

10 questions to help you make sense of qualitative research

Article:

[Professional Uncertainty and Disempowerment Responding to Ethnic](#)

[Diversity in Health Care: A Qualitative Study](#) Kai J, Beavan J, Faull C, Dodson L, Gill P, et al. *PLoS Medicine* Vol. 4, No. 11, e323 doi:10.1371/journal.pmed.0040323

Discussed by: CLIST, 20th November 2008

Screening Questions

1. Was there a clear statement of the aims of the research? Yes

In the introduction, **The authors state their goals as follows:**

“Using cancer care as a clinical context, we aimed to explore how practising health professionals experience and perceive their work with patients of ethnicity different from their own to inform interventions to enhance quality of care”

They put this in context by saying:

“There is a lack of relevant qualitative data, in particular concerning hypotheses that health professional behaviour may be influenced by patient ethnicity in ways which contribute to disparities”

There was some discussion in the CLIST session about whether it was appropriate to start off with a hypothesis in qualitative research, rather than allow this to emerge from the data, and how detailed a literature search should be conducted in advance. Also, as to whether there was some inherent bias in starting from a negative standpoint (assuming that health professionals had perceptions and experiences which impact negatively on patient care).

However, it was agreed that there obviously needs to be a balance between addressing a reasonably focused question, and putting this in context/avoiding duplication, without rigidly testing a fixed hypothesis (as you would with quantitative research)

2. Is a qualitative methodology appropriate? Yes

Is it worth continuing? Yes!

Detailed questions

Appropriate research design

3. Was the research design appropriate to address the aims of the research?

In the data generation section, the authors justify the choice of method: “we used focus groups rather than one-to-one interviews to seek insight into attitudes, opinions, and underlying assumptions that group interactions can enable, allowing participants to discuss each others’ perspectives”

However, they also recognise in the discussion (under methodological considerations) that:

“a recognised challenge is the possibility of group dynamics promoting uniformity of views” but that they “sought to address this potential limitation by emphasising our interest in differing perspectives as equally important and valid within groups, and by including a range of group compositions”

There is little further justification of the methods, but it was discussed in the CLIST session that this isn’t unusual in qualitative research. **There was no reference in the article to the possibility of triangulation of methods**, e.g. conducting interviews as well as focus groups (though this was referred to in the discussion as an option for further research)

Sampling

4. Was the recruitment strategy appropriate to the aims of the research?

In the methods section (sampling and ethical approval) the authors justify their use of purposeful sampling:

“Participants were **sampled purposefully** from a range of health service settings and networks in the Midlands of the UK to include health professionals of varying disciplines and experiences in working with ethnically diverse patients in a variety of care settings”

In terms of recruitment, in data generation they state that:

“Following invitations sent via local service contacts, **professionals willing to participate** were selected ...”

They acknowledge in the methodological considerations section that:

“Participants were likely to have been particularly interested in ethnic diversity and health care”

There was some discussion at CLIST around the factors purposefully sampled, and whether ethnicity should have been one of them.

Table 1 gives details of characteristics of respondents, but there is nothing to benchmark these against to see if they reflect the health professional population in that area (though it was recognised that ‘the Midlands’ has a wide variation in ethnic profile from one area to another) .

A characteristic which was missing from Table 1 was people’s experiences of cultural competence training – which is relevant as this training is referred to on numerous occasions in the article, including in the implications for practice.

There was also no reference in the article as to how many people were approached to participate, how many refused and if they gave a reason, or if the characteristics of those who accepted differed from those who declined.

It was agreed that there was a very large sample size for a piece of qualitative research (106 participants, 18 focus groups)

Data collection

5. Were the data collected in a way that addressed the research issue?

In the data generation section, authors further justify their focus group method:

“each focus group was either generally homogenous by discipline to promote sharing of experiences and equality of professional power (13 groups), or multidisciplinary to encourage exploration of views from members of the same care team (five groups)”

Additional pros and cons of focus groups are discussed in question 3 above.

In terms of how and where the focus group was facilitated , the authors state that *“Following a **pilot focus group to develop our initial topic guide** and procedures, 18 focus groups (range 5–11 participants) involving 106 respondents were facilitated by JB, with other authors cofacilitating some groups, **mostly in participants’ work settings**”.*

There is no justification of the setting (other than obvious logistical ones).

CLIST felt that we would have liked more detail on the pilot focus group, and the resulting topic guide.

They state that: *“Interviews commenced with a broad introductory question, “Could you comment on any experiences you have had when caring for people from an ethnic minority background?”*

but there is no further information on the rest of the topic guide or procedures.

In terms of modification of methods, in data analysis the authors state :
“We used constant comparison, in which data were collected and analysed concurrently, enabling emergent themes and ideas to be incorporated and explored in subsequent interviews, to develop categories

However, there is no reference to how/if methods were modified as result of this process.

In terms of recording the discussions, the authors state:
*“Group discussions lasted between one and a half to two hours, and were **audiotaped and transcribed verbatim**”.*

It was suggested at CLIST that some of the quotes, e.g. Box 4, gave an indication of some of the group dynamics at work.

There is reference to saturation in the article at several points, e.g.:
*“ This large number of interviews enabled generation of data, **and their saturation**, from a wide range of health professionals and settings.*

Reflexivity

6. Has the relationship between researcher and participants been adequately considered?

In Methodological considerations, the authors state that they *“recognize the potential influence of our own, largely health professional, backgrounds on data interpretation”.*

There is a more general discussion elsewhere in the article about the influence of healthcare culture on professionals' behaviour.

“This field has its own set of interests, biases, and influences on care, awareness of which might inform crosscultural care”.

However, they don't discuss how/if their background could have influenced other elements of the research process, e.g. data collection.

Though, as mentioned in question 3 above, they mention *“emphasising our interest in differing perspectives as equally important and valid”*

Ethical Issues

7. Have ethical issues been taken into consideration?

In Methods (sampling and ethical approval) the authors state:
*“The study protocol, participant information, and consent procedures were reviewed by a **UK multi-centre research ethics committee**, which had no ethical objections”.*

CLIST would be interested to know which committee this was, as it is usual for the committee to be named in an article.

Data Analysis

8. Was the data analysis sufficiently rigorous?

In terms of the analysis process, as mentioned in question 5 above, authors state that:

“Group discussions ... were audiotaped and transcribed verbatim”

“We used constant comparison, in which data were collected and analysed concurrently, enabling emergent themes and ideas to be incorporated and explored in subsequent interviews, to develop categories”

They elaborate further: *“Coding, assisted by N-Vivo software, was developed and discussed between JK, JB, and CF [3 of the authors]*

There isn't very much more detail about the analysis process.

It's also not clear how data (quotes) was selected to be included in the article, and whether these were representative of views. While it was recognised that this isn't a quantitative article, some CLIST members felt that it would be helpful to give a feel for how many people were expressing similar views.

It also wasn't clear how some quotes were chosen for the boxes as opposed to the text of the article (though it was suggested at CLIST that there was a broad pattern that 'deviant' cases were added into the text rather than the boxes). There was some discussion at CLIST as to whether the boxes helped or hindered reading the article.

They also don't state how/if characteristics in Table 1 had any impact on quotes, e.g. age.

In terms of contradictory data, the authors state that: *“New data were used and deviant cases sought to assess the integrity of the categories identified..”*

There are examples of 'deviant' cases and 'isolated examples' quoted in the article.

In terms of their own role and bias, in Methodological considerations, the authors state that they *“recognize the potential influence of our own, largely health professional, backgrounds on data interpretation”*.

Findings

9. Is there a clear statement of findings?

In the Results section authors state that:

*“respondents ... wrestled with a range of challenges. These challenges included communication, language, and working with patients in the context of their families. **The results presented here focus on** professionals’ common experience of uncertainty and the disempowering effects this uncertainty had on professionals’ clinical practice ...it is hypothesised that professionals’ uncertainty and disempowerment have the potential to be self-perpetuating”.*

The authors state (in the discussion) that:

“Our findings highlight the considerable uncertainty health professionals may experience working with patients of differing ethnicity to their own, alongside professionals’ emphasis upon knowledge about cultural difference. This uncertainty may disempower professionals, creating hesitancy and inertia in their clinical practice to the potential detriment of patient care... “

Some CLIST members felt that there was a large amount of repetition in the article, particularly in terms of stating findings.

There was a discussion both for and against knowledge/content based cultural competence training in the discussion section:

“a shift in emphasis away from knowledge-based cultural expertise toward a greater focus on the patient as an individual is needed..., it should nevertheless be recognised that, as demonstrated here, health professionals and those in training do sense an understandable need for more content-based information about cultural and ethnic differences, and it remains important to address this need in training”

However, there was no discussion of the ‘deviant’ cases in relation to professionals’ perceptions and experiences of uncertainty and disempowerment and its impact on patient care.

In terms of credibility of the findings, as mentioned in question 3, there was no triangulation of methods, e.g. conducting interviews as well as focus groups (though this was referred to in the discussion as an option for further research). **There was triangulation of focus groups** (size, composition) as mentioned in question 5 above. **More than one person facilitated some of the groups, and coded the data** (as mentioned in questions 5 and 8).

Respondent validation methods were used, as well as validating using other groups (discussed in data analysis and validation):

“Preliminary findings were fed back to and discussed with a group of seven health care advocates from minority ethnic communities working with patients, and an eight-strong multidisciplinary advisory group with health service and academic expertise in cultural diversity. Focus group participants were sent, and invited to comment on, a summary of results, and seven also attended a further focus group facilitated by JB and JK to discuss and check validity of our interpretation of the data. These processes confirmed and helped further refine analysis”.

The authors summarise their validation as follows, in the discussion:

“...a broad range of health professionals with varying characteristics were included, data generation continued to saturation, negative cases were sought, and we undertook validation with participants and other groups. These methods increase the qualitative rigour of the study and the likely relevance and transferability of the findings beyond the immediate study.”

In terms of how the findings relate back to the original research questions, the two quotes at the beginning of this answer do so, as do the following from the results and the discussion sections:

“Respondents’ self-perceived low cultural expertise and uncertainty made them uncomfortable as professionals, and some felt that quality of care for patients was being affected as a result.

“The findings might inform interventions to enhance quality of care, and also professionals’ experience of working with diversity”

Value of the research

10. How valuable is the research?

The authors put the findings in context by stating that:

“This study is, to our knowledge, the first to identify professionals’ more personally felt uncertainty and disempowerment working with patients of differing ethnicity to their own”.

In terms of future/additional research they state in the discussion:

“The extent to which quality and equity of care may be enhanced by interventions informed by this study are hypotheses for future testing....

“Further research involving individual interviews with health professional respondents, observation of their practice, and exploration of the perspectives of patients, would be of value in extending the current data and understanding in this field. We are currently conducting a parallel study with patients in this context”

There are a number of “opportunities and implications for practice” listed:

“First, uncertainty should be acknowledged and legitimized as inherent to negotiating care responsive to patient needs....

Second, a shift in emphasis away from knowledge-based cultural expertise toward a greater focus on the patient as an individual is needed....

Third, it should nevertheless be recognised that, as demonstrated here, health professionals and those in training do sense an understandable need for more content-based information about cultural and ethnic differences, and it remains important to address this need in training....

Fundamentally, health care professionals need to be supported to respond to patients as individuals

Fourth, facilitating greater awareness of concepts of Equity... may help those professionals with dilemmas about equality to understand the appropriateness of varying responses to patients to meet similar care needs

In CLIST there was discussion about how such an intervention could be devised, ie to cover both expert knowledge and an emphasis on individualised care.

In terms of transferability, they state in the discussion that:

“While our findings may possibly have been more readily exposed within the emotive context of care relating to cancer, they seem unlikely to be unique to this setting”.

However, under methodological considerations they state:

“Given that our sample may have been particularly interested to reflect on their practice, the challenges experienced by other professionals may be even greater, or perhaps lie unconsidered”