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

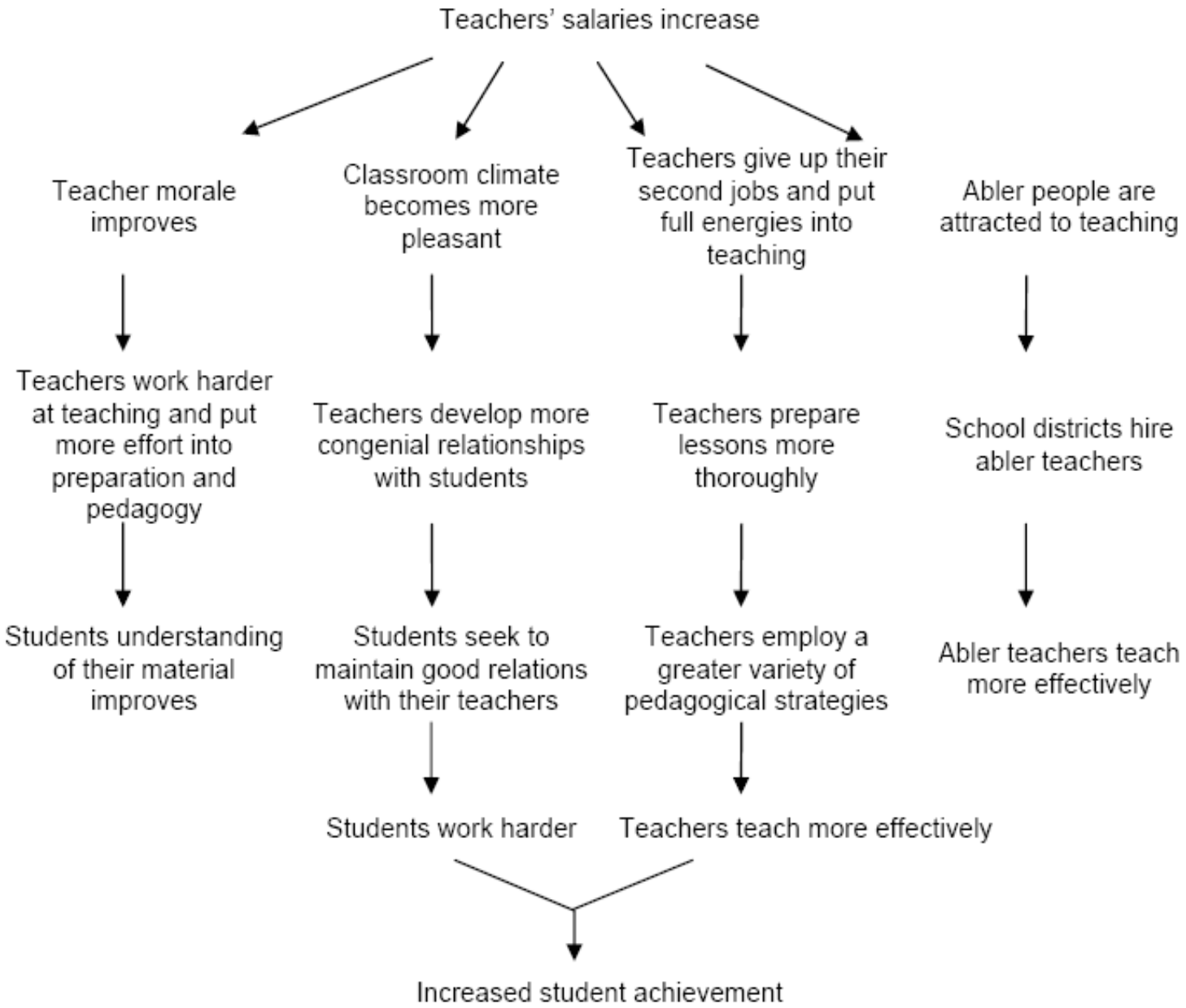


Figure 3. Example of a Programme Theory model: mechanisms by which higher teachers' pay may be linked to increased student achievement (from Weiss, 1998)

Figure 9. Examples of idea webbing

a)

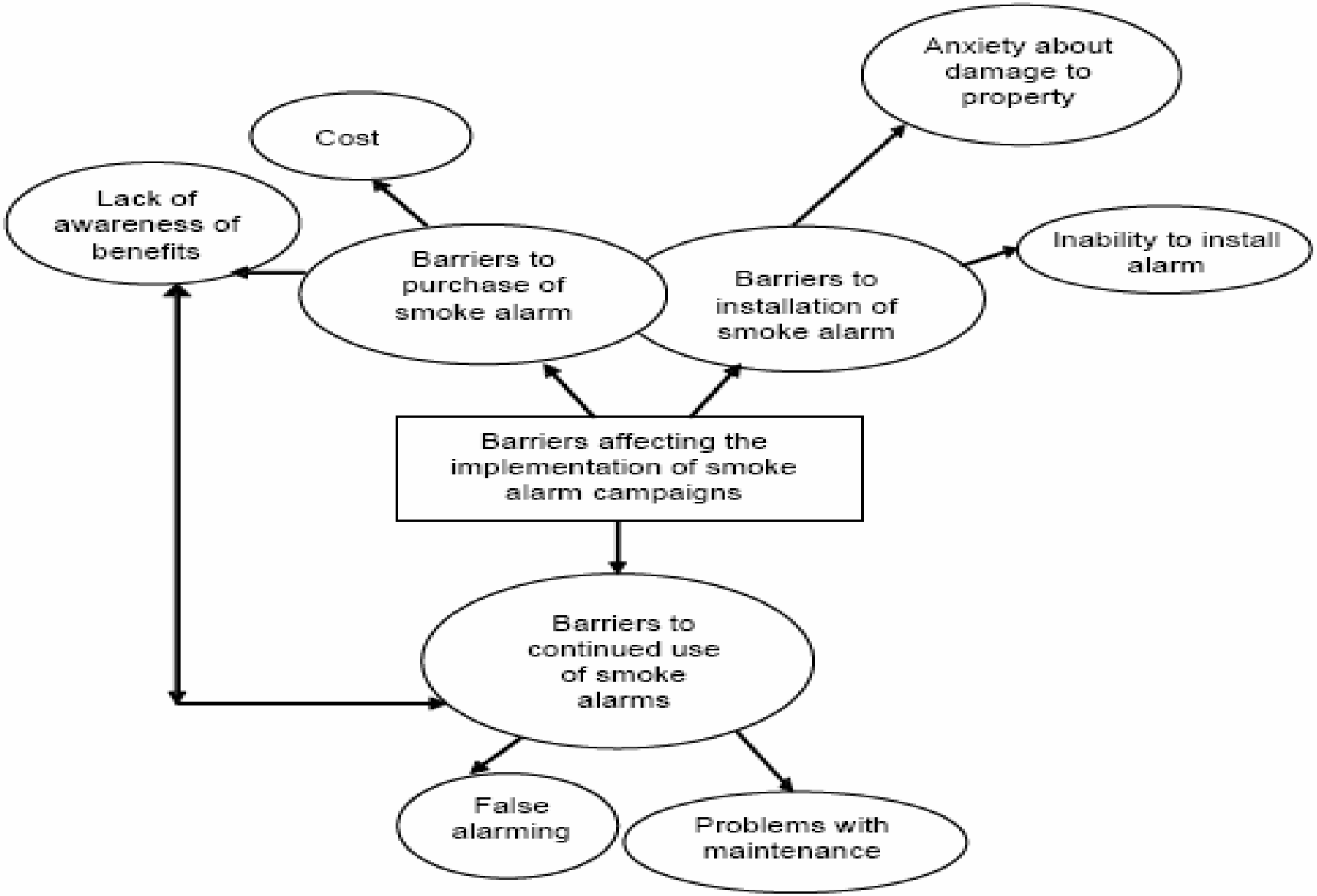
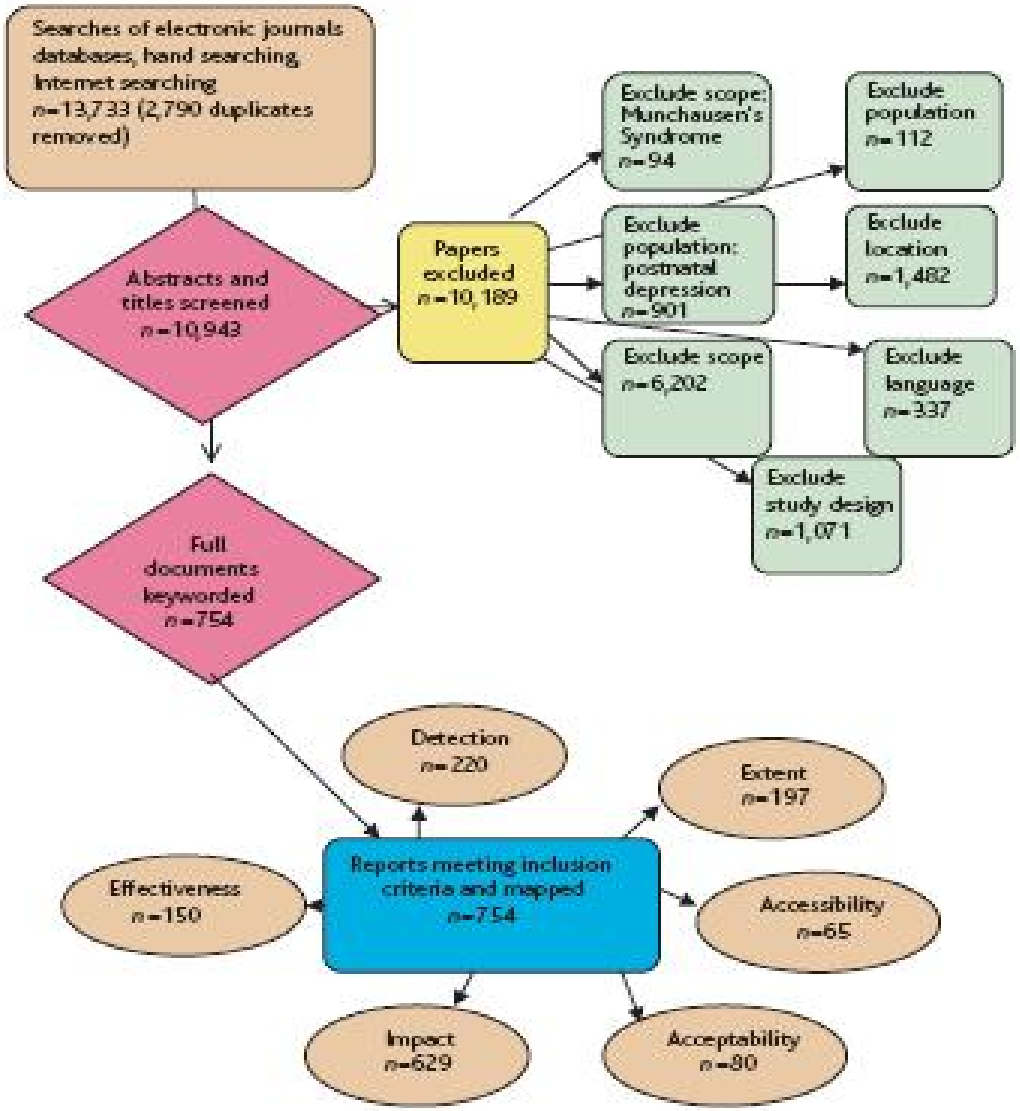


Figure 2 demonstrates the flow of literature through the systematic map.

Figure 2
Flow of literature



Source: Adapted from EPPI-Centre (2004)

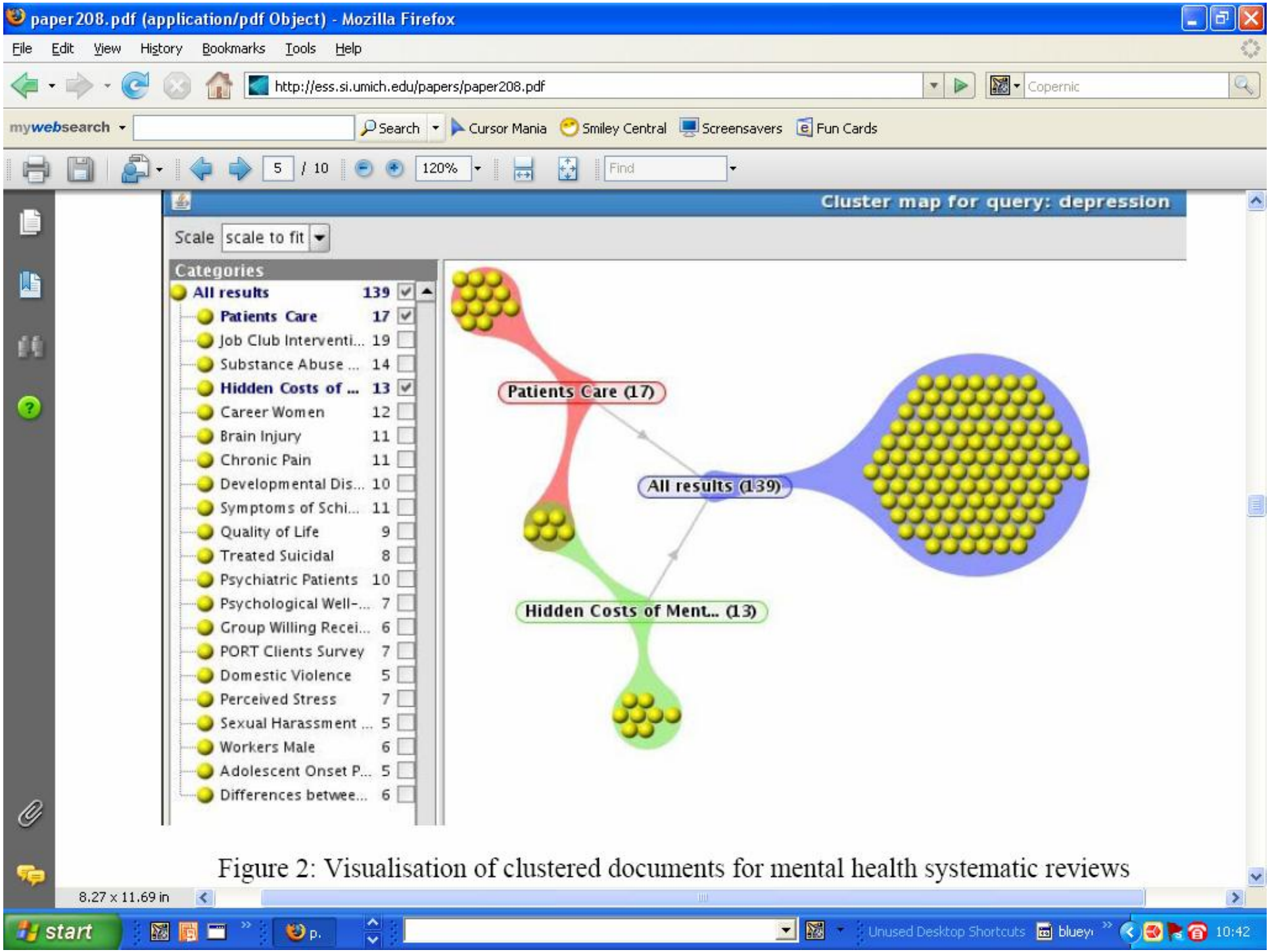
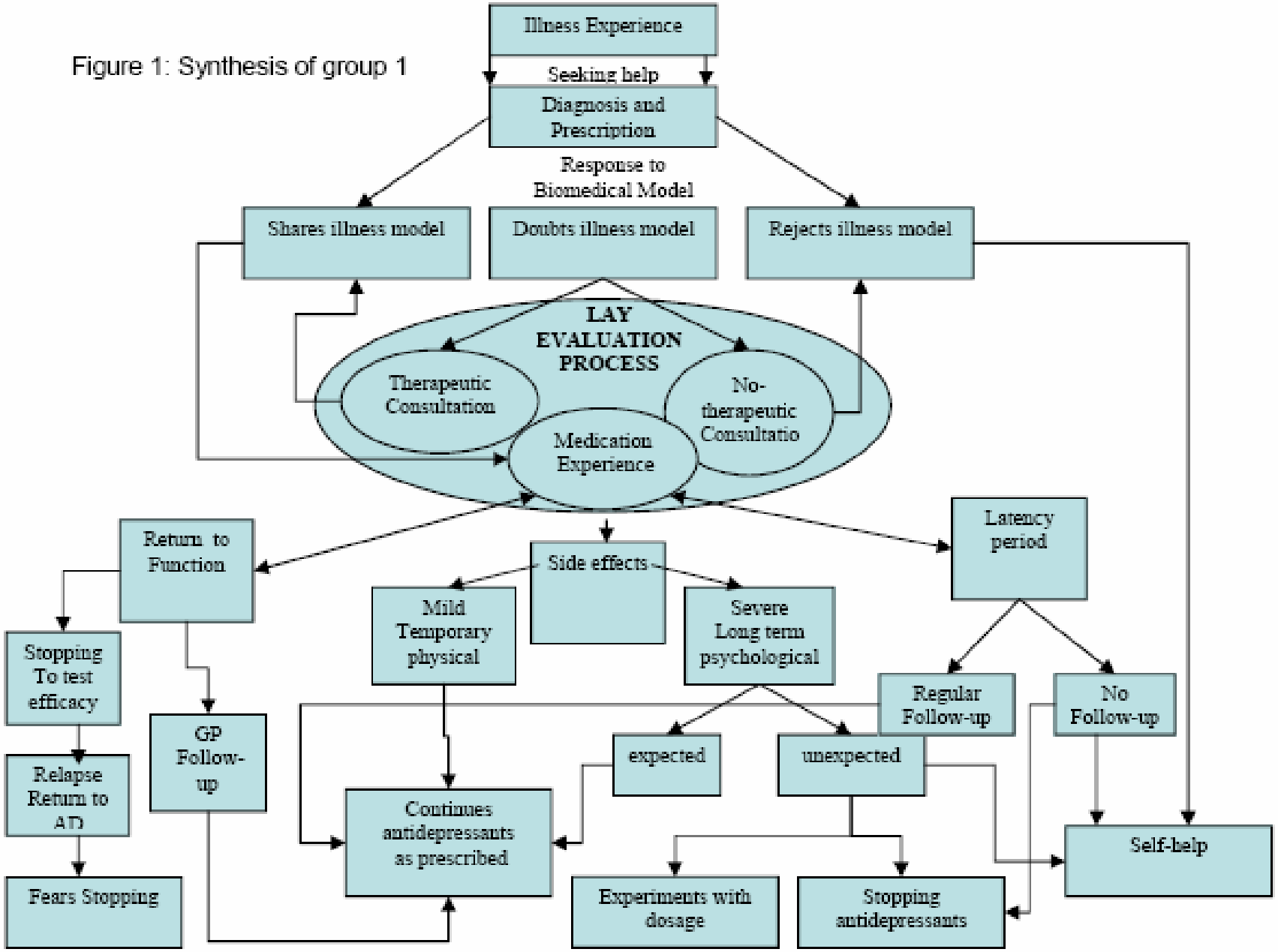
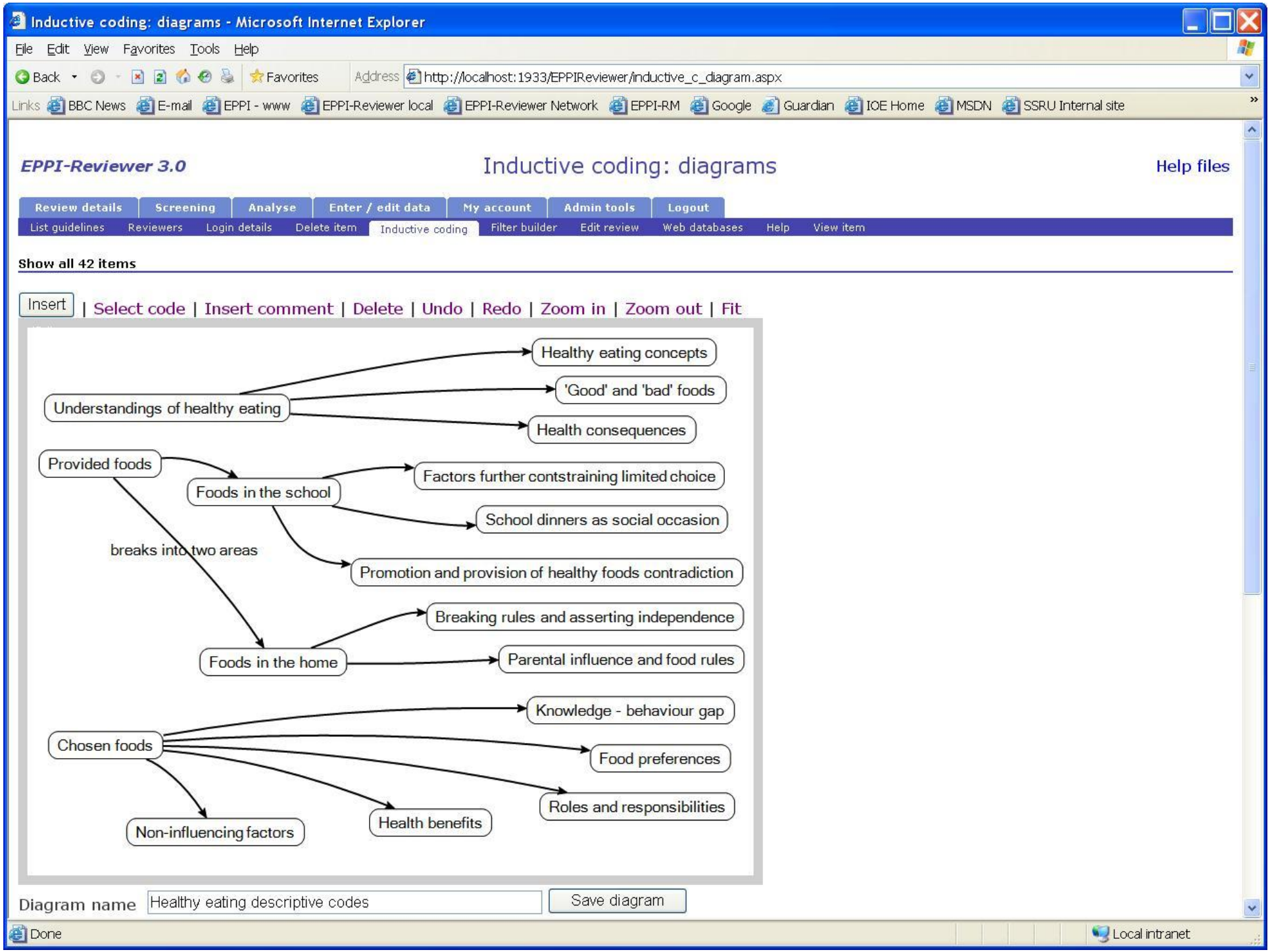


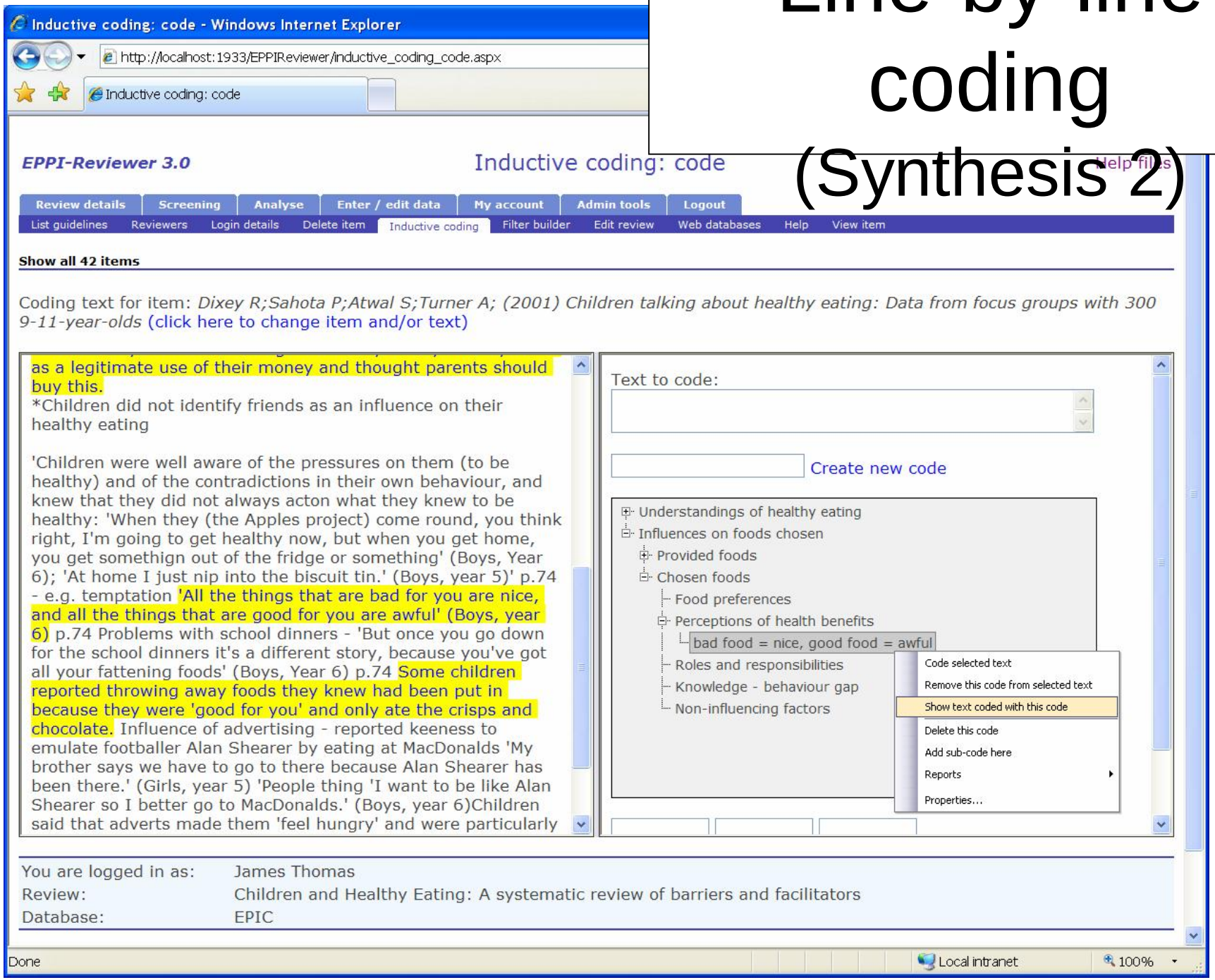
Figure 2: Visualisation of clustered documents for mental health systematic reviews

Figure 1: Synthesis of group 1





Line-by-line coding (Synthesis 2)



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.

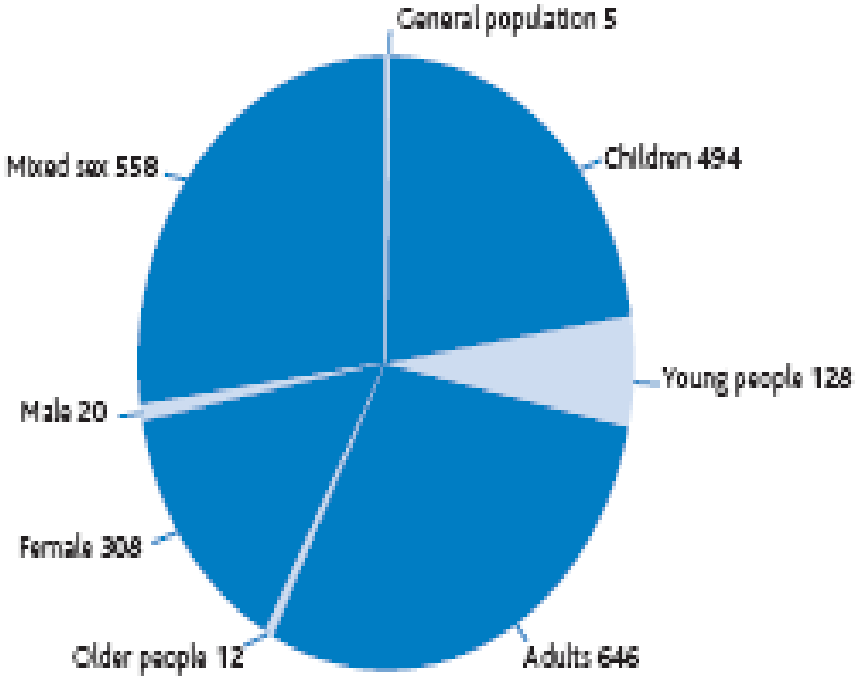
6) Children recognise contradiction between what is promoted and what is provided.

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

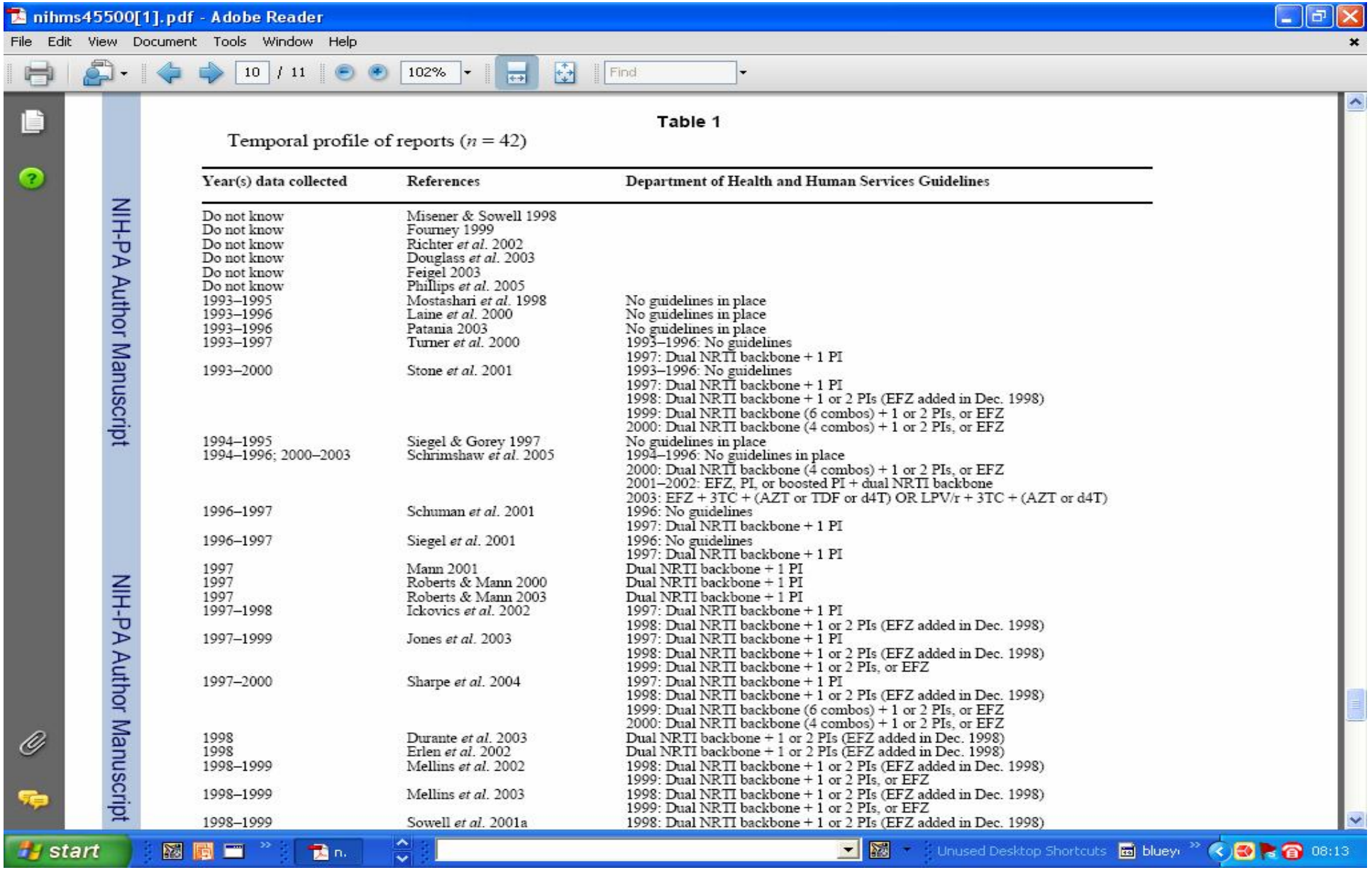


Table 1

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 *et al.* 2002	
Do not know	Douglass *et al.* 2003	
Do not know	Feigel 2003	
Do not know	Phillips *et al.* 2005	
1993–1995	Mostashari *et al.* 1998	No guidelines in place
1993–1996	Laine *et al.* 2000	No guidelines in place
1993–1996	Patania 2003	No guidelines in place
1993–1997	Turner *et al.* 2000	1993–1996: No guidelines 1997: Dual NRTI backbone + 1 PI
1993–2000	Stone *et al.* 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 *et al.* 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 *et al.* 2001	1996: No guidelines 1997: Dual NRTI backbone + 1 PI
1996–1997	Siegel *et al.* 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 *et al.* 2002	1997: Dual NRTI backbone + 1 PI 1998: Dual NRTI backbone + 1 or 2 PIs (EFZ added in Dec. 1998)
1997–1999	Jones *et al.* 2003	1997: Dual NRTI backbone + 1 PI 1998: Dual NRTI backbone + 1 or 2 PIs (EFZ added in Dec. 1998) 1999: Dual NRTI backbone + 1 or 2 PIs, or EFZ
1997–2000	Sharpe *et al.* 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 *et al.* 2003	Dual NRTI backbone + 1 or 2 PIs (EFZ added in Dec. 1998)
1998	Erlen *et al.* 2002	Dual NRTI backbone + 1 or 2 PIs (EFZ added in Dec. 1998)
1998–1999	Mellins *et al.* 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 *et al.* 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 *et al.* 2001a	1998: Dual NRTI backbone + 1 or 2 PIs (EFZ added in Dec. 1998)

Kane et al 2007

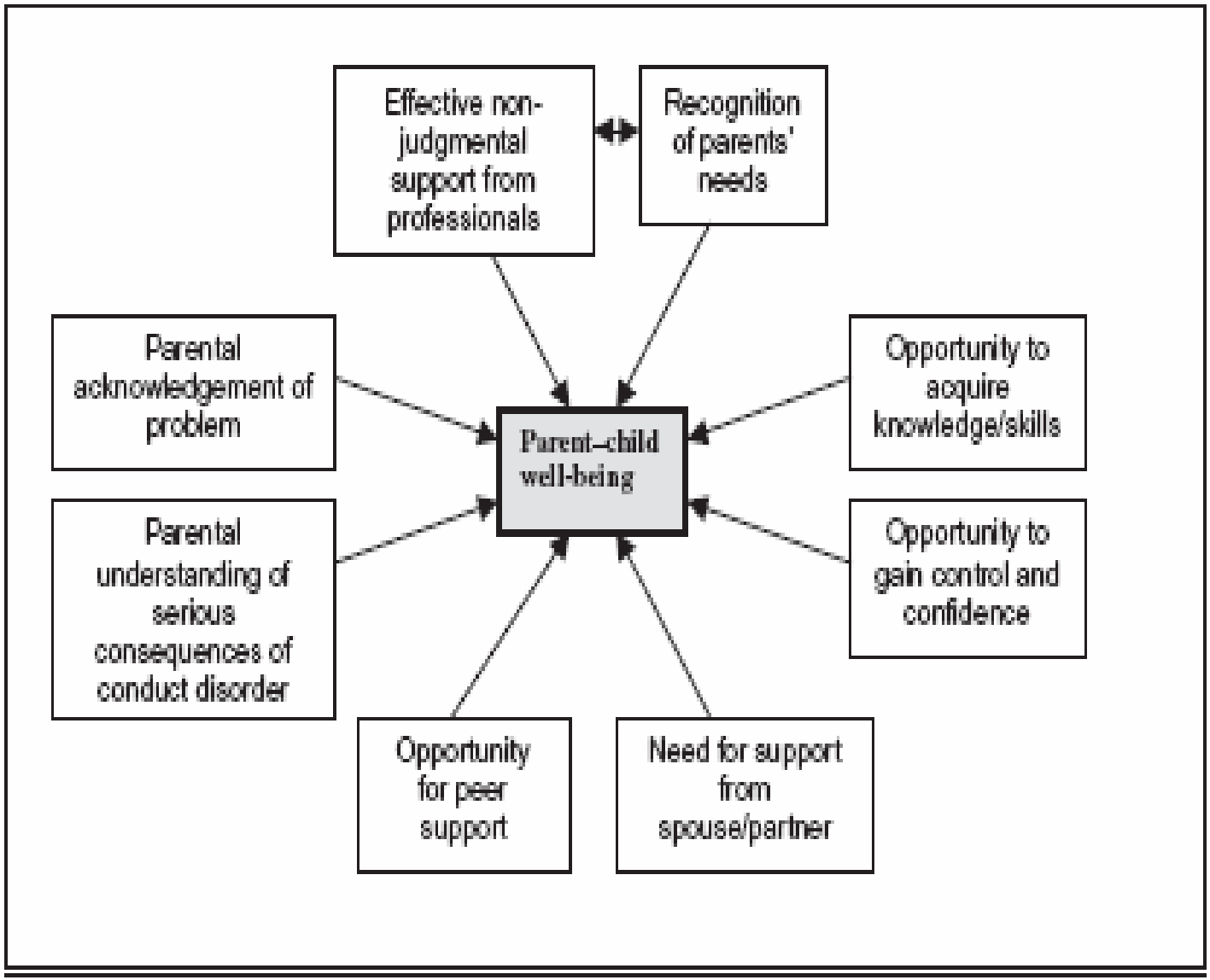
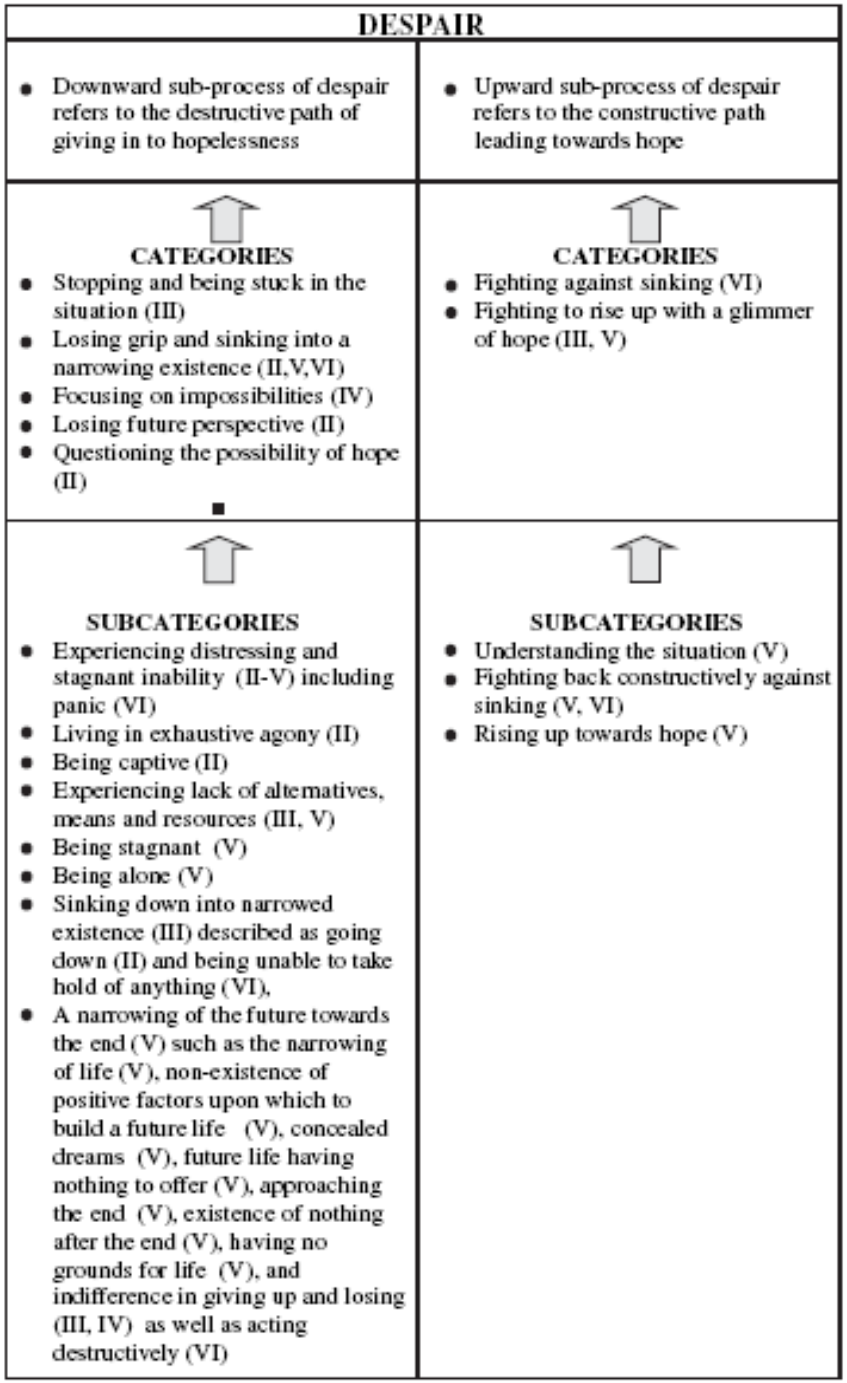


Figure 1. Line-of-argument synthesis: addressing parents' needs and promoting parent–child well-being.

Kylma 2005



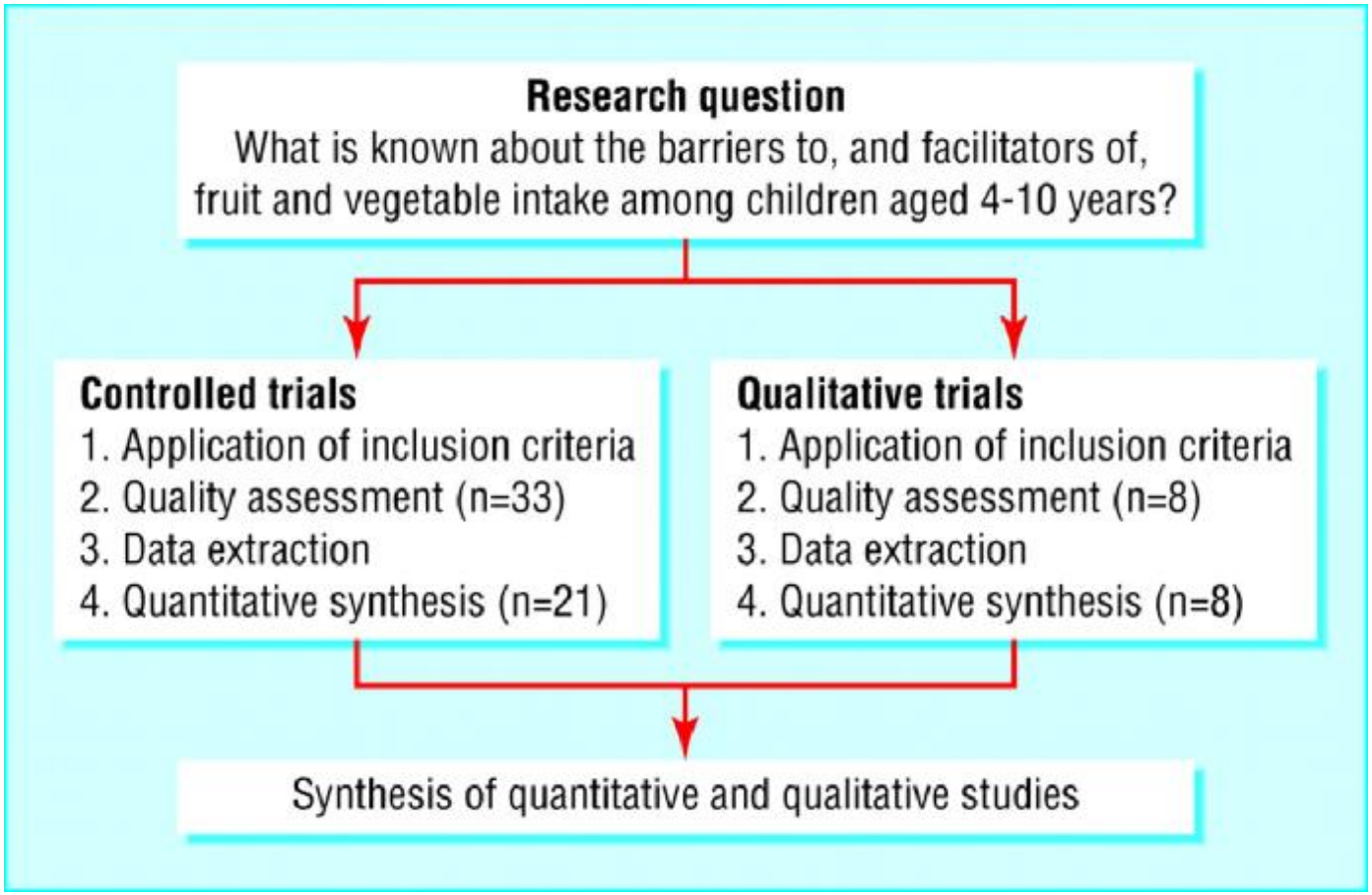
Audit

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).

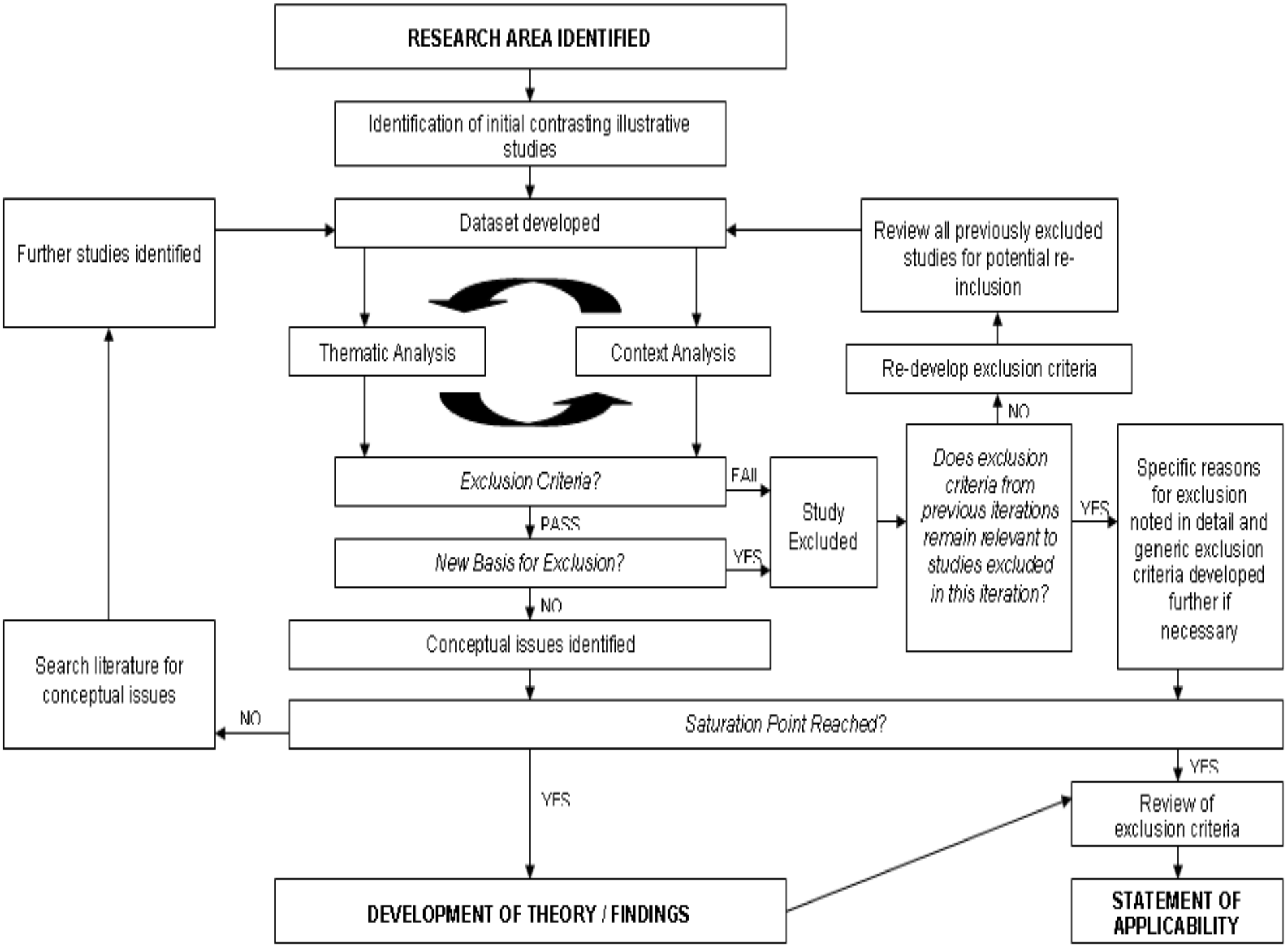
Overall Process

Fig 1 Stages of the review



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

BMJ



Search Process

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

Setting	Perspective	Intervention	Comparison	Evaluation	Social science method
Depression	*Patient View*	*Antidepressants*	*GP and Patient views*	*Anti-depressant use over time*	*Qualitative*
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.

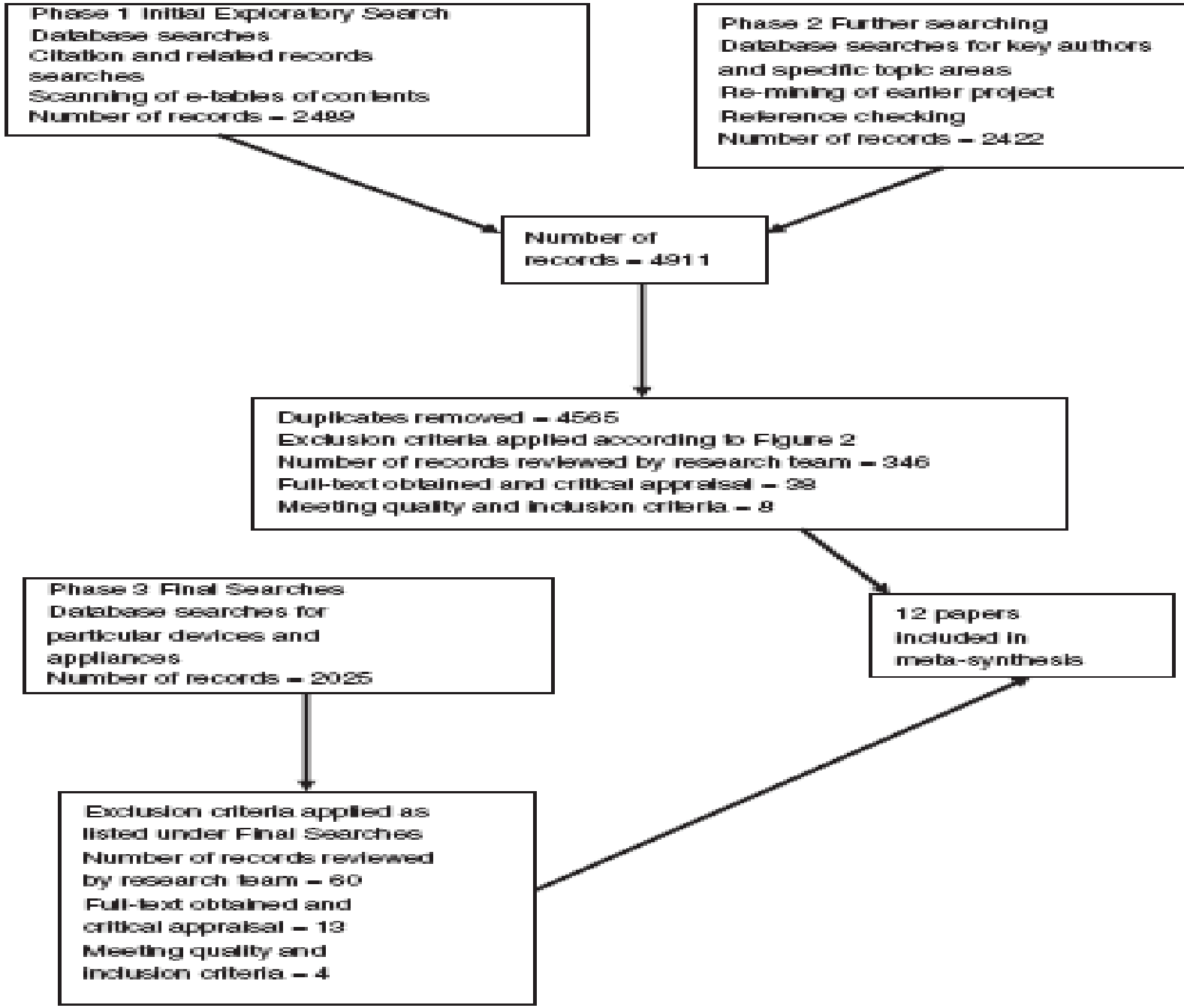


FIG. 2. Identification of relevant literature for inclusion in the meta-synthesis.

Inclusion and Exclusion

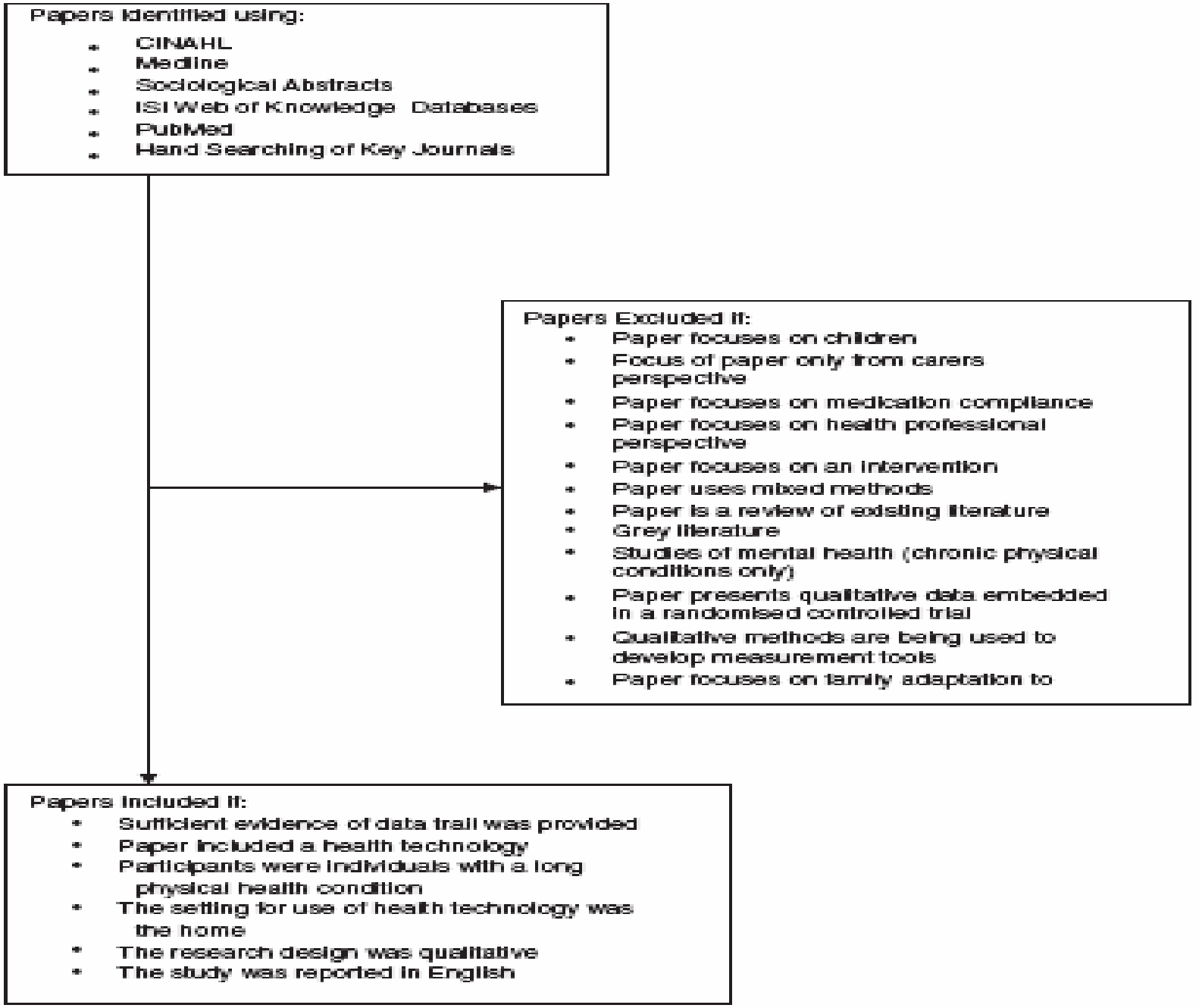
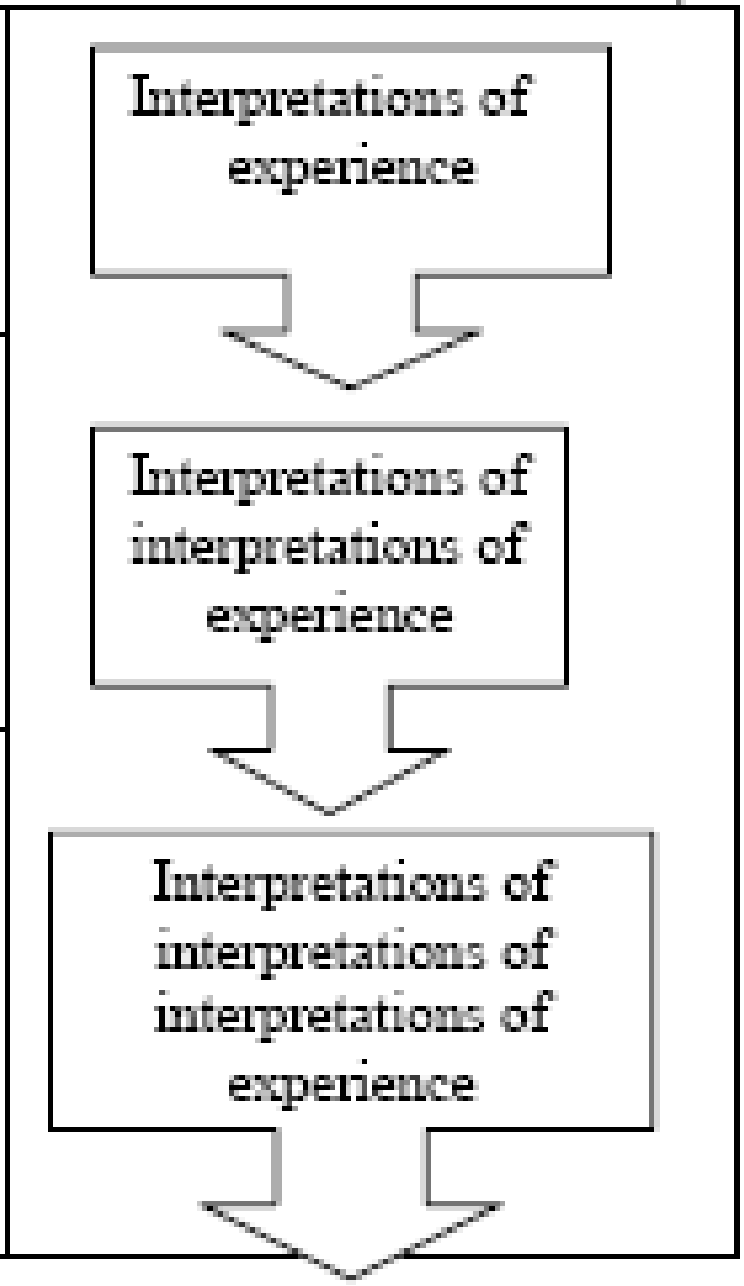


FIG. 1. Inclusion and exclusion criteria for synthesis of patient adaptation to health technologies.

Synthesis Process

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

First order constructs	Patients views, accounts and interpretations of their experiences of using anti-depressants
Second order constructs	The authors views and interpretations (expressed in terms of themes and concepts) of patients views of antidepressant use.
Third order constructs	The views and interpretations of the synthesis team, (expressed in terms of themes and key concepts)

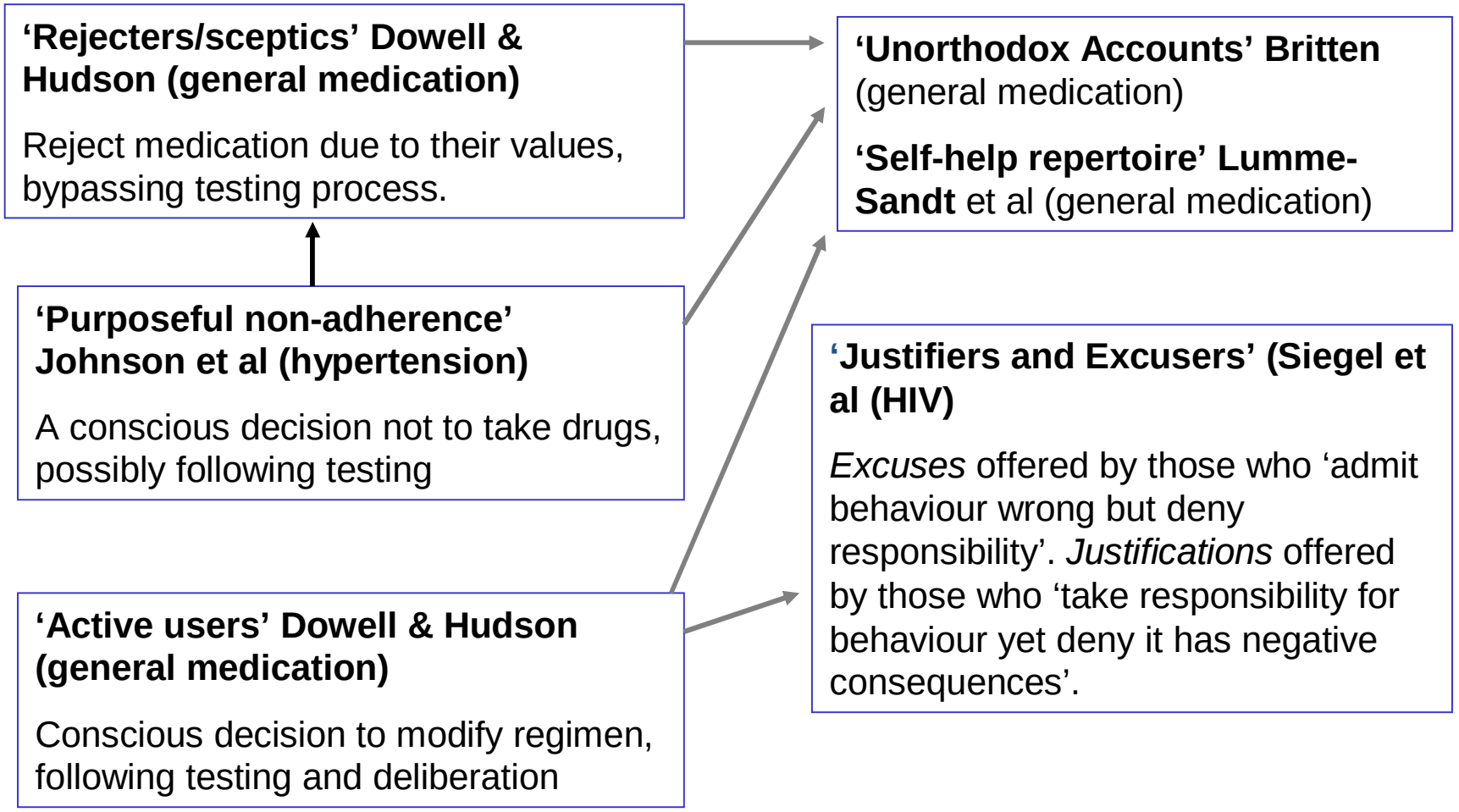


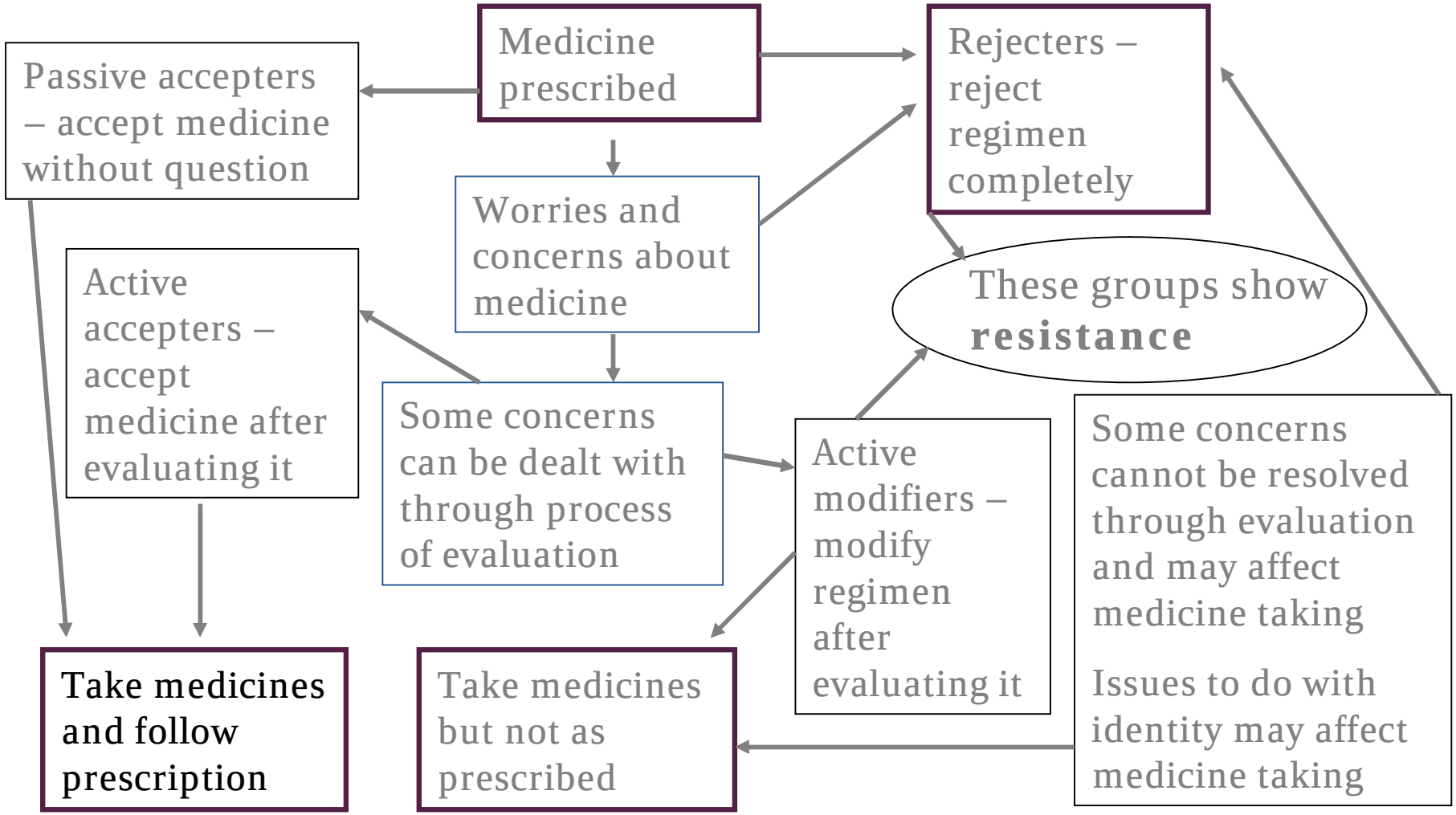
Synthesis Results

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

Synthesis of main findings	Line of argument synthesis
Managing multiple uncertainties 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	Adaptation, accommodation and integration of a technology are an extension of identifying and living life with a chronic condition
The reconstruction of identity 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	The integration of a technology or device into the user's life world can be viewed as an extension of existing 'illness work'
The struggle to remain autonomous while allowing dependence 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	
Coming to terms with living a technology-assisted life 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	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
Usability of devices Acceptance linked to user competency and user friendliness of the device Usability linked to perceived simplicity, convenience and hygiene of the technology	

Example of synthesising translations across illness groups





References

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- 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.