

Further exploration of dissemination bias in qualitative research required to facilitate assessment within qualitative evidence syntheses

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Accepted 12 April 2017; Published online 20 April 2017

Abstract

Objectives: To conceptualise and discuss dissemination bias in qualitative research.

Results: It is likely that the mechanisms leading to dissemination bias in quantitative research, including time lag, language, gray literature, and truncation bias also contribute to dissemination bias in qualitative research. These conceptual considerations have informed the development of a research agenda.

Conclusion: Further exploration of dissemination bias in qualitative research is needed, including the extent of non-dissemination and related dissemination bias, and how to assess dissemination bias within qualitative evidence syntheses. We also need to consider the mechanisms through which dissemination bias in qualitative research could occur to explore approaches for reducing it. © 2017 Elsevier Inc. All rights reserved.

Keywords: Dissemination bias; Publication bias; Qualitative research; Qualitative evidence syntheses; Systematic review; Nondissemination

1. Qualitative research in health and social care: what is it used for?

Qualitative research aims to understand people's experiences and perspectives and can influence how health care and social interventions are conceptualized, developed, and implemented. Qualitative research is well suited to understanding factors that affect the acceptability and

feasibility of interventions, as well as implementation fidelity [1]. Qualitative research can also explore how and why interventions, and different intervention components, might lead to specific outcomes and contribute to theory development and the creation of explanatory hypotheses. Findings from qualitative research can inform decisions on the use of evidence-based health and social care interventions and contribute to policy decisions in these fields. Decision makers in health and social care are therefore increasingly using qualitative evidence alongside other forms of evidence to inform decisions [2–6].

1.1. Qualitative evidence synthesis

Qualitative evidence is increasingly brought together in qualitative evidence syntheses [7]. Qualitative evidence syntheses provide an overview of people's views, perspectives, and experiences of a particular phenomenon. A qualitative evidence synthesis analyses and further interprets

Conflict of interest: None.

Funding: This work was supported in part by funding from the Alliance for Health Policy and Systems Research (www.who.int/alliancehpsr/en/) (Grant number: SPHQ15-APW-1510), WHO, Norad (Norwegian Agency for Development Cooperation: www.norad.no), and the Research Council of Norway (www.forskningsradet.no) (Grant number: 237757/H10). S.L. is supported by funding from the South African Medical Research Council (www.mrc.ac.za). The funders had no role in preparation of the manuscript or the decision to publish.

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What is new?

Key findings

- Evidence on dissemination bias in qualitative research is scarce.
- Plausible biases that might affect the full dissemination of qualitative studies include time-lag bias, language bias, gray literature bias, and truncation bias.

What this study adds to what was known?

- Given the paucity of literature on dissemination bias in qualitative research, several subbiases are proposed to help conceptualize dissemination bias in qualitative research.
- Based on conceptual considerations, a research agenda has been developed.

What is the implication and what should change now?

- More evidence on the extent of dissemination bias in qualitative research and its effects is needed; and we need to further explore the underlying mechanisms of dissemination bias in qualitative research.

evidence from individual qualitative research studies addressing similar research questions or phenomena of interest. There are over 20 methods of qualitative evidence syntheses to select from and new guidance has been published on selecting the most appropriate method for a specific context [8]. Qualitative evidence syntheses are designed to create new understanding of phenomena of interest, generate theoretical and conceptual models, identify research gaps, and provide evidence for the development, implementation, and evaluation of interventions. These syntheses can be used when developing fields of research, for instance by contributing to empirical generalizations [9]. They can also be used to complement systematic reviews of quantitative evidence as part of clinical and health system decision-making processes. For instance, qualitative evidence syntheses are increasingly used in the development of clinical and health system guidelines [6,10]. Here, they can help define the scope of the guideline, including detailing the populations, interventions, comparisons, and outcomes on which each guideline question should focus [11]. They can help assess the acceptability of the intervention to key stakeholders as well as the intervention's feasibility [11]. They can also ascertain how different stakeholders and population groups value different outcomes and help ensure that the voices of important and sometimes underrepresented groups of people are heard. Finally, they can identify implementation considerations

for interventions that a guideline recommends (see Box 1) [11].

Accordingly, systematic review organizations such as Cochrane, NICE Public Health Guidelines, the EPPI Centre, Joanna Briggs, and UK funders such as the National Institute for Health Research, increasingly value syntheses of qualitative health and social care research [3]. A challenge to using evidence from qualitative research, however, has been assessing and communicating how much confidence decision makers should have in the review findings.

1.2. Assessing confidence in findings from qualitative evidence syntheses

The Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach was originally designed to assess how much confidence to place in findings from reviews of quantitative studies of the effectiveness of interventions. The GRADE Working Group has since expanded its remit and now includes approaches for assessing confidence in a range of different types of evidence. The GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative research: www.cerqual.org) approach was specifically developed for findings from syntheses of qualitative evidence [15]. According to the GRADE-CERQual approach, review authors and/or

Box 1 Example of how findings from a qualitative evidence synthesis can inform understanding of the factors affecting implementation of a health care intervention

The benefit of clinical safety checklists for patient safety has been demonstrated in a large, prospective study [12], but the uptake of checklists in clinical practice is slow [13]. To find out why clinical checklists are not regularly and successfully used in clinical settings, Bergs et al. [14] synthesized 18 qualitative studies in a qualitative evidence synthesis aiming to identify the barriers and facilitators to implementing clinical checklists. The evidence suggests that staff's perceptions of checklists play a major role, with some staff being reluctant to use a checklist because they doubt its evidence base. Staff's perceptions of patient safety also influenced the use of checklists: for example, nurses would not read out checklist items that might cause distress to patients. Finally, workflow adjustments, such as changing the workflow of the involved staff, were identified as a barrier to implementing clinical checklists. The authors also highlighted aspects which could improve the use and success of clinical safety checklists.

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