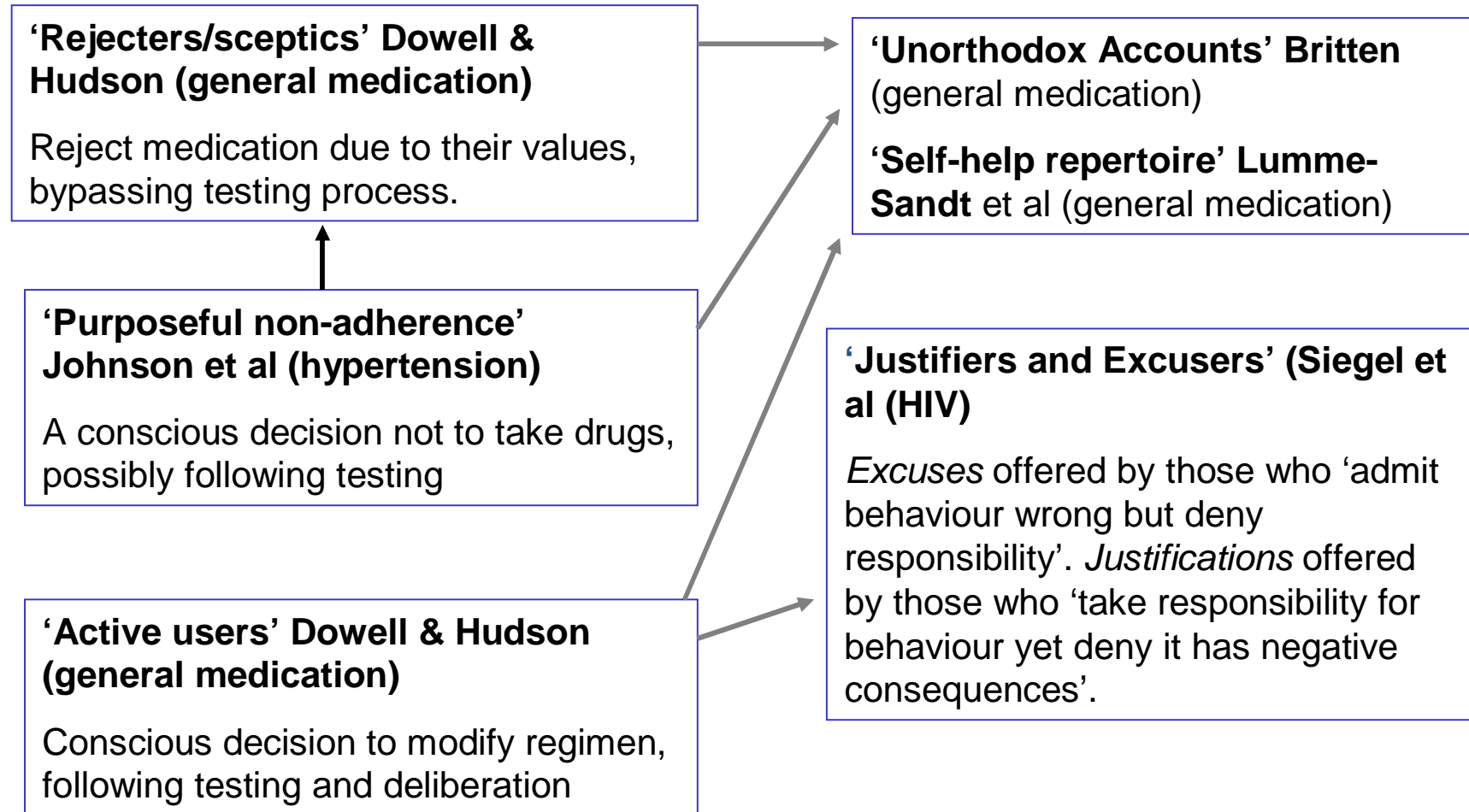
<p><b>First order constructs</b></p>	<p>Patients views, accounts and interpretations of their experiences of using anti-depressants</p>	 <pre> graph TD     A[Interpretations of experience] --&gt; B[Interpretations of interpretations of experience]     B --&gt; C[Interpretations of interpretations of interpretations of experience]             </pre>
<p><b>Second order constructs</b></p>	<p>The authors views and interpretations (expressed in terms of themes and concepts) of patients views of antidepressant use.</p>	
<p><b>Third order constructs</b></p>	<p>The views and interpretations of the synthesis team, (expressed in terms of themes and key concepts)</p>	

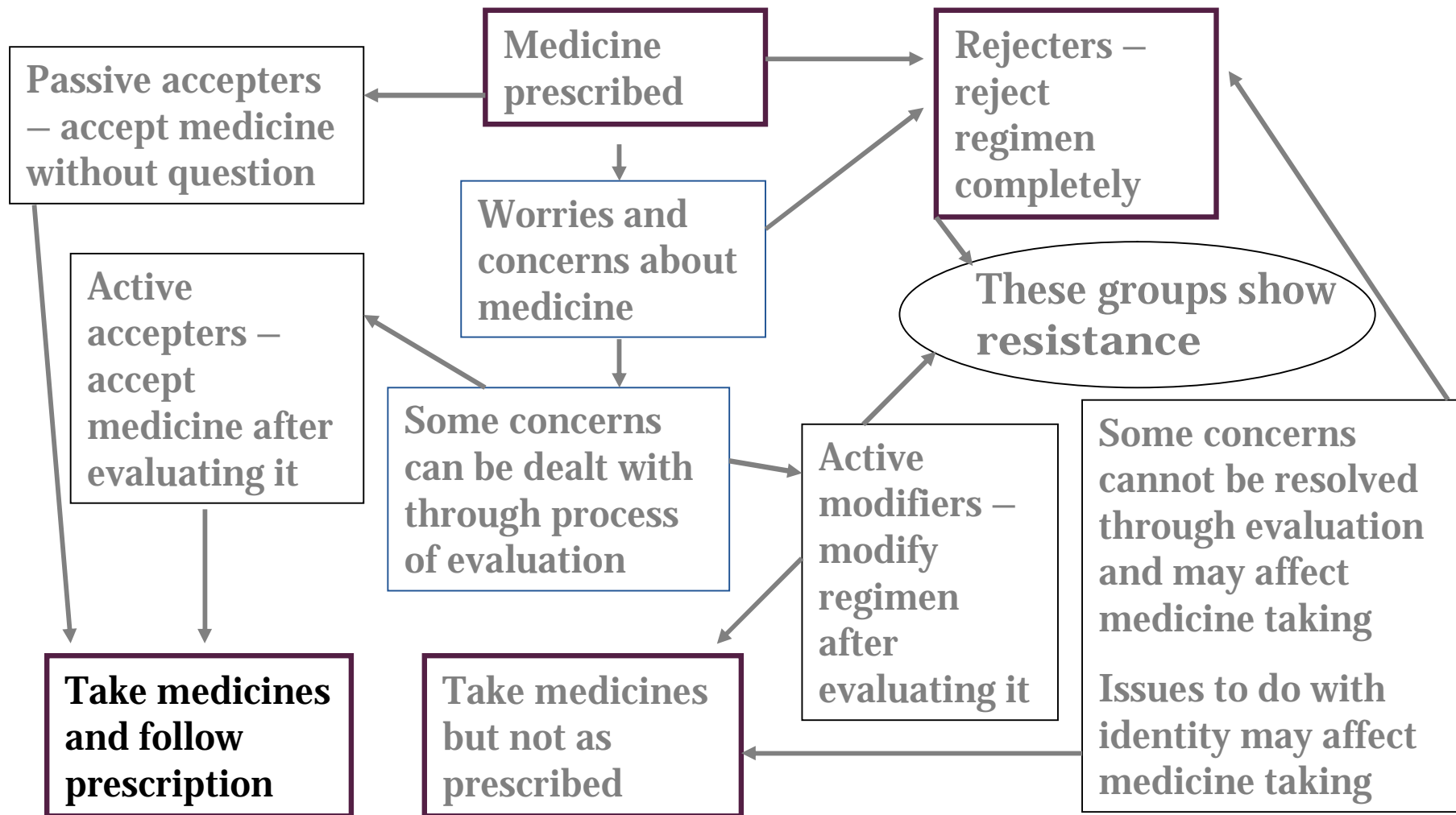
# Synthesis Results

TABLE 2. *Main results from the meta-synthesis*

Synthesis of main findings	Line of argument synthesis
<p><i>Managing multiple uncertainties</i>            Heightened awareness of health deteriorating            Continuous feelings of uncertainty about the future            New vulnerability to technological failure            Living in hope of technological advances            Technology imposed a routine that facilitated a sense of control and certainty</p>	<p>Adaptation, accommodation and integration of a technology are an extension of identifying and living life with a chronic condition</p>
<p><i>The reconstruction of identity</i>            Moral imperative to accept a technology            Process of comprehension as to how technology will impact upon illness identity.            Technology perceived as a signifier of illness            Presumption that others will make inaccurate assumptions about the individual.            Reconstruction of identity that retains a part of pre-illness identity</p>	<p>The integration of a technology or device into the user's life world can be viewed as an extension of existing 'illness work'</p>
<p><i>The struggle to remain autonomous while allowing dependence</i>            Technology helped maintain some level of independence            Devices permitted a greater sense of self-regulation            Human qualities attached to the technology that aided engagement            A new autonomy brought dependence on the technology and others            Changes to relationships with health professionals experienced            Health professional's views perceived to dominate</p>	<p>The introduction of a technology imposes a new time frame on the individual that must be adhered to, to meet the needs of the technology</p>
<p><i>Coming to terms with living a technology-assisted life</i>            Integration involved a process of normalization            New values and norms incorporated following the introduction of a technology            Balance needed between illness regimen and daily life            Alterations made to minimize intrusion</p>	<p>The introduction of a technology imposes a new time frame on the individual that must be adhered to, to meet the needs of the technology</p>
<p><i>Usability of devices</i>            Acceptance linked to user competency and user friendliness of the device            Usability linked to perceived simplicity, convenience and hygiene of the technology</p>	<p>The introduction of a technology imposes a new time frame on the individual that must be adhered to, to meet the needs of the technology</p>

# Example of synthesising translations across illness groups







# References

- Booth A. "Brimful of STARLITE": toward standards for reporting literature searches. *J Med Libr Assoc.* 2006 Oct;94(4):421-9,
- Dixon-Woods M, Booth A. & Sutton AJ (2007) Synthesizing qualitative research: a review of published reports *Qualitative Research*, Vol. 7, No. 3, 375-422
- Popay J., Rogers A. & Williams G. (1998) Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research* 8(3), 341–351.