VaST
Values Search Tools

A manual for searching electronic databases for publications on health-related values

with the support of the Laces Trust
Acknowledgements

This manual arose from the challenges we encountered in a scoping study on identifying materials on health-related values. We would like to share some of the lessons learnt from addressing those challenges. The manual represents work in progress. Some of the issues discussed in it have been explored in detail and backed up by substantial research; with others we have only made a start. In spite of its limitations, the manual reflects findings from methodologically robust research on literature searching for ‘evidence on values’, including a word frequency analysis study of over 4,400 citations. Such research is practically non-existent, whereas values are becoming increasingly important in healthcare.

We will welcome any suggestions on how to make this manual a useful, rich resource for a broad range of users. We will try to incorporate them in subsequent versions – our intention is to update and enrich this manual regularly. This version can be cited as: Petrova M, Sutcliffe P, Fulford K W M and Dale J. VaST (Values Search Tools): A manual for searching electronic databases for publications on health-related values. Version 3, Mar 2012.

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1.1. **Why is a manual on searching for health-related values needed?**

This manual will guide you in searching for publications on health-related values in electronic resources.

Values in medicine and healthcare are receiving increasing attention. A broad understanding of values will include not only ethical, moral, religious, cultural and other types of values ‘proper’, but also value-laden phenomena such as attitudes, perceptions, preferences, wishes, choices, rights, beliefs, satisfaction with care, quality of life, and many more. Values are an integral part of any health-related decision, of any stakeholder in healthcare.

Identifying publications on health-related values – identifying what is in fact ‘evidence on values’ – is a challenging task. For example, the word ‘value’ used in MEDLINE, the premier medical and health research database, will mostly capture phrases referring to clinical measurements, laboratory test values, and statistical significance values. Box 1.1 gives further details of the difficulties of retrieving publications on health-related values. Such difficulties are apparent at every stage of exploring the relevant literature, including the stages of formulating a research question, selecting databases, specifying inclusion and exclusion criteria for publications returned by the searches, and analysing and synthesising findings.

This manual draws together our experience of addressing these difficulties, including findings from a word frequency analysis study of over 4,400 citations on diabetes, obesity, dementia and schizophrenia.

The manual is a working document. We intend to produce further versions of it. It is nevertheless an extensive and, to our knowledge, the only resource on the topic of health-related values defined in such broad terms. We hope you will find it helpful and will appreciate any feedback on it.
Box 1.1: Why is searching for publications on health-related values difficult?

The following are the main challenges in searching for publications on health-related values. None of these is adequately addressed in the research literature:

1) **It is difficult to predict how free text words for values contents will perform** (“free text words” are ‘normal’ words generated by the searcher, as opposed to “thesaurus terms”, which need to be identified from a pre-existing vocabulary, see below). **Generally, free text words have low precision** (that is, retrieve a large number of false positives):

   For example, *Diabetes AND (patient* OR patients*) AND values* in MEDLINE (search run 16 Sep 11) returned 130 articles containing phrases such as “mean values of glutamic acid decarboxylase 65Ab”, “less prominent peak values of cardiac biomarkers”, “patients not at target values at baseline”, *HbA(1c)* values, etc. before reaching a phrase that signalled a true positive (P values for a quality of life score). It was still a chance hit though – good hits would have been, for instance, “meaningful values in the activities and decisions of everyday life” or “cultural, ethical, personal and religious values” (these are phrases from other searches; up to the 200th article in the above set of publications no such phrase was found).

2) **It is difficult to predict how thesaurus terms for values contents will perform** (“thesaurus terms” are part of a fixed, “controlled” vocabulary. They are assigned to citations in databases to indicate their main topics and publication type. They enable more effective and efficient searches. See also Chapter 4, *Quick guide* box). **Generally, in the case of values research thesaurus terms have low sensitivity** (tend to miss relevant records):

   For example, *Diabetes AND Social Values [MeSH]* (MeSH, or Medical Subject Headings, are the thesaurus terms of MEDLINE, see Chapter 4) retrieve only 30 publications for all years (search run 16 Sep 11). In addition, thesaurus terms are often unintuitive. Identifying relevant ones may be a research task in its own right.

3) **A wide range of keywords must be used in searches, as values are implicated in a wide range of phenomena.** Values may typically be thought of as highly abstract categories associated with different cultures, religions and belief systems, but they are also implicated in numerous other phenomena such as preferences, priorities, concerns, attitudes, choices, decisions, wishes, goals, emotional responses, illness experiences, quality of life judgements, models of care, communication difficulties ... The list can continue indefinitely. It is unclear:

   - what a ‘complete list’ of health-related values includes, or at least which its most important members are;
   - how these values and value-laden phenomena are reflected in natural language and thesaurus terms.

4) As values and related phenomena can be explored from several disciplinary perspectives (e.g. sociology, psychology, philosophy), as well as from non-research perspectives (e.g. through the arts, in personal narratives, in the media), it is unclear **what sources to search** and to what extent their contents and messages are similar or different.

5) As there are no widely accepted methods of appraising, analysing and synthesising knowledge about values and of bringing it to bear on practice (clinical practice, healthcare organisation, medical education, policy making, etc.), no **established criteria of research quality and practical relevance** are available that could help guide literature searching.

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1 Here and later in the text we use double quotation marks to indicate established terminology or a quotation, and single quotation marks to indicate metaphoric or cautious usage, highlight a word, or suggest a vocabulary convention where none has been established.
1.2. How was this manual developed?

1.2.1. Work underpinning the manual

In 2004 we ran initial searches for ‘values publications’ in diabetes, obesity, personality disorders, dementia, schizophrenia and accident and emergency care, with a focus on electronic bibliographic databases. The aim was to scope the availability of health condition-specific materials on values. These were intended to complement generic training materials and research in values-based practice and other areas of work concerned with health-related values (Fulford, 1989; Fulford, 2004; Woodbridge and Fulford, 2004; VBP website – see end of chapter for references).

These searches demonstrated that there is a large number and variety of potentially relevant materials on values, but it is unclear how best to search for them and where to draw the boundary between values and non-values publications and concepts. This extended our work into: 1) identifying optimally performing search terms to underpin the development of optimal search strategies; 2) articulating what health-related values are and how and where they are discussed, and 3) exploring approaches to bringing the identified knowledge together. This manual focuses primarily on 1) and 2) and begins to identify issues relevant to 3).

The core work which underpins the manual is a word frequency analysis study of 4,440 citations on diabetes, obesity, dementia and schizophrenia obtained through MEDLINE (different to the citations from the scoping searches). Word occurrences within true and false positive values citations were counted using the Concordance® software (www.concordancesoftware.co.uk). Details of the study methodology are reported in Petrova, Sutcliffe, Fulford and Dale J, 2011 (see references at end).

In addition to being a source of ideas for search terms, citations were also used to extend our understanding of the concept of values and identify the topics and approaches that have dominated health research in recent years. Some of the resulting ideas are presented in Chapter 2: Getting started and Chapter 6: Selecting relevant publications – inclusion/ exclusion criteria for values studies.

We also carried out pilot studies on analysing and synthesising findings from samples of the materials identified, concerning primarily values in overweight and obesity. This experience is briefly described in Chapter 7: Analysing and synthesising values research.

The manual also draws on selected information from authoritative external sources.

Much further research is needed before good processes of identifying, appraising, analysing and synthesising evidence on values can be confidently recommended. Research priorities are identified in Chapter 9: Where are we now and what comes next? Also, several points throughout the manual have been marked with a symbol for an incomplete jigsaw puzzle. It indicates issues which need to be expanded on most urgently. Your suggestions on these will be very welcome.

1.2.2. What perspectives on values can the manual accommodate?

Work on the manual was motivated by ideas of the Values-Based Practice framework (Fulford, 1989; Fulford, 2004; Woodbridge and Fulford, 2004). However, the manual can support literature searching on a wide range of psycho-social, socio-cultural and ethical issues in healthcare (see 2.1.2. in Chapter 2 for further comments). Somewhat paradoxically, it cannot quite accommodate the values-based practice perspective itself. This is partly due to the fact that current research is not enough values-aware. It is also due to the uneasy relationship between some of the core ideas of values-based practice, with its strong emphasis on the individual and his or her unique values system, and the typical aims of research favouring general principles rather than uniqueness. We have tried to
include non-research, ‘alternative sources’ of values publications (such as personal narratives, art work, mass media materials – see 3.2.4. and 3.2.5. in Chapter 3) to strengthen the presence of idiosyncratic individual perspectives. This aspect of the manual, however, is still in early stages of development.

1.3. Who is the manual for?

- This manual has been written for readers with different levels of knowledge and experience. It does not assume systematic knowledge of the field of health-related values. It assumes, however, some basic researcher skills (e.g. planning a study, formulating a research question) and some experience with searching bibliographic databases. If you do not have such skills yet, we would suggest that you first explore some of the sources given at the beginning of each chapter (in Quick guide to expected background knowledge boxes).

- The manual is suitable for searchers with a different degree of ambition for comprehensiveness and thoroughness – it can help you with extended, rigorous searches (see 1.7 for further details), but also with quick, scoping searches (see 1.8).

- The manual is suitable for health researchers, students, educators, librarians, clinicians, policy- and decision-makers, members of patient advocacy groups and other stakeholders who would like to find out more about issues concerning the psychological, social, cultural, ethical, political, etc. aspects of health, illness and healthcare. Its primary intended audience is of health researchers who apply social and behavioural sciences approaches to a health context; clinical educators (including curriculum planners, faculty developers, clinical tutors and those involved in designing clinician assessment methods); and postgraduate students of health and medicine. A word of caution: if you are not affiliated to a university or another organisation providing you with access to library and information resources (e.g. the National Health Service or a professional body), you may have access to only a few of the databases suggested here. On the positive side, the focus of our research has been PubMed – the freely available interface of MEDLINE.

- The manual, and the issue of evidence about values more generally, will appeal to searchers who have a high tolerance for uncertainty and enjoy working in novel areas. Even with the manual’s guidance, a large number of decisions will need to come from you and your team.

- We hope that the manual will be useful to searchers from within and outside the English-speaking world. Currently, it does not list non-English language databases, but the search terms we are suggesting have been shown to identify studies from a wide range of countries and journals (as per initial estimates, over 60 countries for the test conditions we have experimented with). We will be very interested to hear about local and non-English language sources. We will also appreciate feedback on issues that may need clarification for non-UK readers.

1.4. What competences and skills will the manual help you develop?

This manual will help you:

- Develop new search strategies on topics concerning health-related values in a methodologically sound and creative way, or refine previously developed search strategies on such issues;
• Develop searches that match the time and resource parameters of a particular project – highly comprehensive; quick and efficient; or somewhere in between;

• Develop your ideas about values and related issues and appreciate the importance of knowing more about them;

• Anticipate some of the decisions you will need to make about the scope and contents of your values searches;

• Develop a more realistic idea of the parameters of the task you are undertaking – in terms of the amount of work involved and the challenges of identifying and making sense of values materials;

• If you have some, but not advanced skills in literature searching, it will help you become more competent in literature searching in general;

• If you have some, but not advanced skills in literature searching, it will raise your awareness of generic standards of methodological quality in literature searching.

1.5. What questions does the manual cover?

Table 1.1 lists the key questions addressed by the manual, the types of answers given, and the respective chapters or sections.
### Table 1.1: What questions does this manual address and how?

<table>
<thead>
<tr>
<th>Question</th>
<th>Ways in which this manual addresses it</th>
<th>Chapter/section and pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to formulate a research question on health-related values?</td>
<td>Outlines a view of ‘values’ that is broader than typical conceptualisations and opens up a number of new or less familiar research directions.</td>
<td>2.1 (pp. 12-16)</td>
</tr>
<tr>
<td></td>
<td>Offers a typology of values questions to help you articulate your primary research interest and avoid hidden sub-questions.</td>
<td>2.2.1 (pp. 18-21)</td>
</tr>
<tr>
<td></td>
<td>Offers generic advice on good research questions and initial recommendations on formulating good values questions.</td>
<td>2.2 (pp. 17-18); 2.2.2 (p. 22), see also 2.2.1.</td>
</tr>
<tr>
<td></td>
<td>The lists of suggested search terms may also help you narrow, extend or modify your initial research question.</td>
<td>4.1 and 4.2 (pp. 74-85)</td>
</tr>
<tr>
<td>Which databases to search for values publications?</td>
<td>Clarifies concepts and terms concerning databases and database searching. Some prior knowledge of generic principles of electronic database searching (e.g. Boolean operators, order of commands, truncating of terms) is assumed. External sources are recommended.</td>
<td>Quick guide box to Chapter 3 (pp. 29-31)</td>
</tr>
<tr>
<td></td>
<td>Provides summary information on a range of research-focused databases that index values publications.</td>
<td>3.2.1 – 3.2.4 (pp. 33-63)</td>
</tr>
<tr>
<td></td>
<td>Highlights considerations to take into account when choosing and combining databases.</td>
<td>3.3 (pp. 65-66), Quick guide box to Chapter 3, and 3.1 (31-32)</td>
</tr>
<tr>
<td></td>
<td>Offers initial suggestions on sources of ‘alternative’ (non-research) materials on values, such as personal narratives, mass media materials, and art work.</td>
<td>3.2.5 (pp. 64-65)</td>
</tr>
<tr>
<td>Question</td>
<td>Ways in which this manual addresses it</td>
<td>Chapter/section and pages</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>What search terms to use?</td>
<td>Suggests a pool of approx. 600 search terms – both free text and MEDLINE Medical Subject Headings (MeSH). Offers data on the effectiveness of over 260 of these.</td>
<td>4.1 and 4.2 (pp. 74-85)</td>
</tr>
<tr>
<td></td>
<td>The lists of terms are derived through the above mentioned word frequency analysis study (Petrova, Sutcliffe, Fulford and Dale, 2011). It included 4,440 citations on diabetes, obesity, dementia and schizophrenia (MEDLINE, Jan 04 – Dec 06). This work was preceded by a feasibility study of approximately 7,500 citations and complemented by the screening of over 15,000 citations. 11 databases, various time periods, and an extended list of topics were used.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Although a notable degree of overlap of the performance of free text terms was observed across databases, topics and time periods, this has not been quantified yet. As far as thesaurus terms are concerned, they differ across databases and the suggested MeSH can be used only in databases incorporating the MeSH tree (see Chapter 3). Much further research is needed on effective search terms.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lists generic techniques for generating search terms.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Helps you specify the scope of your search, which is the first step in generating appropriate search terms.</td>
<td>4.4 (p. 87)</td>
</tr>
<tr>
<td></td>
<td>Suggests considerations that may help predict how a values keyword will perform in searches.</td>
<td></td>
</tr>
<tr>
<td>How to perform quick, easy but effective values searches? How to achieve maximum breadth and depth in a minimum amount of time?</td>
<td>Suggests a validated ‘brief values filter’ (22 lines) for quick scoping searches in MEDLINE. Refers you to a range of relevant external search filters (optimal search strategies developed by experts). Suggests ways of further optimising your retrieval through formal operations.</td>
<td>5.2 (pp. 93-94)</td>
</tr>
<tr>
<td></td>
<td>Quick guide box to Chapter 5 (pp. 89-91) and 5.1 (pp. 91-93)</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Ways in which this manual addresses it</td>
<td>Chapter/section and pages</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>How to select relevant publications?</td>
<td>Introduces you to some of the main difficulties concerning inclusion/exclusion criteria for values publications – with regard to both contents and quality. This is one of the most complex and under-researched areas concerning the searching for values publications. Again, much further research is needed. Gives you generic recommendations on managing the retrieval of a literature search.</td>
<td>6.1 – 6.5 (pp. 99-126) Quick guide box to Chapter 6 (pp. 96-98)</td>
</tr>
<tr>
<td>How to analyse the selected publications?</td>
<td>Outlines the main practical and theoretical difficulties in analysing and synthesising values research. Suggests preliminary recommendations on how to approach the analysis and synthesis of values research. Briefly describes approaches we have tried. Refers you to currently available approaches for synthesising heterogeneous studies.</td>
<td>7.1 and 7.2 (pp. 128-35) As above 7.2.1 (pp. 130-1)</td>
</tr>
<tr>
<td>How to describe a literature search?</td>
<td>Suggests what information to include when reporting your search process.</td>
<td>8.1 (pp. 138-41 )</td>
</tr>
<tr>
<td>How to make your own work easier to identify in literature searches?</td>
<td>Suggests good practices in formulating your title, writing an abstract and assigning keywords to your publications, with a view to making them easier to identify in literature searches.</td>
<td>8.2 (pp. 142-3)</td>
</tr>
</tbody>
</table>
1.6. How is the manual structured?

1.6.1. Structure of the manual as a whole

Chapter 5 is the quick values searches chapter – it suggests how to approach a values search when you need to retrieve the most useful information in the minimum amount of time. The order of the other chapters reflects a standard process of conducting a literature-based study. The manual starts with:

- Formulating your research question/search query (Chapter 2);
- Choosing your sources (Chapter 3, which covers both research databases and sources of ‘alternative’ materials, such as personal narratives, art work, and mass media materials);
- Identifying appropriate search terms or search filters (Chapter 4).

It moves onto:

- Selecting relevant records (Chapter 6);
- Analysing and/or synthesising findings (Chapter 7).

It concludes with:

- Reporting on your search process (Chapter 8, which also includes a section on how to make your own study easier to retrieve by your target audience);
- Summary of what you have learnt and priority directions for future development of the manual (Chapter 9).

If you are new to the field of values, you will most likely need to reconsider earlier chapters in light of the direction your research has taken after working through later chapters. For instance, Chapter 4 on keywords may further inform the formulation and operationalisation of your research question, which is discussed in Chapter 2; or Chapter 6 on inclusion/exclusion criteria may prompt you to reconsider some of the search terms you have chosen from Chapter 4.

The chapters are largely independent of one another; in general, you need not to have read any other chapter in the manual to make sense of a particular chapter.

1.6.2. Structure of individual chapters

Each of the subsequent chapters follows a generally consistent structure:

- It starts with a *This chapter will ...* box which outlines the aims and contents of the chapter.

- It continues with a *Quick guide to expected background knowledge* box (sometimes there is no such box at the beginning of the chapter but several section-specific boxes within it). The *Quick guide* box offers a brief summary of the relevant generic debates before the text moves onto the values-specific issues. It also suggests references to sources which you may need to explore if the generic issues are new to you. The summaries are intended to serve as an introduction to readers with limited background knowledge and also to ensure a shared understanding of concepts and terminology for readers with some background knowledge. They are shorter if we can suggest concise high quality external sources and longer if this is not the case.
• The main contents of the chapter follows. In some cases the Quick guide box of a chapter may contain more information that the main, values-specific, text. This is usually because there is little which is values-specific (or little which is known about it).

• The chapters close with a Key points box. It highlights Key learning points and key decisions you should have made. This box also suggests Key references and introduces the Key objectives of next chapter.

1.7. How to use the manual for an extended values search?

We use the phrase extended search (interchangeably with comprehensive search) to mean the equivalent, in the case of values topics, of a Cochrane-type systematic review search.

As our work so far has concerned quite broad questions (e.g. What are the values implicated in diabetes? What are the values that affect self-perceptions as overweight or obese?), we have only aimed to be systematic in terms of identifying ‘all’ topics, concepts and arguments rather than ‘all’ studies. This seems to be the most effective and feasible approach for most values research questions of practical relevance, as they are unlikely to be very narrow. Future work will demonstrate if this is indeed the case. Some of the difficulties and arguments against identifying each and every known article on a particular values topic are discussed in Chapter 7. Chapter 2 also contains relevant considerations.

You will see as you go through the chapters that the number of databases and search terms proposed is substantial. It is unfeasible to use them all in the same study. Yet this is only the beginning of a comprehensive collection of values resources. We expect that even for a comprehensive search, databases and search terms from the manual will be used selectively and also complemented with ideas from other sources. As our knowledge increases, we will be better positioned to judge how comprehensive/systematic is comprehensive/systematic enough, how this varies across topics, and how it translates into time and resource units.

1.8. How to use the manual for a quick values search?

If you would like to do a quick values search, focus on the following sections and chapters:

- 2.1.2. The many faces of values in medicine and health care – typical associations and coverage in the manual
- 2.2.3. A working typology of research questions on values
- 2.2.4. Some initial considerations on ‘good values questions’
- 3.2. Searching under time and resource constraints – how many and which databases?
- 5. The whole chapter
- 7.2.2. Main challenges in the synthesis of values research – our experience so far
**Key learning points**

After working through this chapter, you should have...

» understood what the aims and contents of this manual are, and considered how these relate to the needs of your project.

**Key references**

**Books and articles:**


**Websites:**

[www2.warwick.ac.uk/fac/med/study/cpd/subject_index/pemh/vbp_introduction](http://www2.warwick.ac.uk/fac/med/study/cpd/subject_index/pemh/vbp_introduction) – website on Values Based Practice (under development. Section on further references is well developed).

**Key objectives of next chapter**

» to help you develop your thinking about health-related values;

» to prepare you to formulate your own research question/search query – by presenting a typology of values questions and discussing what makes good values questions.
Getting started

CHAPTER 2

This chapter will ...

» identify the most typical contexts and meanings of the concept of values in medicine and healthcare;
» prompt you to explore your own understanding of ‘values’;
» suggest a working typology of research questions on values;
» offer initial advice concerning: good values questions; the aims of a values study; and how to control for researcher bias arising from your own values.

The Quick guide to expected background knowledge boxes will ...

» briefly discuss the fundamentals of a good research question and the PICO(S) framework for formulating systematic review questions;
» consider how research questions are translated into study aims;
» highlight the recording practices which you need to establish from the very beginning of your literature searches.

2.1. What are health-related values?

2.1.1. What do you associate ‘values’ with?

Take a few minutes to analyse your own understanding of the concept of values. What do you think values are? What are your immediate associations when you hear the word ‘values’? Try to list at least three such associations before you read on (you can use the box on the next page). Do use this opportunity for a ‘baseline assessment’. You will find it interesting to see how your thinking about values has changed at the end of your project. More importantly, these associations are likely to hold the key to your research interests and biases, and this awareness is crucial for sustaining your motivation and ensuring the rigour of your research.

We have used this exercise many times and found that although people’s associations may differ substantially, they readily accept the associations of those around them as contributing to a fuller picture of what values are. You can find a box illustrating responses of trainee psychiatrists on the page after the next one. You will see that not only we differ in our values, but we also differ in which aspects of this highly complex concept we are most attuned to.
What do I associate ‘value’ and ‘values’ with?
## Box 2.1. Patients, doctors and managers on ‘values’ – examples of associations generated during training sessions on raising values awareness


<table>
<thead>
<tr>
<th>List 1 – Patients</th>
<th>List 2 - Doctors</th>
<th>List 3 - Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core beliefs</td>
<td>Concepts that govern ethics</td>
<td>What you believe in</td>
</tr>
<tr>
<td>Your perspective on the world</td>
<td>Right and wrong</td>
<td>Self esteem</td>
</tr>
<tr>
<td>Principles – cultural, individual</td>
<td>Belief systems</td>
<td>Principles</td>
</tr>
<tr>
<td>Justice</td>
<td>Ideals and priorities</td>
<td>Integrity</td>
</tr>
<tr>
<td>Anything that’s valued</td>
<td>Govern behaviour and decisions</td>
<td>Openness/honesty</td>
</tr>
<tr>
<td>Integral to being human</td>
<td>Community health – individuals, society, culture</td>
<td>Personal motivating force</td>
</tr>
<tr>
<td>Quality of life</td>
<td>Ideals</td>
<td>Ethics</td>
</tr>
<tr>
<td>Right to be heard</td>
<td>Morals</td>
<td>Virtues</td>
</tr>
<tr>
<td>Social values</td>
<td>Principles</td>
<td>Sharing</td>
</tr>
<tr>
<td>Self respect</td>
<td>Standards</td>
<td>Touchstones/bases</td>
</tr>
<tr>
<td>Valuing neighbours</td>
<td>Conscience</td>
<td>Willing to sacrifice for</td>
</tr>
<tr>
<td></td>
<td>Fluid/changeable</td>
<td>Self-interested tenets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Areas of negotiation in relationships</td>
</tr>
</tbody>
</table>

### 2.1.2. The many faces of values in medicine and healthcare – typical associations and coverage in the manual

In this manual, we adopt a very broad understanding of the concept of values. We consider values to be extending to anything that can engender a positive or negative association or experience – anything to which a positive or negative sign can be assigned. Below we outline the most typical contexts and meanings in which values appear in the health-related literature (the focus has already been narrowed down to ‘social’ as opposed to, for instance, statistical values or diagnostic test values). We have distinguished between these particular contexts and meanings as they constitute clearly identifiable domains of health-related research activity. The extent to which they are covered in the manual, in terms of suggested databases and keywords, is indicated in the accompanying boxes.
**Medical ethics**

In medicine and health care, values are perhaps most often associated with medical ethics – with issues like autonomy, best interests, involuntary treatment, healthcare rationing, informed consent, decision-making capacity, etc. Databases and keywords to help you search for medical ethics literature are included in this manual, but are not its exclusive or primary focus. If you are interested in traditional concepts of medical ethics, you may prefer to use the following publication as your primary source and this manual as a complementary one.


(Kahn and Ninomiya’s guide is an extensive source on searching for bio- and medical ethics literature. It reflects years of research and in-depth knowledge of the contents and indexing of holdings at The Kennedy Institute of Ethics, the world’s oldest and probably most renowned academic bioethics centre.)

**Cultural, ethnic, religious, etc. values**

Another strong association for values in medicine and healthcare concerns differences in culture and ethnicity, often associated with differences in religious affiliation and other belief systems, and their relationship with care seeking, health behaviours, treatment choices, health inequalities, etc. Relevant databases and keywords are covered in the manual.

**Preferences, wishes, needs, concerns, perceptions ...**

Values are often mentioned within sets of concepts including preferences, wishes, needs, concerns, attitudes, perceptions, priorities, expectations ... It is hard to argue against the value-ladenness of such phenomena. These have been widely explored in social sciences and psychological research on health and illness or in health research that uses methods from the social sciences and psychology. The bulk of the current literature on health-related values is precisely on issues such as attitudes, perceptions, preferences, concerns, expectations, etc. As the lists of keywords in this manual have been obtained through word frequency analysis of current research, they are dominated by search terms for phenomena of this type.
Utility/disutility

Researchers with a decision-making and cost-effectiveness background have another frequent association for values – the utility/disutility assigned to a certain health state, which is used to compute quality-adjusted life years, or QALYs. The manual offers relevant keywords to the extent to which these have come through in the word frequency analysis study. The research area aiming to quantify the utility of different health states and interventions is quite active and influential, but its current scope is markedly smaller than that of the values areas identified above. As a result, relevant keywords are likely be under-represented on our lists. Further targeted work is needed to improve the usefulness of the manual in this respect.

The values of the ’establishment’

There is yet another sense in which values in medicine and health care have been explored and often challenged. This concerns the often implicit values embedded in the organisation of services, healthcare delivery, disease nomenclature, policy documents, etc. This agenda has been particularly strong in psychiatry. Social sciences researchers and user groups are highly sensitive to such values. Conversely, they escape the notice of the wider society and/or professional groups, as they perceive them as part of the solid, factual nature of things. We have been particularly interested in this type of research and have already identified certain characteristics of its vocabulary. However, we need to explore the latter in greater detail before we can report reliable findings.

Aesthetic values

The manual offers an illustrative selection of medical humanities sources and general literature and arts databases, where illness, health and medicine have an aestheticised presence. This aspect of the manual is still in its early stages of development.

We have suggested several conceptualisations and taxonomies of values in the article below (quite different to the grouping by research areas above). They can provide a useful starting point in operationalising ‘values’ for your project. We would suggest, however, that you first try to develop your definition and categories. Health-related values, conceptualised that broadly, is a new field and needs variety!

2.1.3. Impact of the complexity of the concept of values on literature searching

The theoretical complexity of the concept of values translates into substantial practical difficulties. The following questions, which you may already be asking yourself, exemplify some of these:

- Which are the aspects of the concept of values that should be covered by a comprehensive list of search terms? What makes a rigorous procedure for generating keywords, ensuring that all relevant aspects of the concept are included?

- Which are the most appropriate databases to search? Do databases specialising in the different disciplines interested in health-related values (e.g. health sciences, psychology, social sciences, medical humanities, philosophy) cover different issues or do they tend to overlap?

- What makes a good values question? Which values issues are closely knitted to one another and best studied together?

In the next section, we make a start at considering the issue of ‘good values questions’. The other two sets of issues raised above are addressed in Chapter 4 and Chapter 3 respectively.

2.2. How to formulate a research question about values?

Quick guide to expected background knowledge

Basic requirements of a good research question

The following requirements may appear self-evident, but surprisingly many research questions fail to meet them on closer inspection. We encourage you to assess your research question critically and systematically. Try to inhabit the perspective of a critical outsider. And, ideally, get feedback from such people.

- Your research question should be one that can be answered:
  - in principle – with your methods; within the boundaries of your operationalisation; with the approach you are suggesting; with the type and amount of data you intend to collect;
  - in practice – consider your timeframe; resources; skills; external support available.

- Your research question should be one that is worth answering:
  - important – for instance, because it addresses a healthcare problem that can have grave consequences, arises routinely, or is associated with high costs;
  - relevant to users – to those for whose benefit or information the answer is sought (patients, clinicians, policy makers, etc.);
  - original – which is something you can determine only if you are closely familiar with the literature.
Your research question should be one that is ethical to answer – in terms of procedures comprising the study design, but also in terms of implications and possible misuses of the answer.

Evidence-based medicine advice on formulating good research questions

Within evidence-based medicine, the PICO (or PICOS) framework is considered superior in formulating questions for systematic reviews. The letters in the acronyms stand for the following elements:

- Population (or patient, or problem)
- Intervention (or prognostic factor, or exposure, or cause)
- Comparison (if such is necessary – an alternative intervention, no intervention)
- Outcomes
- (Study design)

PICO(S)-questions are seen as highly relevant to patients and clinicians. Their structure is considered to facilitate the development of literature searches and the attainment of precise answers.

See box at the end for suggestions for further reading.

It is yet to be seen to what extent standard evidence-based recommendations on good research questions would be suitable for values research questions. We are inclined to believe that the PICO(S) framework may be too restrictive in identifying priorities for values research. But before we can decide what values questions should be given priority, we need to clarify what questions can be and are asked in values research.

2.2.1. A working typology of research questions on values

On the next few pages we are suggesting a working typology of values questions, along with examples of publication titles that illustrate them (titles of actual papers we have screened in the process of identifying values search terms and databases).

These are not necessarily examples of good research questions (partly because, strictly speaking, they are not research questions but titles of publications). They illustrate, however, good practice in at least one respect: they avoid asking too many types of question at the same time, which is a shared weakness of much of the values research we have come across.

The types marked with a downward pointing arrow seem to be particularly under-researched, at least as far as the conditions we have explored are concerned (diabetes, obesity, schizophrenia and dementia). The ones marked with an upward pointing arrow seem to be associated with a strong research tradition, again as far as the above clinical conditions are concerned. The remaining question types (unmarked) gravitate towards a midpoint of ‘normal’ research interest.

We have tried to select examples for which the title is enough to explain the assignment to a particular group. This has not always been possible. If you would like to read through the abstracts and see how they fit in a particular group, follow the references at the end of the chapter.
1. Are you interested primarily in identifying the value-variables (exclusively or as a subset within a wider range of factors) that bear on certain health-related behaviours, dispositions or situations?

Examples of studies:

**Barriers** to routine gynecological cancer screening for White and African-American obese women (1)

Understanding help seeking delay in the prodrome to first episode psychosis: a secondary analysis of the perspectives of young people (2)

The influence of the **perceived quality of community environments** on low-income women's efforts to walk more (3)

Does **optimism** affect symptom report in chronic disease? (4)

2. Are you interested primarily in the value-variable itself (or a wider variable with value-components or as seen from a particular perspective) – in describing, measuring, analysing, predicting, or modifying it?

Examples of studies:

**Focus on describing:**

The patient's journey: living with diabetes (5)

Values and beliefs about obesity and weight reduction among African American and Caucasian women (6)

Differences and similarities in perception of schizophrenia between physicians and the general population in Quebec (7)

**Focus on measuring:**

Youth and parent satisfaction with clinical use of the GlucoWatch G2 Biographer in the management of pediatric type 1 diabetes (8)

GP attitudes to early diagnosis of dementia: evidence of improvement (9)

Self-rated fair or poor health among adults with diabetes – United States, 1996-2005 (10)

**Focus on analysing:**

Is there a double standard when it comes to dementia care? (11)

Analysis of patients' rights: dementia and PEG insertion (12)

Must physicians respect an incompetent patient's refusal of treatment? (13)
Focus on **predicting:**

Predictors of fat stereotypes among 9-year-old girls and their parents (14)

Media consumption and desire for social distance towards people with schizophrenia (15)

Pharmacophilia and pharmacophobia: determinants of patients' attitudes towards antipsychotic medication (16)

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Focus on **modifying:**

Altering the perceptions of WIC health professionals about childhood obesity using video with facilitated group discussion (17)

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3. Are you interested primarily in the **relationship** (correlation, effect) between a value-variable and a clinical variable or event?

Examples of studies:

**Attitudes** of schizophrenia outpatients toward psychiatric medications: relationship to clinical variables and insight (18)

Inverse correlations between symptom scores and spiritual well-being among African American patients with first-episode schizophrenia spectrum disorders (19)

**Influence** of nutrition attitudes and motivators for eating on postpartum weight status in low-income new mothers (20)

**Low well-being** is an independent predictor for stroke in elderly patients with diabetes mellitus (21)

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4. Are you interested primarily in the **effect** of a clinical intervention on a certain value-variable (or a wider variable with value-components)?

Examples of studies:

The psychological impact of screening for type 2 diabetes (22)

Integrated treatment of first-episode psychosis: effect of treatment on family burden: OPUS trial (23)

Did anything change? Caregivers and schizophrenia after medication changes (24)
5. Are you interested primarily in interventions that work through value-factors and aim to achieve an effect on clinically important variables and/or value-variables?

Examples of studies:

Implementing **empowerment group education** in diabetes (25)

An educational model for improving diet counselling in primary care: A case study of **the creative use of doctors’ own diet, their attitudes to it and to nutritional counselling** of their patients with diabetes (26)

Effects of a **caregiver intervention** on negative caregiver appraisals of behavior problems in patients with Alzheimer’s disease: results of a randomized trial (27)

The LIFE program: **a wellness approach** to weight loss (28)

6. Are you interested primarily in communicating about values or value-laden issues?

Examples of studies:

**Artificial hydration and nutrition** in advanced Alzheimer’s disease: facilitating family decision-making (29)

7. Are you interested primarily in comparing the explanatory power/impact on health of (a) value-variable(s) vs. (a) traditional biomedical variable(s), or in comparing the effectiveness of respective interventions?

Examples of studies:

Comparison of sleep condition and sleep-related psychological activity after **cognitive-behavior** and pharmacological therapy for chronic insomnia (30)

8. Are you interested primarily in **methods and tools** for exploring values issues (including the values incorporated in those methods and tools)?

Examples of studies:

Cross-cultural equivalence of **feeding beliefs** and practices: the **psychometric properties of the child feeding questionnaire** among Blacks and Hispanics (31)

A new **patient focused scale** for measuring **quality of life** in schizophrenic patients: the Schizophrenia Quality of Life Scale (SOL) (32)
9. Are you interested primarily in analysing clinical practice, the organisation of services, policy, research, theoretical frameworks, etc. for the values which underpin them?

Examples of studies:

- The emergence of overweight as a disease entity: measuring up normality (33)
- The debate on ethnicity and dementia: from category fallacy to person-centred care? (34)
- What do pediatric primary care providers think are important research questions? A perspective from PROS providers (35)
- Scientific and consumer models of recovery in schizophrenia: concordance, contrasts, and implications (36)

2.2.2. Initial considerations on ‘good’ values questions

We can suggest the following preliminary considerations concerning good values questions, which reflect gaps and weaknesses in current values research. This is again an area requiring further research.

- A good research question on values will not mix question types.

- Some of the most clinically relevant question types seem to be amongst the least researched ones (e.g. types 3 and 7). It might be a good strategy to focus on such questions. Their exploration, however, is likely to be much more methodologically and theoretically complex.

- A research question that focuses on a value-variable (e.g. on describing, measuring, analysing it, etc.) can claim importance only if it focuses on a variable that has already been shown to significantly affect health behaviours, dispositions, situations, etc. or if it gives sufficient attention to mechanisms through which this might be happening. This is rarely the case in current research.

- Some of the most useful research questions on values are those that involve comparisons – for instance, between the perspectives of different stakeholders or between the stated and enacted values of the studied population.

- Research questions that focus on patients’ values are not by default more important than those that focus on the values of other stakeholders.

2.3. What else to consider before starting your values search?

Apart from formulating an initial conception of values and a working version of your research question, you will need some further preparation before starting your values searches. This includes translating your research questions into specific aims, setting up logs for your work, and considering potential sources of bias.
2.3.1. How does your values research question translate into study aims?

Quick guide to expected background knowledge

By translating your research question into specific aims you are indicating what exactly answering your research question will involve. From the point of view of literature searching, well-specified aims mean that:

- You will know how to approach your search – e.g. which databases to search, which keywords to use or how to generate them, etc.;
- Your search will not take you (much) longer than you have planned;
- It will be quite straightforward to apply the inclusion/exclusion criteria specified.

Your research aims are like stepping stones: they break down your research question into discrete procedures and intermediate answers that will lead you to the final answer. They are also the accomplishments by which the success of your work will be measured.

Your aims should tie directly with your study design and research methods. All these should be chosen and described in a way that can persuade a sceptical outsider that:

- You know exactly how you will go about achieving your aims and they are indeed achievable;
- What you learn from achieving your aims will fall together into a self-evident answer to the research question you have posed.

Quite likely, you will encounter unforeseen obstacles which prevent you from achieving your aims in the ways expected, or acquire new knowledge showing that the answer to your research question is further away than you had thought. Nevertheless, when you set up and describe your aims, they should be clear, tightly connected to your question, methods and each other, and confidently stated.

Be very specific in formulating your aims and describing how you will achieve them. High level of detail will make it evident if:

- Achieving your aims will allow you to answer the research question, or whether you will need to reformulate it;
- If achieving each particular aim and completing the project as a whole is feasible.

If any of the above criteria is not met, you will need to revisit your aims and possibly your research question.
Below are initial considerations concerning the aims of a values study. Again, this is an area requiring further research.

- A good values study should demonstrate sensitivity to the value-ladenness of its research methods, conceptual framework and context. This might be reflected, for instance, in the inclusion of a variety of perspectives and/or methods, a well-defined comparison background, and critical analysis of background assumptions.

- As value terms are often used quite loosely, a supporting theory or framework may be needed to fix their meaning. At the level of study aims, this may involve specifying the theoretical context within which answers will be sought.

- A values study that claims to be practically important should specifically relate value-variables to clinical variables. This may require the inclusion of aims addressing the mechanisms which underpin the relationship.

2.3.2. How to set up your recording templates?

Quick guide to expected background knowledge

Different audiences and report types have different requirements of how you perform your searches and how you describe your search process. Their stringency varies widely. For instance, you will not be expected to describe the search strategy for a background literature review accompanying a piece of primary research (yet the reviewers may comment that you have failed to take into account seminal work in the field, so you’d better do your searches well!). Conversely, systematic reviews will need to be accompanied by a highly detailed report of your search process.

There are no widely agreed criteria concerning the performance and reporting of a literature search (this is further discussed in Chapter 8). You will need to spend some time identifying what your audience’s explicit and tacit criteria of adequate/high standards of searching are – by reading written guidance and identifying high quality examples. Ideally, secure the support of a library and information specialist – they are an invaluable source of advice!

It is crucial to set up a proper recording system at the very beginning of your searches. In the field of research, not having documented something is equal to not having done it. On the other hand, replicating what you have done and failed to record properly is time consuming and may not always be possible due to changes in retrieval, including for specified past periods. Consider the data below:

Between March 07 and March 09 we had been monitoring the retrieval of publications on diabetes, obesity, dementia and schizophrenia in MEDLINE for the period between January 2004 and December 2006 (that is, a period that fell fully in the past). Retrieval increased by an average of 5%, which, for diabetes for example, meant an additional 1,500 records. This happens because: databases enrich their past holdings; non-indexed records are indexed and become ‘visible’ to the search engine; and the functionality of search engines is constantly being improved. These database enhancements, however, create inconsistencies in replicating searches.
Here are the main recording issues to plan for before starting your searches. Chapter 8 (on reporting) and the *Quick guide* box to Chapter 6 (on managing your retrieval) will give you further ideas.

- Record your precise search terms and syntax (e.g. if you search for *attitud*\*, record *attitud*\*, not *attitude*). Make sure to include brackets, inverted commas, etc;
- Record the limits you are applying (publication dates, languages, subsets of databases, etc.);
- Record the dates on which you are performing your searches (month and year is generally enough) – even if you are searching the literature from a period up to a point in the past, rather than “to present”, an earlier or later date may make a difference to the number of records returned;
- Record total retrieval (which you might lose track of if you are only saving true positives);
- Record all terms you have tried, even if they did not work well and were discarded – this is useful information for other searchers who may have initial intuitions similar to yours;
- If you are doing a systematic review, or any review that involves strict inclusion/exclusion criteria, save all your citations, not only the true positive ones.

There do not seem to be values-specific recommendations on recording your search process different to complement the generic ones above. However, as values are not an established research topic, you may need to provide a greater level of detail in describing your search process than with more familiar research topics.

Readers, including peer reviewers, examiners and journal editors, may have quite firm beliefs about the value or otherwise of researching health-related values and about appropriate approaches for so doing. This is not a values-specific problem – it concerns any topic that has both something very new and something very old about it. It helps enormously to be very explicit about and justify the assumptions, decisions and interpretations which have informed your search process.

### 2.3.3. How to control for bias arising from your own values?

The following are initial prompts to help you guard against bias arising from your own values. These reflect weaknesses identified in a substantial number of recent values studies:

- Do you believe that certain values or value-laden beliefs, dispositions, behaviours, etc. are ‘better’ or ‘worse’, more rational or irrational, etc. than others as far as health is concerned? Is your primary aim to learn about values so that you can help modify the dysfunctional ones? If so, you may be prone to bias (as much as your intentions are good!). What strategies have you embedded in the study design to ensure that those potentially dysfunctional values are explored in a wider context, which may elicit their logic and adaptive function? (Paradoxically, being open to the possibility that health-damaging values, value-laden beliefs, dispositions, etc. serve an adaptive function will put you in a better position to identify ways of modifying them, or satisfying them in non health-damaging ways.)

- Do you believe that research into values helps increase understanding and empathy for the groups and individuals studied? Is your primary aim to help achieve changes in practice and service organisation that make them congruent with the values of your research participants? If so, you are similarly prone to bias, again with the best of intentions! What strategies have you embedded in the study design to ensure that the perspective of your...
particular group is explored in the context of other relevant perspectives, which may also highlight its disadvantages and selective blindness, contradictions and uncertainties, self-deceptive potential and negative impact on others? (Doesn’t need to be that bad ...)

**Key learning points**

After working through this chapter, you should have ...

- developed an understanding of the complexity of the concept of values and the main contexts in which values are discussed in medicine and healthcare;
- become better aware of your own ideas about values;
- developed a clearer idea of the type(s) of values research questions you are interested in.

**Key references**

**Books and articles:**


**Websites:**

http://grants.nih.gov/grants/writing_application.htm, and related pages of the US National Institutes of Health website – for advice on writing grant applications. Includes useful tips on formulating research questions and developing study aims.

www.cebm.net/index.aspx?o=1036 – for a table on the PICO framework (this is a resource on the website of the Centre for Evidence Based Medicine (CEBM) in Oxford).

www.cebm.net/index.aspx?o=2311 – for a literature searching exercise using the PICO framework (also on the CEBM website).

http://www.york.ac.uk/inst/crd/systematic_reviews_book.htm - for the PICOS framework as presented in the guidance on systematic reviewing of the Centre for Reviews and Dissemination (see 1.2. The Review Protocol)

**Key objectives of next chapter**

- to introduce you to a wide range of electronic resources, both research and ‘alternative’, non-research ones, where you can find materials on health-related values.
References to the titles used to illustrate question types under 2.2.1.


Databases and other sources of values materials

CHAPTER 3

This chapter will ...

» offer brief descriptions, mainly as table summaries, of databases containing values records.
   The majority of included databases have a research focus. The remaining are databases containing ‘alternative’ materials (such as personal narratives, mass media materials, literature and art work, etc.);

» offer preliminary suggestions on how to select values databases when searching under time and resource constraints.

The Quick guide to expected background knowledge box will ...

» distinguish among various types of databases;
» clarify frequently used terms;
» point out frequent sources of confusion, which may lead to duplication of effort.

Quick guide to expected background knowledge

Types of databases

Databases are usually grouped into types on the basis of their thematic coverage. A thematic typology will underlie the structure of section 3.2. Here we will focus on a number of formal parameters, which provide less obvious but equally important considerations in deciding which databases to search.

- access – databases requiring subscription vs. open access databases
  Most high quality databases have a paid-for access, usually secured through institutional subscriptions.

At the same time, the drive for open access to reliable health-related information has been extremely strong in recent years. An increasing number of funders require open access to publications from research they have funded. Provisions are also available for securing preferential access to health-related information for developing countries. Currently, PubMed Central (http://www.ncbi.nlm.nih.gov/pmc/) is the largest digital archive of free full text publications in the life sciences, including medical and health-related publications. MEDLINE, probably the most widely known medical and healthcare database, can also be accessed free of charge through the PubMed interface: (http://www.ncbi.nlm.nih.gov/sites/entrez).

The majority of databases listed in this manual have restricted access. At least in the UK, however, as long as you are associated with a university or the NHS, you will most likely
have access to them. In contrast, our empirical work on keywords and thesaurus terms has focused solely on the freely accessible PubMed MEDLINE.

- **completeness of information within each citation** – bibliographic vs. full text databases
  Traditionally, most research databases have been bibliographic – containing summary information about a publication (title, authors, source, sometimes abstract and references), but not the publication itself. In recent years differences between bibliographic and full text databases are diminishing, with database providers linking more and more bibliographic records to full texts, or to services that allow users to order or purchase the full text.

- **preselection of records for quality**
  Databases differ in the extent to which the records on them have undergone a quality assessment process. Research databases tend to index predominantly or only publications that have gone through a peer-review process. Some have even stricter criteria, primarily concerning the methodological quality of studies. This is the case, for instance, in the Cochrane databases and study registers or NHS Evidence (formerly the UK National Library for Health).

At the opposite end of the spectrum are **grey literature** databases – referencing publications that are still work in progress and non-definitive (e.g. conference presentations) or that address highly specific, local or temporary concerns (e.g. organisational bulletins, policy documents, brochures). Grey literature sources are particularly useful in locating research on new, under-researched or controversial topics as well as in counteracting “publication bias” (the tendency for negative results to be published less frequently). The quality of such publications, however, is less certain.

- **availability of thesaurus**
  One of the most effective approaches to facilitating searches and improving the quality of retrieval from a database is by indexing each of its records with terms from a predefined vocabulary. By supplying and using such “controlled” terms (also called “indexing terms”, “descriptors”, “preferred terms”, etc.), the variability of language between authors, research traditions and time periods is circumvented. This predefined vocabulary makes up the thesaurus of a database. High quality databases usually incorporate a thesaurus. The latter may be specific to that particular database, or fully or partly based on the thesaurus of another, usually more comprehensive and authoritative, database.

  Identifying terms from browsable thesauri is one of the most effective habits you can develop in searching electronic database. A huge intellectual effort goes in developing thesauri and classification systems and in indexing publications. The ease and quality of your searches will improve dramatically if you take full advantage of it.

**Some terminological clarifications** – databases, providers, interfaces, platforms ...

A database is usually produced by a single organisation, but services/products providing access to its data can be developed and made available by many. For example, MEDLINE is compiled by the US National Library of Medicine but is offered by Ovid, Elsevier, the National Library of Medicine itself, etc. Each of these providers offers a unique user interface, through which users communicate with the database, and has its own technological underpinnings through which the data are stored, searched, retrieved, etc. For example:
**PubMed** is one of the *interfaces* through which MEDLINE is made available. More widely, it is a service provided by the US National Library of Medicine which offers a range of products associated with information storage, retrieval and delivery. PubMed and MEDLINE are thus in many respects one and the same thing. Nevertheless, it is not unusual for research reports to describe that both have been searched. This is an unnecessary duplication of effort – the differences in retrieval resulting from technological differences between providers are too small to justify it.

**Ovid** (as in **Ovid MEDLINE**) is a *provider* of services, including access to databases through its own (and highly acclaimed) interface. A provider usually offers access to a number of databases – e.g. you can have Ovid MEDLINE and Ovid PsycINFO, or ProQuest Sociological Abstracts and ProQuest ASSIA (Applied Social Sciences Index and Abstracts). If you have access to two or more databases through the same provider, you can search them simultaneously and have duplicates automatically excluded.

SilverPlatter (which used to appear in the combination Ovid/Silver Platter MEDLINE) is a *platform* which underpins technologically the access and delivery of information through Ovid. (To complicate matters further, SilverPlatter used to be a provider. It merged with Ovid and now the SilverPlatter platform is used by Ovid). Illumina, of CSA, is another example of a platform (and CSA another example of a partner in a merger, with ProQuest this time. You can see how confusions about terms arise!).

It is important to indicate the interface you have used to search a particular database. It tells your readers whether they can use your search strategy directly or will need to adapt it. Different interfaces require the use of a slightly different syntax (e.g. symbols for truncation, such as * or $). Thesauri and classification systems are also likely to differ between providers. Reporting on the platform (e.g. Illumina) is generally unnecessary, as once having chosen a particular provider, users do not have a choice over its technological decisions.

### 3.1. General observations on the databases indexing values materials

The following values-specific observations concern some of the formal parameters on which databases differ (as described in the *Quick guide* box).

- **bibliographic/full text** – the majority of databases which we suggest below are bibliographic. The provider or your institution may have linked citations to full texts. In comparison to more traditional evidence-based research, the quality of bibliographic records for values research (e.g. the length, structure and informational value of abstracts, the quality of indexing, etc.) have started to improve later, for MEDLINE possibly around 2003-2004, and is still far from satisfactory.

- **preselection of records for quality** – in the case of values research, applying strict quality criteria is probably a disadvantage rather than otherwise. Most research on values uses methodologies that are not deemed to generate high quality evidence. In some cases, the critiques of the methodological rigour of values studies are fully justified; in others, these may be the most appropriate methodologies for the research questions asked.
In contrast, in the case of databases with ‘alternative’ materials on health and illness (such as personal narratives or mass media materials), strict selection criteria are extremely helpful. As many of the health-related materials from the wider social environment are likely to be heavily value-laden, and as the level of repetition outside research is high, preselection of materials is a major strength.

As far as variety, contents and ease of searching are concerned, our experience suggests the following:

- **Databases with an exclusive focus on health-related values (both research-focused and ‘alternative’) are only a few.** There seems to be much scope for new databases on health-related values and expansion of currently existing ones.

- **The general medical and health databases cover the widest range of topics and perspectives on health-related values.** They, however, require the most sophisticated search strategies and are the most time consuming to search.

- **General social sciences databases are easy to search for materials on health-related values.** As the social sciences deal predominantly with value-laden issues and as health research is one amongst many subtopics on such databases, it may often be sufficient to use only the medical term of interest. However, a substantial proportion of the records on these databases have **limited relevance to practical issues in health care, being more oriented to theoretical and conceptual issues in the social sciences.**

- **Psychological databases contain highly relevant and practically useful material, but present significant difficulties in terms of boundary issues** (is this a ‘values study’ or not?).

- **Grey literature databases do not seem to cover additional topics and perspectives** to those that can be found in generic medical and health databases (although, of course, they index additional studies).

- **There is substantial overlap of values citations across databases,** but the nature and extent of it require further research.

### 3.2. Examples of databases and other sources

On the following pages, you will find information about a number of databases where you can identify materials on health-related values. It includes databases we have searched at some length and have found useful, as well as authoritative databases with which we have less experience but are typically accessed in systematic searches. 3.2.2 is still a “placeholder category” on which we are currently working.

The information has been organised and colour-coded as outlined below. Whenever two or more databases seem to have similar coverage, they have been described in the same table to facilitate comparisons.
3.2.1. Medical and health databases with a research focus

3.2.1.1. Databases that cover exclusively or primarily topics concerning health-related values
3.2.1.2. Databases that cover topics with strong values elements
3.2.1.3. General medical and health databases
3.2.1.4. Nursing and allied health literature databases

3.2.2. Health-related databases with a more specific thematic coverage and broader focus, not restricted to research (e.g. health policy, medical education, some grey literature databases, etc.)

3.2.3. Research-focused databases where health is one of many subject areas covered

3.2.3.1. Social sciences databases
3.2.3.2. Humanities databases
3.2.3.3. Research-focused grey literature databases

3.2.4. Medical humanities resources

3.2.5. Sources of ‘alternative’ materials

3.2.5.1. Sources of personal narratives
3.2.5.2. Literature and arts databases
3.2.5.3. Mass media collections

The entries on the list of databases as well as the provision of values-specific information for each of them are work in progress. We welcome your suggestions, particularly for databases with an exclusive coverage of values topics and non-English language databases.

We have been contacting providers of databases where the information on their websites has been insufficient or dated. We would like to thank once again the editors, resource managers and advisors who helped us (please see Acknowledgements). Information is correct as of January 2012, unless otherwise specified.

3.2.1. Medical and health databases with a research focus

3.2.1.1. Databases that cover exclusively or primarily topics concerning health-related values

At present, the number of databases dedicated to values topics appears limited, with the richest database covering ethical values (see second table below).
Patient and Public Involvement (PPI) Specialist Collection

**NB:** Until recently, this database could be browsed and had webpages of its own (we last used it extensively in 2009). The information below is mostly from that time. The database is now included in NHS Evidence where it can no longer be browsed but only searched. We left the 2009 information to give you prompts for searches in the current format.

If you feel this is a collection requiring greater visibility, you may provide feedback concerning the A-Z list of topics on NHS Evidence. The list is under development and feedback has been welcomed: [https://www.evidence.nhs.uk/topics](https://www.evidence.nhs.uk/topics).

<table>
<thead>
<tr>
<th><strong>Producer</strong></th>
<th>Part of NHS Evidence (formerly National Library for Health), funded by the UK NHS (National Health Service), developed and managed by NICE (UK National Institute for Health and Clinical Excellence).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider(s)</strong></td>
<td>NHS Evidence</td>
</tr>
</tbody>
</table>
| **Subject scope** | *As per information when database was browsable:*  
Introductory articles on PPI  
PPI policy  
Guidance on implementation  
Methods of patient and public involvement  
Collective involvement (including community involvement, the equalities agenda, consultation processes)  
Individual involvement (including patient experience, shared decision making, self management and patient choice)  
Involvement in accountability  
Involvement in research  
Education for involvement  
Organisations supporting PPI |
| **Open access?** | Yes, although some full texts may require an Athens registration. |
| **Bibliographic or full text?** | Full text |
| **Strength of evidence criteria?** | Yes |
| **Publication types** | *As per information when database was browsable:*  
Policy documents, briefings and service guidance documents; research studies, reports, systematic and other reviews; reference material, learning material and courseware; information about relevant organisations; patient information. |
<table>
<thead>
<tr>
<th><strong>Years</strong></th>
<th>Information not available</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Size</strong></td>
<td>Information not available</td>
</tr>
<tr>
<td><strong>Sources</strong></td>
<td>Information not available</td>
</tr>
<tr>
<td><strong>Languages and regions</strong></td>
<td>English only</td>
</tr>
<tr>
<td><strong>Classification system/thesaurus</strong></td>
<td>Keywords are assigned to records. No information on thesaurus used.</td>
</tr>
</tbody>
</table>

**Coverage of values issues – impressions**

*As per impressions when database was browsable:*

One of the very few databases dedicated to a subject matter so closely associated with health-related values. Focuses on the processes, structures, principles and tools that help identify, negotiate and act in accordance with patients’ and public values, rather than, for instance, the contents and nature of those values, their relationship with health outcomes, etc.

High quality records selected in accordance with rigorous quality or authority criteria. The use of quality criteria may be a weakness in the case of values research, as much of it uses approaches not considered to produce strong evidence.

A strong policy agenda behind patient and public involvement, which may affect the types of issues and perspectives that dominate the included publications.

Many publications seem to be underpinned by rationalist and progressivist assumptions, which may result in underestimating some of the difficulties in identifying, negotiating and acting in accordance with values. There is a strong underlying consumerist ethos, too. The focus on patients and the public may blur the need for attention to other stakeholders’ values. Limited presence of publications written from questioning, alternative, critical perspectives.

In summary: a varied, high quality and well maintained source with great potential and much practical relevance. Somewhat intolerant to critical voices.

**Knowledge gaps from a values searcher’s perspective**

More detailed analysis needed of the issues covered.
<table>
<thead>
<tr>
<th>Sources of this/further information</th>
<th><a href="http://www.library.nhs.uk/PPI/">http://www.library.nhs.uk/PPI/</a> and subpages (link no longer live, information valid as of Sep 09)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="http://www.evidence.nhs.uk/">http://www.evidence.nhs.uk/</a> - the holdings of PPI can now be searched from here.</td>
</tr>
<tr>
<td>Search guides/tutorials</td>
<td>Searches in NHS Evidence are straightforward.</td>
</tr>
<tr>
<td>‘Featured features’</td>
<td>Involvement in Research section (under PPI in practice in left-hand navigation – again, no longer directly accessible)</td>
</tr>
<tr>
<td>Contact details</td>
<td><a href="http://www.evidence.nhs.uk/contact-us">http://www.evidence.nhs.uk/contact-us</a></td>
</tr>
</tbody>
</table>
# ETHXWeb and GenETHX Databases

| **Producer** | Bioethics Research Library, Kennedy Institute of Ethics, Georgetown University, US
| **ETHXWeb** – for most of its history, project of the National Reference Centre for Bioethics Literature and the National Library of Medicine
| **GenETHX** (subset of ETHXWeb) – for most of its history, project of the National Human Genome Research Institute
| Both databases currently continue as the Bioethics Research Library at Georgetown University.

| **Provider(s)** | Bioethics Research Library, Kennedy Institute of Ethics, Georgetown University, US

| **Open access?** | Yes, although some links may be to paid full text publications.

| **Subject scope** | ETHXWeb – bioethics and professional ethics
| GenETHX – ethics and public policy issues in genetics

| **Bibliographic or full text?** | Bibliographic, with some links to websites providing full texts

| **Strength of evidence criteria?** | No

| **Publications types** | Journal and newspaper articles; books, book chapters and book reviews; government reports; court decisions, bills, laws; position statements; unpublished documents; audio-visual materials; press releases and news items. The wider information resources also include a Syllabus Exchange Database and an International Bioethics Organizations Database.

| **Years** | Approx. 83% of journal article records are from 1988 to the present. Retrospective coverage of seminal documents back to 1801. Books and audio-visuals – since 1975.

| **Size** | ETHXWeb – over 286,000 (2009 data)
| GenETHX – 42,000 (2009 data)
| Updated twice monthly.

| **Sources** | Almost 500 periodical subscriptions, a regularly updated collection of books (27,000) and audio-visuals (350) (2009 data)
<table>
<thead>
<tr>
<th><strong>Languages and regions</strong></th>
<th>Predominantly English; citations to materials in 28 other languages, mostly Dutch, French, German, Italian, Portuguese, Spanish, and Swedish</th>
</tr>
</thead>
</table>
| **Classification system/thesaurus** | Intentionally small classification system – 22 categories and subcategories: [http://bioethics.georgetown.edu/databases/classcheme/index.html](http://bioethics.georgetown.edu/databases/classcheme/index.html)  
Regularly updated bioethics thesaurus (informing and informed by the MeSH thesaurus), which, however, is not used for indexing purposes: [http://bioethics.georgetown.edu/databases/bt/index.html](http://bioethics.georgetown.edu/databases/bt/index.html) |
| **Coverage of values issues – impressions** | Ideal source for materials of values in the traditional ethical sense |
| **Knowledge gaps from a values searcher’s perspective** | No particular issues |
| **Sources of this/further information** | [http://bioethics.georgetown.edu/databases/dbfaqs.htm](http://bioethics.georgetown.edu/databases/dbfaqs.htm) (link no longer live, used in 2009)  
[http://bioethics.georgetown.edu/](http://bioethics.georgetown.edu/) and related pages |
| **Search guides/tutorials** | [http://bioethics.georgetown.edu/databases/howtosearch/index.html](http://bioethics.georgetown.edu/databases/howtosearch/index.html) |
| **‘Featured features’** | (included are collections of the Bioethics Research Library that are not part of ETHXWeb and GenETHX)  
The Bioethics QuickBibs – showing 100 most recent bibliographic citations on a range of controversial topics: [http://bioethics.georgetown.edu/resources/quickbibs/index.html](http://bioethics.georgetown.edu/resources/quickbibs/index.html)  
<table>
<thead>
<tr>
<th>Contact details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="mailto:bioethics@georgetown.edu">bioethics@georgetown.edu</a></td>
<td></td>
</tr>
<tr>
<td>Request Search Assistance facility – <a href="https://www4.georgetown.edu/uis/keybridge/keyform/form.cfm?FormID=2568">https://www4.georgetown.edu/uis/keybridge/keyform/form.cfm?FormID=2568</a></td>
<td></td>
</tr>
</tbody>
</table>
Patient-Reported Outcome Measures (PROMs) Bibliography – no longer updated

<p>| <strong>Producer</strong> | National Centre for Health Outcomes Development (NCHOD), based at the Unit of Health-Care Epidemiology, the University of Oxford Department of Health funded between 2002-2005; then property of the NHS Information Centre for Health &amp; Social care. The bibliography is no longer updated. However, reviews aimed to support the selection of PROMs are still published on pages of the same website. |
| <strong>Provider(s)</strong> | As above |
| <strong>Open access?</strong> | Yes |
| <strong>Subject scope</strong> | Patient-reported outcome measures and patient-reported health instruments |
| <strong>Bibliographic or full text?</strong> | Bibliographic |
| <strong>Strength of evidence criteria?</strong> | Not stated. |
| <strong>Publication types</strong> | Appears to be primarily journal articles, but no specific information provided. |
| <strong>Years</strong> | First published in 2002. No information on which year the records date back to. Last updated in December 2005. No further updates planned. |
| <strong>Size</strong> | Over 16,000 records |
| <strong>Sources</strong> | Information not provided. |
| <strong>Languages and regions</strong> | Information not provided. |
| <strong>Classification system/thesaurus</strong> | Specifically designed keyword search facility. Keywords seem to have been used to (re)index the citations. |
| <strong>Coverage of values issues – impressions</strong> | Uniquely large and very useful resource on patient-reported outcomes instruments. However, until recently, such instruments... |</p>
<table>
<thead>
<tr>
<th><strong>Coverage of values issues – impressions</strong></th>
<th>were developed from a predominantly or exclusively researcher’s perspective, without any patient input. This may have compromised their validity.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge gaps from a values searcher’s perspective</strong></td>
<td>Is there a way of identifying instruments developed with patients’ input?</td>
</tr>
<tr>
<td><strong>Sources of this/further information</strong></td>
<td><a href="http://phi.uhce.ox.ac.uk/home.php">http://phi.uhce.ox.ac.uk/home.php</a></td>
</tr>
<tr>
<td><strong>Search guides/tutorials</strong></td>
<td>Help and Hints and Tips pages; straightforward to search</td>
</tr>
<tr>
<td><strong>‘Featured features’</strong></td>
<td>Useful links to other websites sites on outcome measures, e.g. quality of life instruments or end-of-life care tools (Under Links/Resources)</td>
</tr>
<tr>
<td><strong>Contact details</strong></td>
<td>As the site is no longer updated, no official contact name/address is provided.</td>
</tr>
</tbody>
</table>
### 3.2.1.2. Databases that cover topics with strong values elements

Library of reviews of the Cochrane Consumers and Communication Review Group (part of the Cochrane Library)

<table>
<thead>
<tr>
<th><strong>Producer</strong></th>
<th>Produced by The Cochrane Consumers and Communication Review Group (coordinated from La Trobe University, Australia). Part of the Cochrane Library: <a href="http://www.thecochranelibrary.com/view/0/index.html">http://www.thecochranelibrary.com/view/0/index.html</a></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider(s)</strong></td>
<td>The Cochrane Collaboration with Wiley InterScience</td>
</tr>
<tr>
<td><strong>Open access?</strong></td>
<td>Depends – The Cochrane Library is available on subscription, but a number of countries have national provisions for free access. Freely available for users in the UK – through funding from the NHS. Information for other countries: <a href="http://www.thecochranelibrary.com/view/0/FreeAccess.html">http://www.thecochranelibrary.com/view/0/FreeAccess.html</a></td>
</tr>
<tr>
<td><strong>Subject scope</strong></td>
<td>Reviews relevant to communication with and involvement of consumers of health care – interventions which affect people’s interactions with healthcare professionals, services and researchers. Includes diverse interventions that may seek to educate, communicate with, inform, support, involve and seek the participation of consumers of health care. The interventions may relate to individual use of healthcare services, or to consumer participation in health planning, policy and research.</td>
</tr>
<tr>
<td><strong>Bibliographic or full text?</strong></td>
<td>See Open access? above</td>
</tr>
<tr>
<td><strong>Strength of evidence criteria?</strong></td>
<td>Very strict – as with any Cochrane systematic review</td>
</tr>
<tr>
<td><strong>Publications types</strong></td>
<td>Systematic reviews and protocols</td>
</tr>
<tr>
<td><strong>Years</strong></td>
<td>First review of the group from 1999. Searches for primary studies for the reviews generally go back to start dates of relevant databases.</td>
</tr>
<tr>
<td><strong>Size</strong></td>
<td>38 reviews and 24 protocols (Jan 12) The Cochrane Database of Systematic Reviews (the part of the Cochrane Library where the reviews of the group are deposited) is updated every month. Reviews of the group tend to be updated every three years.</td>
</tr>
<tr>
<td><strong>Sources</strong></td>
<td>All reviews and protocols of the Consumers and Communication Review Group</td>
</tr>
<tr>
<td><strong>Languages and regions</strong></td>
<td>Reviews are in English, but coverage of primary articles aims to be comprehensive.</td>
</tr>
<tr>
<td><strong>Classification system/thesaurus</strong></td>
<td>Not as such, although a simple classification is used to group the reviews.</td>
</tr>
<tr>
<td><strong>Coverage of values issues – impressions</strong></td>
<td>A small range of issues, but important practical implications. Rigorous search strategies which can be used in conjunction with suggestions from this manual. The traditional systematic review methodology, however, has some important limitations in relation to studies on values – levelling out of differences, and criteria of scientific rigour that are unfavourable to the majority of research on values.</td>
</tr>
<tr>
<td><strong>Knowledge gaps from a values searcher’s perspective</strong></td>
<td>No particular issues</td>
</tr>
</tbody>
</table>
| **Sources of this/further information** | [http://www.latrobe.edu.au/chcp/cochrane/index.html](http://www.latrobe.edu.au/chcp/cochrane/index.html) and subpages  
[http://www.cochrane.org/index.htm](http://www.cochrane.org/index.htm) and subpages  
The Group’s editorial office |
| **Search guides/tutorials** | Straightforward to search |
| **‘Featured features’** | The reviews under *Interventions for communication exchange between providers and consumers* (as per the categories on [http://www.latrobe.edu.au/chcp/cochrane/reviews.html](http://www.latrobe.edu.au/chcp/cochrane/reviews.html)). |
| **Contact details** | cochrane@latrobe.edu.au |
Ethnicity and Health Specialist Collection

NB: As was the case with the Patient and Public Involvement Specialist Collection above, this database is now included in NHS Evidence where it can no longer be browsed but only searched. The information below is mostly from the time when the collection was browsable and had webpages of its own (it was extracted in 2009). We left this information to give you prompts for searches in the current format.¹

Currently (Jan 2012), important new evidence on topics within the remit of the former collection is included under Important New Evidence/Equality and Diversity:


However, the number of publications there is very limited. The remainder of the relevant evidence in incorporated into the generic NHS Evidence. A selection of publications is also accessible through the Centre for Evidence in Ethnicity, Health and Diversity (CEEHD) website: www.ethnic-health.co.uk.

If you feel this is a collection requiring greater visibility, you may provide feedback concerning the A-Z list of topics on NHS Evidence. The list is under development and feedback has been welcomed: https://www.evidence.nhs.uk/topics.

<table>
<thead>
<tr>
<th>Producer</th>
<th>Part of NHS Evidence (formerly National Library for Health), funded by the UK NHS (National Health Service), developed and managed by NICE (UK National Institute for Health and Clinical Excellence), and compiled by a team of the UK Centre for Evidence in Ethnicity, Health and Diversity.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider(s)</td>
<td>NHS Evidence</td>
</tr>
<tr>
<td>Subject scope</td>
<td>As per information when database was browsable: Diseases and conditions relevant to ethnic minorities Information on cultural, religious, dietary and demographic variations in health and health behaviours</td>
</tr>
</tbody>
</table>

¹ The rethinking of the Collection’s format and contents has also resulted in most of its records being re-indexed as Equality and Diversity rather than Ethnicity and Health. With such a focus the Collection will most likely belong to 3.2.1.1. Databases that cover exclusively or primarily topics concerning health-related values rather than to the current category of more mixed contents (in the original collection, a substantial part of the ethnicity documents concerned biomedical characteristics associated with different ethnic groups rather than their health beliefs, values, perceptions, etc.). At the same time, the database practically no longer exists and need not be included at all.

We will include a table on NHS Evidence and suggest keywords for Patient and Public Involvement, Equality and Diversity and other relevant subtopics in a future version of the Manual. In the meantime, we will leave information about the original collections to raise awareness of the issues they covered and information on which continues to be added.
<table>
<thead>
<tr>
<th><strong>Open access?</strong></th>
<th>Yes, although some of the full texts may be on paid-for websites.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bibliographic or full text?</strong></td>
<td>Combined. Depends on availability and access to full text.</td>
</tr>
<tr>
<td><strong>Strength of evidence criteria?</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Publications types</strong></td>
<td>As per information when database was browsable:</td>
</tr>
<tr>
<td></td>
<td>Synopses, systematic reviews and other high quality research studies</td>
</tr>
<tr>
<td></td>
<td>Nationally recognised clinical guidelines and international guidelines (if no suitable UK ones)</td>
</tr>
<tr>
<td></td>
<td>National standards, health policies and strategies</td>
</tr>
<tr>
<td></td>
<td>‘Best practice’ examples</td>
</tr>
<tr>
<td></td>
<td>Statistical data</td>
</tr>
<tr>
<td></td>
<td>Qualitative data</td>
</tr>
<tr>
<td></td>
<td>Guidance on ‘Ethnic Monitoring’ and use of ‘ethnicity’ data</td>
</tr>
<tr>
<td></td>
<td>Patient information for minority ethnic users</td>
</tr>
<tr>
<td></td>
<td>Education/Continued Professional Development sources</td>
</tr>
<tr>
<td></td>
<td>Information about organisations with a specific interest in ethnicity and cultural diversity</td>
</tr>
<tr>
<td><strong>Years</strong></td>
<td>Since the late 1990s, with most of the material since 2008-9</td>
</tr>
<tr>
<td><strong>Size</strong></td>
<td>Over 4,000 records indexed as Equality and Diversity which is, however, much broader than the original remit of the Ethnicity and Health Specialist Collection (Jan 2012 data).</td>
</tr>
<tr>
<td><strong>Sources</strong></td>
<td>Systematic searching of approved databases and websites; postings on other Specialist Collections from the NHS Evidence Health Information Resources; discussion lists of the UK Centre for Evidence in Ethnicity, Health and Diversity; recommendation by the Project Team and Editorial Panel, Reference Groups and users of the collection; contacts with key researchers.</td>
</tr>
<tr>
<td></td>
<td>Approx. 250 core sources for Equality and Diversity, along with all other sources searched for the needs of NHS Evidence.</td>
</tr>
<tr>
<td><strong>Languages and regions</strong></td>
<td>English</td>
</tr>
<tr>
<td><strong>Classification system/thesaurus</strong></td>
<td>No specific classification system or browsable thesaurus. Records indexed with ethnicity terms drawn from SNOMED (the Systematized Nomenclature of Medicine collection of terms).</td>
</tr>
<tr>
<td>Coverage of values issues – impressions</td>
<td>Little experience with this collection</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Knowledge gaps from a values searcher’s perspective</td>
<td>Little experience with this collection</td>
</tr>
<tr>
<td>Sources of this/further information</td>
<td><a href="http://www.library.nhs.uk/ethnicity/page.aspx?pagename=CD">http://www.library.nhs.uk/ethnicity/page.aspx?pagename=CD</a> and related pages (link no longer live, used in 2009)</td>
</tr>
<tr>
<td></td>
<td>The team of the UK Centre for Evidence in Ethnicity, Health and Diversity</td>
</tr>
<tr>
<td>Search guides/tutorials</td>
<td>Straightforward to search.</td>
</tr>
<tr>
<td>‘Featured features’</td>
<td>The <em>Language and Communication</em> subset of records (under <em>Cultural Competence</em> in left-hand navigation) – again, no longer browsable</td>
</tr>
<tr>
<td>Contact details</td>
<td><a href="mailto:sleh@dmu.ac.uk">sleh@dmu.ac.uk</a> (of the team identifying and appraising the resources)</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.evidence.nhs.uk/contact-us">http://www.evidence.nhs.uk/contact-us</a></td>
</tr>
</tbody>
</table>
3.2.1.3. **General medical and health databases**

| | MEDLINE®
Medical Literature Analysis and Retrieval System Online | EMBASE
The Excerpta Medica Database |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Producer</strong></td>
<td>The US National Library of Medicine</td>
<td>Elsevier</td>
</tr>
<tr>
<td><strong>Provider(s)</strong></td>
<td>Provided freely through PubMed. Other providers include: Ovid, Elsevier, EbscoHost, DIALOG/DataStar, Lexis-Nexis, OCLC, ISI Web of Knowledge, etc.</td>
<td>Elsevier, DataStar, DIALOG, DIMDI, EBSCO, Ovid, ProQuest, STN</td>
</tr>
</tbody>
</table>
| **Subject scope** | *In summary:* Life sciences, concentration on biomedicine  
*In detail:* Biomedicine and health, broadly defined to encompass those areas of the life sciences, behavioural sciences, chemical sciences and bioengineering needed by health professionals and others engaged in basic research, clinical care, public health, health policy development and related educational activities. Also covers life sciences, including aspects of biology, environmental science, marine biology, plant and animal science as well as biophysics and chemistry. | *In summary:* broad biomedical scope. Particularly strong on drug and pharmaceutical research.  
*In detail:* Drug therapy and research, Clinical and experimental medicine, Basic biological science relevant to human medicine, Biotechnology and biomedical engineering, Health policy and management, Public, occupational and environmental health, Psychiatry and mental health, Forensic science, Alternative and complementary medicine |
| **Open access?** | Yes – through PubMed  
No – through other providers | No |
<table>
<thead>
<tr>
<th><strong>Bibliographic or full text?</strong></th>
<th><strong>MEDLINE®</strong> Medical Literature Analysis and Retrieval System Online</th>
<th><strong>EMBASE</strong> The Excerpta Medica Database</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bibliographic. Providers tend to offer links to full texts where available.</td>
<td>Bibliographic</td>
<td>Bibliographic</td>
</tr>
<tr>
<td><strong>Strength of evidence criteria?</strong></td>
<td>No (apart from indexing almost exclusively peer-reviewed journals)</td>
<td>No (apart from indexing almost exclusively peer-reviewed journals)</td>
</tr>
<tr>
<td><strong>Publication types</strong></td>
<td>Mainly scholarly journals; a small number of newspapers, magazines and newsletters</td>
<td>Scholarly journals; since 2009 – conference abstracts</td>
</tr>
<tr>
<td><strong>Years</strong></td>
<td>Since 1946, with some older material</td>
<td>Since 1947</td>
</tr>
<tr>
<td><strong>Size</strong></td>
<td>Over 19 million references 2,000 – 4,000 completed references added each day.</td>
<td>Over 24 million – including all MEDLINE references Currently over 1 million records added annually.</td>
</tr>
<tr>
<td><strong>Sources</strong></td>
<td>Approximately 5,600 journals</td>
<td>Over 7,600 active peer-reviewed journals. Nearly 2,000 unique compared with MEDLINE</td>
</tr>
<tr>
<td><strong>Languages and regions</strong></td>
<td>39 languages (60 for older journals)</td>
<td>40 languages, 90 countries The Embase interface is in five languages apart from English (Spanish, French, German, Chinese and Japanese)</td>
</tr>
<tr>
<td><strong>Classification system/thesaurus</strong></td>
<td>Medical Subject Headings (MeSH), updated yearly. 11-level hierarchy; 26,142 descriptors in the 2011 MeSH. Over 177,000 entry terms assisting in finding the appropriate</td>
<td>Emtree, Elsevier’s Life Science thesaurus, updated yearly. Up to 12 levels; over 58,000 preferred terms. Over 240,000 synonyms. All MeSH terms are included.</td>
</tr>
</tbody>
</table>
| **Classification system/thesaurus** | **MEDLINE®**  
Medical Literature Analysis and Retrieval System Online | **EMBASE**  
The Excerpta Medica Database |
|---|---|
| MeSH. MeSH terms can be searched and browsed at: [http://www.nlm.nih.gov/mesh/meshhome.html](http://www.nlm.nih.gov/mesh/meshhome.html)  
The branches under the following general categories (as per the 2012 tree structure) are worth browsing for values search terms:  
Anthropology, Education, Sociology and Social Phenomena (category I)  
Behavior and Behavior Mechanisms (F01 under Psychiatry and Psychology, category F)  
Health Care Facilities, Manpower, and Services (N02 under Health Care, category N)  
Health Care Quality, Access, and Evaluation (N05 under Health Care, category N)  
Health Services Administration (N04 under Health Care, category N)  
Humanities (category K)  
Persons (M01 under Named Persons, category M)  
Psychological Phenomena and Processes (F02 under Psychiatry and Psychology, category F)  
(on the MeSH browser page: [http://www.nlm.nih.gov/mesh/MBrowser.html](http://www.nlm.nih.gov/mesh/MBrowser.html), choose Navigate from tree-top button) | To browse in Ovid, you can enter Emtree thesaurus in the search field which appears under Search Tools and having chosen the option Thesaurus from the box next to the search field.  
There are five main ‘facets’ (as they are called in Emtree) that are worth browsing for relevant values search terms:  
Facet F: Psychological and Psychiatric Phenomena  
Facet I: Society and Environment  
Facet L: Groups by Age and Sex  
Facet M: Named Groups of Persons (ethnic, racial and religious groups can be found here)  
Facet Q: Biomedical Disciplines, Science and Art (Humanities, Anthropology, etc. listed here) |
| **Coverage of values issues – impressions** | Rough estimates suggest that 5-10% of the records on MEDLINE address ‘values’ in the broad sense used here (estimates based on samples from our work)  
Highly comprehensive database. In our experience, it includes virtually all values topics and issues (not all studies) that we have identified through searching across a wide range of | Limited experience with this database |
| **Coverage of values issues – impressions** | **MEDLINE**  
Medical Literature Analysis and Retrieval System Online | **EMBASE**  
The Excerpta Medica Database |
|------------------------------------------|------------------------------------------------|----------------------------------|
| databases (2000 – 2009). Its focus on medicine and healthcare ensures higher practical relevance of records in comparison to that of the social sciences databases.  
A large number of false positives – requires sophisticated search strategies. | | |

| **Knowledge gaps from a values searcher’s perspective** | **MEDLINE**  
Medical Literature Analysis and Retrieval System Online | **EMBASE**  
The Excerpta Medica Database |
|----------------------------------------------------------|------------------------------------------------|----------------------------------|
| The degree and main areas of overlap with other databases indexing values material in unclear.  
The extent to which the MeSH vocabulary adequately represents topics from the values range requires further research.  
The extent to which values aspects of studies are noticed and accurately annotated by indexers also requires further research. Our impressions so far are that this is suboptimal. | | Limited experience with this database |

| **Which is better for values research?** | **MEDLINE**  
Medical Literature Analysis and Retrieval System Online | **EMBASE**  
The Excerpta Medica Database |
|------------------------------------------|------------------------------------------------|----------------------------------|
| Embase encompasses the records of MEDLINE. Research is needed, however, on the extent to which the Embase-only journals tend to address values issues or otherwise.  
The records on Embase are indexed using Emtree, which means that findings about MeSH terms in this manual will have limitations when applied to Embase (MeSH terms, however, are part of the wider Emtree thesaurus). | | |
| Sources of this/further information | MEDLINE®
Medical Literature Analysis and Retrieval System Online | EMBASE
The Excerpta Medica Database |
|-----------------------------------|------------------------------------------------------|-------------------------------------------------|

<table>
<thead>
<tr>
<th>Search guides/tutorials</th>
<th>PubMed tutorials can be found at:</th>
<th><a href="http://trainingdesk.elsevier.com/embase">http://trainingdesk.elsevier.com/embase</a></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="http://www.nlm.nih.gov/bsd/disted/pubmed.html">http://www.nlm.nih.gov/bsd/disted/pubmed.html</a></td>
<td><a href="http://info.embase.com/user_support/online_classes.shtml">http://info.embase.com/user_support/online_classes.shtml</a> - to set up online classes for groups interested in EMBASE.</td>
</tr>
<tr>
<td></td>
<td>If you are using a different interface, find the tutorial offered by your provider, as it will be better suited to the specifics of that particular interface. The PubMed tutorial is still well worth accessing, however, for detailed background information on MEDLINE.</td>
<td>If you are not using the Elsevier interface (for which the tools above have been developed), find the tutorial developed by your provider, as it is best suited to the interface they are offering.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>‘Featured features’</th>
<th>The MeSH database feature of PubMed allowing you to search and browse the controlled vocabulary of MEDLINE and to adjust your searches in accordance with it:</th>
<th>Limited experience with the database.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDLINE®</strong>&lt;br&gt;Medical Literature Analysis and Retrieval System Online</td>
<td><strong>EMBASE</strong>&lt;br&gt;The Excerpta Medica Database</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>‘Featured features’</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The <em>My NCBI</em> feature of PubMed – very rich in functionalities personal web space on PubMed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contact details</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="mailto:custserv@nlm.nih.gov">custserv@nlm.nih.gov</a></td>
<td><a href="http://embase.com/info/contact-us">http://embase.com/info/contact-us</a></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.nlm.nih.gov/mesh/meshsugg.html">http://www.nlm.nih.gov/mesh/meshsugg.html</a> – for suggestions for MeSH terms</td>
<td>If you are using OVID, the form you fill in from the ‘Ask a Librarian’ option, will be sent to your institutional librarian.</td>
<td></td>
</tr>
<tr>
<td>If you are using OVID, the form you fill in from the ‘Ask a Librarian’ option, will be sent to your institutional librarian.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 3.2.1.4. Nursing and allied health literature databases

**CINAHL (The Cumulative Index to Nursing and Allied Health Literature)**

(Cinahl has four versions, two of them containing full texts. Information below concerns the main database – “The Cinahl database”)

<table>
<thead>
<tr>
<th><strong>Producer</strong></th>
<th>EBSCO Publishing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider(s)</strong></td>
<td>EBSCO only</td>
</tr>
<tr>
<td><strong>Subject scope</strong></td>
<td>Major areas:</td>
</tr>
<tr>
<td></td>
<td>nursing</td>
</tr>
<tr>
<td></td>
<td>biomedicine</td>
</tr>
<tr>
<td></td>
<td>health sciences librarianship</td>
</tr>
<tr>
<td></td>
<td>alternative/complementary medicine</td>
</tr>
<tr>
<td></td>
<td>consumer health</td>
</tr>
<tr>
<td></td>
<td>17 allied health disciplines</td>
</tr>
<tr>
<td><strong>Open access?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Bibliographic or full text?</strong></td>
<td>Primarily bibliographic, with some full text records (completely full text versions of Cinahl also available).</td>
</tr>
<tr>
<td><strong>Strength of evidence criteria?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Publications types</strong></td>
<td>Primarily journals, but also health care books and book chapters, nursing dissertations, conference proceedings, standards of practice, educational software, audio-visuals.</td>
</tr>
<tr>
<td><strong>Years</strong></td>
<td>From 1981 to the present</td>
</tr>
<tr>
<td><strong>Size</strong></td>
<td>More than 2,3 million records (Jan 2012)</td>
</tr>
<tr>
<td><strong>Sources</strong></td>
<td>Over 3,000 journals indexed</td>
</tr>
<tr>
<td></td>
<td>71 full-text journals</td>
</tr>
<tr>
<td><strong>Languages and regions</strong></td>
<td>English, selected foreign language journals</td>
</tr>
</tbody>
</table>
### Classification system/thesaurus
12,714 Cinahl subject headings, following the structure of MeSH. Also includes MeSH terms.

### Coverage of values issues – impressions
Much of the nursing and nursing methodology literature can be considered ‘values literature’.

### Knowledge gaps from a values searcher’s perspective
What are the relevant Cinahl thesaurus terms that are different to the values MeSH in MEDLINE?
Cinahl has been identified as the best database for searching for qualitative health research, by far outperforming MEDLINE, EMBASE, PsycINFO, British Nursing Index, Social Sciences Citation Index and ASSIA (FLEMMING, K. & BRIGGS, M. (2007) Electronic searching to locate qualitative research: evaluation of three strategies. *J Adv Nurs*, 57, 95-100). This makes it a research priority to explore Cinahl’s potential as a first choice database for identifying values research.

### Sources of this/further information

### Search guides/tutorials
- [http://support.ebsco.com/Cinahl/documentation.php](http://support.ebsco.com/Cinahl/documentation.php) – help sheets and user guides
- [http://support.ebsco.com/training/tutorials.php](http://support.ebsco.com/training/tutorials.php) – tutorials
- [http://www2.ebsco.com/en-us/app/training/Pages/TrainingForm.aspx](http://www2.ebsco.com/en-us/app/training/Pages/TrainingForm.aspx) – opportunity to sign up for online training

### ‘Featured features’
Limited experience with database

### Contact details
Cinahl provides support in: search strategy hints, search formulation, subject searching, subject vs. keyword searching, limiting/modifying searches, etc.
<table>
<thead>
<tr>
<th><strong>PsycINFO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Producer</strong></td>
</tr>
<tr>
<td><strong>Provider(s)</strong></td>
</tr>
<tr>
<td><strong>Subject scope</strong></td>
</tr>
<tr>
<td><strong>Open access?</strong></td>
</tr>
<tr>
<td><strong>Bibliographic or full text?</strong></td>
</tr>
<tr>
<td><strong>Strength of evidence criteria?</strong></td>
</tr>
<tr>
<td><strong>Publication types</strong></td>
</tr>
<tr>
<td><strong>Years</strong></td>
</tr>
<tr>
<td><strong>Size</strong></td>
</tr>
<tr>
<td><strong>Sources</strong></td>
</tr>
<tr>
<td><strong>Languages and regions</strong></td>
</tr>
<tr>
<td>Classification system/thesaurus</td>
</tr>
<tr>
<td>---------------------------------</td>
</tr>
<tr>
<td>Coverage of values issues – impressions</td>
</tr>
<tr>
<td>Knowledge gaps from a values searcher’s perspective</td>
</tr>
</tbody>
</table>
| Sources of this/further information | [http://www.apa.org/psycinfo/](http://www.apa.org/psycinfo/)  
| ‘Featured features’ | Searching with PsycINFO’s classification codes: [http://www.apa.org/databases/training/classcodes.html](http://www.apa.org/databases/training/classcodes.html) |
| Contact details | psycinfo@apa.org – general information |
3.2.2. Health-related databases with a more specific thematic coverage and broader focus, not restricted to research

Depending on your search area, you may need to add databases with a special focus, e.g. health policy, health management, medical education, medical law, alternative and complementary medicine, occupational health, grey literature databases, etc. We are currently working on developing this section. See Box 3.1 at the end of this chapter for suggestions on how to identify databases.

3.2.3. Research-focused databases where health is one of many subject areas covered

3.2.3.1. Social sciences databases

<table>
<thead>
<tr>
<th>Producer</th>
<th>ASSIA (Applied Social Sciences Index and Abstracts)</th>
<th>IBSS (International Bibliography of the Social Sciences)</th>
<th>SA (Sociological Abstracts)</th>
<th>SSA (Social Services Abstracts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ProQuest</td>
<td>ProQuest</td>
<td>ProQuest</td>
<td>ProQuest</td>
<td>ProQuest</td>
</tr>
<tr>
<td></td>
<td>ProQuest (all)</td>
<td>Until recently – produced by the London School of Economics and Political Science (LSE) and jointly funded by the UK Economic and Social Research Council (ESRC) and the LSE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject scope</td>
<td>ASSIA (Applied Social Sciences Index and Abstracts)</td>
<td>IBSS (International Bibliography of the Social Sciences)</td>
<td>SA (Sociological Abstracts)</td>
<td>SSA (Social Services Abstracts)</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>-----------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td><strong>Subject coverage</strong></td>
<td>Aim – to cover the information needs of the caring professions. Subject coverage includes: Health Social services Psychology Sociology Economics Politics Race relations Education.</td>
<td>Aim – to provide wide coverage of high quality social science research carried out in and about all parts of the world. Subject coverage includes: Anthropology Archaeology Cultural studies Demography Economics Education Ethnology and ethnography Political science Religious studies Sociology. Selected additional interdisciplinary material.</td>
<td>Aim – to offer access to the international literature in sociology and related disciplines in the social and behavioural sciences. Subject coverage includes: Culture and social structure Family and marriage History and theory of sociology Organizational sociology Political sociology Poverty and homelessness Race and ethnicity Social change and economic development Social control Sociology of health and medicine Sociology of education.</td>
<td>Aim – to enable access to relevant and timely research in social services fields and areas of study. Subject coverage includes: Community and mental health services Crisis intervention The family and social welfare Gerontology Poverty and homelessness Professional issues in social work Social and health policy Social services in addiction Social work education Social work practice Support groups/networks Violence, abuse, neglect Welfare services.</td>
</tr>
<tr>
<td><strong>Which aspects of health and medicine?</strong></td>
<td>Health care: policy, professions and practices. Strong coverage of disability, geriatrics, mental health, nursing and midwifery, psychology and substance abuse. Health aspects of social problems and issues (e.g. crime, ethnicity, discrimination, migration, sexuality, etc.)</td>
<td>Health policy, sociology of health and illness, medical anthropology, health economics, health and development</td>
<td>Sociology of health and medicine, social psychiatry (mental health), substance use/abuse, compulsive behaviours</td>
<td>Health care promotion/education, health policy, addiction, mental and physical disabilities, mental and emotional health problems</td>
</tr>
<tr>
<td></td>
<td>ASSIA (Applied Social Sciences Index and Abstracts)</td>
<td>IBSS (International Bibliography of the Social Sciences)</td>
<td>SA (Sociological Abstracts)</td>
<td>SSA (Social Services Abstracts)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>-----------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td><strong>Open access?</strong></td>
<td>No</td>
<td>No. In the UK, access funded by the ESRC for higher and further education institutions, ESRC-recognised research institutes and government departments.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Bibliographic or full text?</strong></td>
<td>Bibliographic (all)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Strength of evidence criteria?</strong></td>
<td>No, but the majority of titles are from peer-reviewed journals.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Publications types</strong></td>
<td>Journal articles – 99.99% Dissertations – 0.01% (Jan 2012)</td>
<td>Journal articles – 63% Reviews – 19% Books and book chapters – 18% Conference papers &lt;0.1% (Jan 2012)</td>
<td>Journal articles – 73% Reviews – 17% Books and book chapters – 18% Conference papers &lt;0.1% (Jan 2012)</td>
<td>Journal articles – 87% Reviews – 9% Dissertations – 3.8% Conference papers &lt;0.1% (Jan 2012)</td>
</tr>
<tr>
<td><strong>Size, total</strong></td>
<td>Over 524,000 records (Jan 2012)</td>
<td>Over 2.8 million records (Jan 2012)</td>
<td>Over 941,900 records (Jan 2012)</td>
<td>Over 153,500 records (Jan 2012)</td>
</tr>
<tr>
<td></td>
<td>ASSIA <em>(Applied Social Sciences Index and Abstracts)</em></td>
<td>IBSS <em>(International Bibliography of the Social Sciences)</em></td>
<td>SA <em>(Sociological Abstracts)</em></td>
<td>SSA <em>(Social Services Abstracts)</em></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>-----------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td><strong>Size, health</strong></td>
<td>Approx. 55,000 (count excludes related areas like psychology and substance abuse)</td>
<td>Approx. 100,000</td>
<td>Approx. 80,000</td>
<td>Approx. 50,000</td>
</tr>
<tr>
<td><strong>Sources, total</strong></td>
<td>Over 500 journals</td>
<td>Over 2,800 journals. Further 1,415 journals which are no longer being published. Approx. 7,000 books included each year.</td>
<td>Approx. 1,915 serials</td>
<td>Over 1,300 serials</td>
</tr>
<tr>
<td><strong>Sources, health</strong> <em>(only indicative – non-health focused journals also return relevant titles)</em></td>
<td>Approx. 200 journals with a primary focus on health (overlap of journals smallest between ASSIA and IBSS)</td>
<td>Approx. 130 journals</td>
<td>Approx. 190 journals (overlap of journals largest between SA and SSA)</td>
<td>Approx. 200 journals</td>
</tr>
<tr>
<td><strong>Languages and regions</strong></td>
<td>16 countries. Majority of articles are from the United Kingdom (~46%) and US (~43%). Almost all records are English language records.</td>
<td>Records from over 100 countries and in 60 languages. Over 50% of the journals covered published outside the US or UK. Main languages: English, French, German, Spanish, Italian and Russian. 25% of references since 1990s in languages other than English.</td>
<td>North America: 60% Western Europe: 31% Eastern Europe: 4% Asia, Middle East and Africa: 3% Australia and New Zealand: 1% South and Central America: 1% (2008 data)</td>
<td>50 countries, more than 20 languages</td>
</tr>
<tr>
<td>Languages and regions, health</td>
<td>ASSIA (Applied Social Sciences Index and Abstracts)</td>
<td>IBSS (International Bibliography of the Social Sciences)</td>
<td>SA (Sociological Abstracts)</td>
<td>SSA (Social Services Abstracts)</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------------------------</td>
<td>-------------------------------------------------------</td>
<td>---------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>84 of the health journals from the UK, 60 from the US. Other countries include the Netherlands, Australia, Canada, Sweden, Ireland, India, Bangladesh and Spain.</td>
<td>50% of the health titles are from the UK, US – 14%, the Netherlands – 7%, other Europe –18%. A small number of health journals from Canada, Australia, China, India, Colombia, South Africa, Zimbabwe and Israel.</td>
<td>45% of journals with a health focus are from the UK, US – 28%, the Netherlands – 8%, other Europe – 7.5%, Australia – 2.5%, Canada – 2%, Africa –2%. A small number of journals from Brazil, China, India and Jamaica.</td>
<td>Percentages quite similar to SA</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Classification system/thesaurus</th>
<th>ASSIA Thesaurus – over 18,000 terms</th>
<th>IBSS thesaurus – around 8,000 subject terms</th>
<th>Thesaurus of Sociological Indexing Terms (6th edition, in English, with beta versions in Spanish and French)</th>
<th>Thesaurus of Sociological Indexing Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Classification codes – 123 broad areas of sociology</td>
<td>Classification codes – 26 broad areas</td>
</tr>
</tbody>
</table>

| Coverage of values issues – impressions | Limited experience with these databases |

| Knowledge gaps from a values searcher’s perspective | What proportion of the health and medical records on social sciences databases are not indexed on standard medical and health databases? What issues do they address? How do the four databases compare in terms of specific health-related topics? What are effective thesaurus terms for searches on health-related values? |

<p>| Which is best for values research? | Needs to be researched. |</p>
<table>
<thead>
<tr>
<th>Databases and other sources of values materials</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sources of this/further information</strong></td>
</tr>
<tr>
<td>Advice from ProQuest staff</td>
</tr>
<tr>
<td>Advice from ProQuest staff</td>
</tr>
<tr>
<td>Advice from ProQuest staff</td>
</tr>
<tr>
<td>Advice from ProQuest staff</td>
</tr>
<tr>
<td><strong>Search guides/tutorials</strong></td>
</tr>
<tr>
<td>Extensive advice for searching ProQuest databases under Help</td>
</tr>
<tr>
<td><strong>‘Featured features’</strong></td>
</tr>
<tr>
<td>Figure and Table searching (available on the other ProQuest databases, too)</td>
</tr>
<tr>
<td>Limited experience with this database</td>
</tr>
<tr>
<td>Searching the Thesaurus of Sociological Indexing Terms for ‘values’ retrieves a rich set of related terms.</td>
</tr>
<tr>
<td><strong>Contact details</strong></td>
</tr>
<tr>
<td><a href="http://www.proquest.co.uk/en-UK/support/contact.shtml">http://www.proquest.co.uk/en-UK/support/contact.shtml</a></td>
</tr>
<tr>
<td><a href="mailto:support@proquest.co.uk">support@proquest.co.uk</a></td>
</tr>
</tbody>
</table>
3.2.3.2. Humanities databases

The Philosopher’s Index may be an appropriate source if you are looking for theoretical research on values, for instance to help you clarify definitions and operationalisations in a health research context.

Medical humanities resources are suggested further below. To identify other generic humanities databases, see suggestions in Box 3.1 at the end of this chapter.

3.2.3.3. Research-focused grey literature databases

Our experience with grey literature databases is still relatively limited. The main research-focused grey literature databases we have been searching are databases indexing dissertations and theses (such as Dissertations & Theses, Index to Theses, ETHOS – Electronic Theses Online Delivery Service) and conference proceedings (such as Conference Papers Index, Papers First, Proceedings First and Conference Proceedings Citation Index). OpenGrey is a recent partnership providing open access to over 700,000 references to grey literature produced in Europe (it incorporates the SIGLE database, which has been used frequently as a grey literature source in systematic reviews). Again, consult Box 3.1 on identifying further resources.

3.2.4. Medical humanities resources

The medical humanities fall at the intersection between the humanities, the arts and research. Some of the materials in such databases are works of art (or references to such), which can take various formats (texts, visual images, film references, etc.). Others are research studies in areas such as: the history of medicine; medical ethics; the intersection between medicine and religion; the effect of literature and the arts on coping with illness and disability; the mechanisms through which literature and the arts exercise their healing powers; the contribution of the medical humanities to medical education, etc. Below are several examples of medical humanities resources. So far, we have not performed an extensive search in this field and suggestions for further resources will be very welcome.

The Wellcome Collection is an impressive collection of materials on the history of medicine and includes books, manuscripts, archives, films and pictures on the history of medicine from the earliest times to the present day:
http://library.wellcome.ac.uk/index.html

Medical Humanities Resource Database of University College London:
http://www.mhrd.ucl.ac.uk/

The Literature, Arts, & Medicine Database of New York University:
http://litmed.med.nyu.edu/Main?action=aboutDB – the database contains annotated multimedia listings of prose, poetry, film, video and art.
3.2.5. Sources of ‘alternative’ materials

3.2.5.1. Sources of personal narratives

Below are examples of databases for personal narratives containing pre-selected and annotated materials:

**Healthtalkonline and Youthhealthtalk** – audio, visual, and text files on personal experiences of over 2,000 people with regard to over 60 health-related conditions and illnesses:
http://www.healthtalkonline.org/
http://www.youthhealthtalk.org/

**The PRIME Patient Experience Database** – experiences of people with ME/CFS (Chronic Fatigue Syndrome):

In a less organised form, the web is an inexhaustible source of narratives on personal experiences of illness and health. These can be found on blogs and social networking sites; forums and discussion groups; YouTube videos and i-casts, etc. The websites of patients’ organisations and medical charities are often an excellent source of personal stories, too. The availability of such unfathomable sources of material is probably the reason why dedicated patient experiences websites are only a few. There are, however, ethical issues involved if personal narratives posted outside such dedicated sites are used for research purposes. Whitehead, 2007 offers a very helpful introductory paper (see references at the end).

**International Alliance of Patients’ Organisations** – this is not a database of personal narratives, but a good starting point to exploring websites of patients’ organisations, which often contain personal narratives or may facilitate contact with individuals willing to share their stories:
http://www.patientsorganizations.org/index.pl

A similar source of information for bioethics organisations is the **International Bioethics Organizations Database**:
http://bioethics.georgetown.edu/databases/organizations/index.html

3.2.5.2. Literature and arts databases

This section is intended to cover literature and arts databases which are not health-specific (unlike the medical humanities databases listed under 3.2.4.). It will be extended if it turns out that such generic humanities resources can offer something over and above good medical humanities collections. The following database is an illustrative example:

**LION (Literature Online)** – contains works of English and American poetry, drama and prose (full texts of over 350,000 works), full text literature journals, and other key criticism and reference resources. Retrieves a substantial number of publications on health-related issues:
http://lion.chadwyck.co.uk/
3.2.5.3. Mass media collections

As with personal narratives, the mass media resources available on the internet are endless: virtually any newspaper, magazine, TV or radio channel has a web archive. A very important advantage of databases suggested below is that the materials on them are pre-selected and thus both varied and of a more manageable number. Such databases are an excellent source of information on, for instance, the prevalent social and cultural values concerning a certain medical condition or the attitudes towards people diagnosed with it. Access to them is subscription-based.

**British Humanities Index** – The BHI covers research in the humanities, as published in academic journals. It also indexes weekly magazines from the UK and other English-speaking countries, as well as quality UK newspapers.

**Periodicals Abstracts** – a general reference resource that contains indexes and abstracts to significant articles appearing in top general and academic periodicals, covering, for instance, academic topics of general interest, editorial materials, commentaries, etc.

**Television and Radio Index for Learning and Teaching** – TRILT is a comprehensive online listing of UK television and radio. The database is provided by The British Universities Film & Video Council (BUFVC) and the Society for Screen-based Learning. It is possible to obtain copies for teaching purposes of the materials indexed on it: [http://bufvc.ac.uk/tvandradio/trilt/](http://bufvc.ac.uk/tvandradio/trilt/)

**HERMES** is another service provided by BUFVC. The items on it are selected for their usefulness in higher and further education and cover films, videos, DVDs, slides, sound recordings, tape-slide packages, computer courseware and interactive multimedia: [http://bufvc.ac.uk/hermes/](http://bufvc.ac.uk/hermes/)

3.3. Searching under time and resource constraints – how many and which databases?

Ideally, your decisions on which databases to search should be supported by data on topic-specific overlap and unique coverage of databases. Such information, however, is very limited, and for values research is practically non-existent. Below are generic suggestions on how to make more informed choices about databases:

- You may run searches with a few classification codes of interest and compare the numbers retrieved – for instance, with the social sciences databases, try searching with health and illness codes, which are usually no more than four or five. (If you are not familiar with classification codes, see the *Quick guide* box to Chapter 4.)

- To explore the overlap and unique coverage of two or more (preferably smaller) databases, you may compare their journal titles lists. Usually, these can be found in Excel tables or lists on the producer’s web pages.

- You may try identifying research comparing the retrieval of different databases on a particular topic – by searching for various combinations of database names and your topic of interest, all in title (e.g. MEDLINE [ti] AND EMBASE (ti) AND “family medicine” [ti]). Bear in mind that such research is quite limited.

- The JISC Academic Database Assessment Tool at [http://www.jisc-ADAT.com/adat/home.pl](http://www.jisc-ADAT.com/adat/home.pl) is a user-friendly database comparison tool, but the depth of information it provides and the
number of participating providers is still limited. It has, however, evolved in recent years and may become more useful with time.

Ideally, your searches should cover a broad and varied range of resources. However, this needs to be balanced against practical constraints. Below are initial recommendations, based on our experience so far, on how to select databases for values searches when time and resources are minimal.

If you are interested in a narrow values topic, it is likely that there will be a discipline-specific database which is clearly most relevant (e.g. sociological, psychological, bioethical). To minimise bias, however, you should also consider:

- adding a very focused search in a generic database (using, for example, a small number of thesaurus terms as “major topics” – see Chapter 5);
- adding a ‘counterpoint’ database – by this we mean a database where your topic (or you) is not entirely ‘in its element’ but is still likely to be explored from an informative viewpoint. For instance, power differentials in the clinical encounter are most likely to be explored from a sociological perspective, and thus a sociological database is likely to be your primary choice. However, psychology too is interested in power relations and psychological databases are likely to hold highly relevant research. Having a counterpoint database in a small scale search will help you maintain a critical stance. It may also allow you to bring together ideas that are closely related but explored in isolation.

If you are interested in a general overview of values issues, our experience suggests that an in-depth search of a generic database (e.g. MEDLINE) will allow you to capture the major values topics and issues. The publications retrieved from generic medical and health databases are also more likely to have a vocabulary and emphases appropriate for a health professionals’ audience. For a short list of highly efficient search terms to use in MEDLINE, see Chapter 5.

You can add to this a condition-specific database or register (e.g. of cancer studies) and several key journals. Such a combination is likely to allow you to reach saturation of topics and issues. The PubMed Journal database at http://www.ncbi.nlm.nih.gov/journals?itool=sidebar is a good source for identifying relevant journals. You can also search for journals through ZETOC, a British Library service which enables browsing of over 20,000 journal titles.
Box 3.1.: How to search for databases

Although the number of authoritative, comprehensive and widely used databases in health and medicine (the likes of MEDLINE, Embase, Cinahl, PsycINFO) is relatively small, the world of specialised databases and collections is vast and constantly evolving. Below are some suggestions on identifying appropriate databases.

If you want to identify a list of authoritative databases, it is best to go through a number of Cochrane reviews exploring a topic from your area of interest.

If you would like to explore the wider world of databases, you may try browsing the catalogues of the major libraries in the world, such as the British Library (the latter, for instance, lists over 800 databases - http://www.bl.uk/eresources/main.shtml).

You can also run searches in library and information sciences databases (such as Library, Information Science & Technology Abstracts) and library and information sciences journals.

And, by all means, check the website of your institutional library and talk to your local librarian – they can be an invaluable source of information and support!

Examples of search terms you may want to try are: database, archive, repository, library, collection, index, catalogue, bibliography, digest, abstracts, sources ...
Key learning points

After working through this chapter, you should have …
  » become aware of the wide variety of databases containing values materials of different types (traditional research, but also ‘alternative’ materials). You should also have started to formulate criteria on the basis of which to select databases for your study.

Key references

Books and articles:

WHITEHEAD, L. C. (2007) Methodological and ethical issues in Internet-mediated research in the field of health: An integrated review of the literature. Soc Sci Med, 65, 782-791 – reviews issues concerning the use of materials available on the web which have not been posted for research purposes (such as personal narratives and group discussions – i.e. certain types of ‘alternative’ materials).

Websites:

http://www.nlm.nih.gov/bsd/disted/pubmedtutorial/ - link to the PubMed tutorial. In the process of teaching users how to search PubMed, the tutorial provides quite interesting and easy to understand information on how MEDLINE and databases more generally are compiled and structured and what automated and human processes are under way ‘below the surface’.

See individual tables for a range of database-specific references.

Key objectives of next chapter

» to suggest keywords and combinations of keywords that will allow you to enhance the sensitivity and precision of your searches.
What search terms to use?

CHAPTER 4

This chapter will ...

» list effective values search terms as identified through a word frequency analysis of 4,4400 citations on diabetes, obesity, dementia and schizophrenia;
» provide examples and suggest sources of values-related search filters;
» suggest indicators of likely low precision of values keywords.

The Quick guide to expected background knowledge box will ...
» clarify frequently used terms for search units and their properties;
» list popular graphical conventions used in more sophisticated searching — to help you understand the processes encoded in published search strategies;
» outline standard procedures for the generation of search terms.

Quick guide to expected background knowledge

Electronic databases and approaches to searching them have been developing at a remarkable speed in the last few years. As a result, the field of electronic database searching does not have a well established, standardised terminology. Relevant terms are also generally unfamiliar to non-specialists. Below we suggest some definitions and clarifications concerning search units and their properties, which will help you in acquiring the vocabulary and understanding of a competent user.

You will, however, be encountering differences in terminology as well as loose and imprecise usage. Clarify terms in your own writing. Good sources of definitions and explanations are the help pages of databases (e.g. PubMed Help), papers of the “Hedges” team of McMaster University (e.g. Haynes RB, 2005), review papers in library and information sciences journals (such as Journal of the Medical Library Association; Health information and libraries journal; Library & information science research), and the glossary of the Cochrane Collaboration (http://www.cochrane.org/resources/handbook/glossary.pdf).

Some basic concepts related to search units

thesaurus terms (also referred to as controlled vocabulary terms, preferred terms, index/indexing terms, descriptors ...) are pre-selected terms that are assigned to records in databases, catalogues, registers, etc. to indicate their main topics and publication type.

Advantages:
The use of controlled vocabulary terms helps to avoid two main problems: that different authors may use different words to refer to the same thing, and that many natural language terms (‘ordinary’ words, see below) have a wide range of uses and as a result generate a large number of false positives.
Disadvantages:
Thesaurus terms function well as search terms only to the extent to which they have been appropriately and consistently assigned. They may also be unintuitive and require a lengthier process of identification (e.g. through browsing database thesauri or analysing the indexing field of relevant articles).

Some further details:
Thesaurus terms tend to be database-specific (although smaller or specialised databases may prefer to use parts of comprehensive vocabularies such as MeSH, the controlled vocabulary developed by the National Library of Medicine, primarily for the indexing needs of MEDLINE).

Thesaurus terms are usually assigned by indexers who are experts in a particular thematic field, although automatic approaches are also used.

For most databases, you will be able to search or browse their thesauri online. The remaining ones are available in hard copies (see tables in Chapter 3 for information about database thesauri and classification systems).

MeSH (the thesaurus underpinning MEDLINE) and Emtree (the thesaurus underpinning Embase) are the most comprehensive, authoritative and regularly updated thesauri used in medical and health databases. You can find out more about them here:

http://www.elsevier.com/wps/find/bibliographicdatabasedescription.cws_home/707574/description#description
http://pbt.up2els.com/sites/default/files/MEDLINE%20in%20Embase_Whitepaper_2011_print.12May2011.pdf (for the ways in which MeSH indexing is mapped onto Emtree indexing, from the producers of Embase)

free text words (also referred to as text words or natural language terms) – these are ‘ordinary’ words that have not been sourced from an existing thesaurus.

Advantages:
Free text words can be used more flexibly than thesaurus terms by truncating them (e.g. use prefer* to capture preference, preferences, preferred, etc.), substituting variable letters with wildcards (e.g. priorit?e to retrieve prioritise and prioritize), doing proximity searches (searches looking for words within a close distance from one another), etc. Free text words are particularly helpful for identifying publications on new topics or research carried out before the introduction of a particular thesaurus term.

Disadvantages:
Free text words often produce a large number of false positives. Also, a large number of free text words is needed to capture the variability of vocabulary between authors and research traditions.

Some further details:
Some database search engines automatically map free text words onto thesaurus terms (on the basis of pre-existing indices that link these) in order to improve the performance of searches done by non-specialists. This may be the reason why you cannot find the word you have been searching with in some of the retrieved citations.
Free text words are invariably used to complement thesaurus terms in systematic review searches in order to overcome omissions of indexing.

**MeSH (Medical Subject Headings)** – Medical Subject Headings comprise the controlled vocabulary of biomedical terms of the US National Library of Medicine, producer of MEDLINE. A journal article in MEDLINE is typically assigned 10-12 MeSH, as specific as possible.

**subheadings** – subheadings are used with thesaurus terms to further qualify a topic. For example, an article discussing the legal aspects of *Personal Autonomy* will be indexed as *Personal Autonomy/legislation and jurisprudence*. In this example, *Personal Autonomy* is a subject heading (MeSH in MEDLINE) and *legislation and jurisprudence* is a subheading. Other examples of subheadings are: *diagnosis, therapy, prognosis, education, ethology, psychology, ethics*, etc. Subheadings can be thought of as indicating different perspectives towards the same topic, associated, for instance, with a particular profession or a phase in clinical decision making.

**classification codes** – numeric codes which correspond to larger thematic areas and which can be used directly for searching in some database interfaces. The following are examples from PsycINFO: 2930 *Culture and Ethnology*; 3040 *Social Perception and Cognition*; 3355 *Lay and Paraprofessional and Pastoral Counseling*. Classification codes are published on the web pages containing general information about the database you are using, and are sometimes available through the search interfaces providing access to it. See tables in Chapter 3 for links.

**search string, search query, search statement** – terms designating a search unit of unspecified length and content.

**search filter/optimal search strategy** – a predefined search strategy traditionally designed to retrieve high quality evidence (e.g. from randomised controlled trials, systematic reviews – also referred to as *methodological search filters, or hedges*) and/or evidence pertaining to one of the generic areas of clinical concern (diagnosis, prognosis, etc.). A review by Jenkins (Jenkins, 2004) suggests that at least eight synonyms for methodological search filters have been noted in the literature. Filters can be “thematic” too, but most of the effort in developing search filters has focused on methodological ones.

### Some popular notations and graphical markers

The following notations and graphical markers can help you recognise the type of term used in a published search strategy. These conventions vary across databases.

**Thesaurus terms may be indicated by:**

- capital letters (e.g. *Personal Autonomy*, rather than *personal autonomy*). Note, however, that this applies to subject headings and not subheadings. Subheadings tend start with small letters (*legislation and jurisprudence*);
- hyphens at the end of a term or between the words within a phrase (e.g. *Discrimination-*; *Nonverbal-Communication*);
- symbols indicating procedures that cannot be performed with free text words (such as explosions or selection of all subheadings, see below);
- the lack of indication that the term has been used as a free text word (e.g. is not followed by abbreviations such as *tw* or is not truncated, see below);
- MeSH terms are often indicated by [MeSH] or [mh] following the term in square brackets.
**Free text words:**

- are often truncated and/or contain a wildcard;
- are followed by an abbreviation such as .mp and .tw (see below);
- may be linked by operators indicating procedures that are not normally performed on thesaurus terms (e.g. searching for words that appear in close proximity within a text).

Below are some popular symbols from the syntax used by library and information specialists when searching electronic databases. You will need little of this syntax for standard database searching – most of the time you will be able to select the option you need by ticking a box. Knowing some of the most widely used symbols, however, will help you read published search strategies. The list below is partly based on [www.sign.ac.uk/methodology/filters.html](http://www.sign.ac.uk/methodology/filters.html) (a page of The Scottish Intercollegiate Guidelines Network). TT is used to stand for thesaurus term and FT for free text word. For further notations, check the tutorials and help pages of your provider. (Note that the full information on syntax may be available only to users with premium subscriptions.)

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>/</td>
<td>after TT</td>
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<tr>
<td>*</td>
<td>before TT</td>
</tr>
<tr>
<td>$</td>
<td>within or at the end of FT</td>
</tr>
<tr>
<td>?</td>
<td>within or at the end of FT</td>
</tr>
<tr>
<td>adj</td>
<td>between two FTs</td>
</tr>
<tr>
<td>exp</td>
<td>before TT</td>
</tr>
<tr>
<td>mp</td>
<td>after FT</td>
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<tr>
<td>pt</td>
<td>after TT</td>
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<tr>
<td>sh</td>
<td>after TT</td>
</tr>
<tr>
<td>tw</td>
<td>after FT</td>
</tr>
</tbody>
</table>
Performance measures

The following are brief definitions of the main parameters characterising the performance of a search term or search strategy. Again, the papers of the Hedges team of McMaster University (e.g. Haynes RB et al., 2005) and the glossary of the Cochrane collaboration manual (http://www.cochrane.org/resources/handbook/glossary.pdf) are good sources of further detail.

sensitivity – the number of relevant articles identified by a search as a proportion of the total number of known relevant articles (i.e. true positives from a particular search divided by total number of “cases”). Also referred to as recall. The assumption is that it is possible to know the total ‘population’ of relevant articles (usually a collection accumulated over a long period and through different methods is used as a reference number).

specificity – the number of irrelevant articles avoided by a search as a proportion of the total number of irrelevant articles (i.e. false positives from a particular search divided by total number of “non-cases”). Relatively rarely used to describe the performance of a search strategy; precision is preferred instead.

precision – the number of relevant articles identified by a search as a proportion of the total number of articles retrieved by that particular search (equivalent to positive predictive value in diagnostic test terminology).

accuracy – “the proportion of all articles that are correctly dealt with by the strategy (articles that met criteria and were retrieved plus articles that did not meet criteria and were not retrieved divided by all articles in the dataset)” – Haynes RB et al., 2005.

Generating search terms

Most of the standard approaches to generating and identifying search terms involve a strong subjective element. We list them briefly below, along with some more objective methods. Ideally, you should identify search strategies on your topic before getting down to developing a completely original search strategy on it. Even if available strategies do not meet your needs, you will be able to build on them and demonstrate a more rigorous research process.

These are typical processes for generating search terms, which are often combined to achieve a greater degree of methodological rigour:

- have a panel of experts generate and discuss search terms, or survey experts in the field;
- glean keywords from exemplary texts (remember to reference them);
- identify the thesaurus terms used to index exemplary articles;
- search or browse database thesauri for appropriate terms (thesauri are usually found under Search Tools. The MeSH tree can be searched or downloaded freely at: http://www.nlm.nih.gov/mesh/meshhome.html);
- use word frequency analysis of relevant records (usually by means of linguistic analysis software). This is an element of the so-called “objective” approaches to search strategy development.
The recommendations about search terms in this manual are based on the latter approach (described in detail in Petrova, Sutcliffe, Fulford and Dale, 2011). Word frequency analysis is a rarely used method for search strategy development as it is very time- and resource-intensive. It is not an appropriate method if you intend to develop a search strategy for a single study only. One of the key aims of this manual is to provide you with an objectively validated pool of search terms, along with performance statistics for the most frequent of them, so that you can make your search strategies more evidence-based.

Choosing words to include in your search strategy, and more broadly the overall development of the search strategy including use of operators, limits, etc., is a process involving a large number of iterations. Report the process through which you have designed your search strategy in as much detail as possible. If a search strategy has not been validated, the process of its development is the only indication of its likely quality.

If possible, develop your search strategy with the help of a library and information specialist, or have it checked by one.

4.1. Effective values search terms – findings from a word frequency analysis of citations in diabetes, obesity, dementia and schizophrenia

The tables below list the best performing values keywords (MeSH and free text words) as identified in a word frequency analysis of 4,440 citations on diabetes, obesity, dementia and schizophrenia (Petrova, Sutcliffe, Fulford and Dale, 2011).

Table 4.1 lists the 50 best performing MeSH terms for each of the four test conditions. A longer list of alphabetically ordered MeSH terms (including the ones from the tables) is given in 4.2.

Table 4.2 lists the 50 best performing free text words.

In both tables we have overlaid the numerical measures of frequency/sensitivity with a colour code, as shown below. Methodological terms are highlighted in blue.

<table>
<thead>
<tr>
<th>Sensitivity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very high sensitivity</td>
<td>&gt;= 100 occurrences in the analysis dataset</td>
</tr>
<tr>
<td>High sensitivity</td>
<td>&gt;=50 &lt; 100</td>
</tr>
<tr>
<td>Medium sensitivity</td>
<td>&gt;=20 &lt; 50</td>
</tr>
<tr>
<td>Low sensitivity</td>
<td>&lt;20 occurrences</td>
</tr>
</tbody>
</table>
Table 4.1: Best performing MeSH terms

This table includes the first 50 ‘best performing MeSH terms’ for each of the four test conditions. These have been drawn from a list of MeSH terms with precision $\geq 0.90$. Terms with a precision of 1 have been indicated by bold face. As can be seen from the table, the frequency of the 50th term is smallest in the case of obesity which suggests that citations on this condition were indexed by a smaller number of values MeSH terms. This corresponds to researcher impressions of obesity being the condition with the largest number of boundary cases between values and non-values publications.

<table>
<thead>
<tr>
<th>Diabetes 50 most frequent MeSH term, out of approx 270</th>
<th>Obesity 50 most frequent MeSH term, out of approx 260</th>
<th>Dementia 50 most frequent MeSH term, out of approx 360</th>
<th>Schizophrenia 50 most frequent MeSH term, out of approx 370</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionnaires</td>
<td>Body Image</td>
<td>Caregivers</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>Patient Education as Topic</td>
<td>Self Concept</td>
<td>Quality of Life</td>
<td>Attitude to Health</td>
</tr>
<tr>
<td>Self Care</td>
<td>Attitude to Health</td>
<td>Attitude of Health Personnel</td>
<td>Adaptation, Psychological</td>
</tr>
<tr>
<td>Health to Health</td>
<td>Health Knowledge, Attitudes, Practice</td>
<td>Adaptation, Psychological</td>
<td>Social Support</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>Prejudice</td>
<td>Social Support</td>
<td>Attitude of Health Personnel</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>Motivation</td>
<td>Attitude to Health</td>
<td>Family</td>
</tr>
<tr>
<td>Adaptation, Psychological</td>
<td>Stereotyping</td>
<td>Decision Making</td>
<td>Stereotyping</td>
</tr>
<tr>
<td>Physician-Patient Relations</td>
<td>Nurse’s Role</td>
<td>Cost of Illness</td>
<td>Caregivers</td>
</tr>
<tr>
<td>Social Support</td>
<td>Self Efficacy</td>
<td>Home Nursing</td>
<td>Cost of Illness</td>
</tr>
<tr>
<td>Attitude of Health Personnel</td>
<td>Focus Groups</td>
<td>Interviews as Topic</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>Interviews as Topic</td>
<td>Social Support</td>
<td>Nursing Methodology Research</td>
<td>Culture</td>
</tr>
<tr>
<td>Focus Groups</td>
<td>Adaptation, Psychological</td>
<td>Health Knowledge, Attitudes, Practice</td>
<td>Cross-Cultural Comparison</td>
</tr>
<tr>
<td>Patient-Centered Care</td>
<td>Personal Satisfaction</td>
<td>Patient-Centered Care</td>
<td>Health Knowledge, Attitudes, Practice</td>
</tr>
<tr>
<td>Qualitative Research</td>
<td>Interpersonal Relations</td>
<td>Mental Competency</td>
<td>Psychiatric Nursing</td>
</tr>
</tbody>
</table>

What search terms to use?
<table>
<thead>
<tr>
<th>Diabetes</th>
<th>Obesity</th>
<th>Dementia</th>
<th>Schizophrenia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>50 most frequent MeSH term, out of approx 270</strong></td>
<td><strong>50 most frequent MeSH term, out of approx 260</strong></td>
<td><strong>50 most frequent MeSH term, out of approx 360</strong></td>
<td><strong>50 most frequent MeSH term, out of approx 370</strong></td>
</tr>
<tr>
<td>Nurse's Role</td>
<td>Program Evaluation</td>
<td>Communication</td>
<td>Psychotherapy</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>Attitude</td>
<td>Geriatric Nursing</td>
<td>Evidence-Based Medicine</td>
</tr>
<tr>
<td>Program Evaluation</td>
<td>Clinical Competence</td>
<td>Nurse-Patient Relations</td>
<td>Interview, Psychological</td>
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Table 4.2: Best performing free text words

This table includes the first 50 'best performing free text words' for each of the four test conditions. These have been drawn from a list of free text words with a frequency $\geq20$ and precision $\geq0.90$. **Text words with a precision of 1 have been indicated by bold face.** As can be seen from the table, in the case of diabetes and dementia there was a larger number of free text words of very high precision that were also of high frequency (the 50th word in the table has a frequency of 51 in the case of diabetes, 48 in the case of dementia, and, respectively, 20 and 34 for obesity and schizophrenia). This may suggest that there are 'more values words' in citations on diabetes and dementia than in the other two conditions. Words followed by a slash, or two words separated by a slash (e.g. caregivers/ or obesity/epidemiology) are parts of indexing terms that have been analysed by the software as a single word.

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What search terms to use?
4.2. Additional values MeSH terms

This is a list of the MeSH terms denoting values issues identified through the word frequency analysis study. Although most of the terms are widely applicable, the list is likely to be biased towards issues relevant to diabetes, obesity, dementia and schizophrenia.

We are including this list of terms with three main aims:

- to sensitise you to the nature, variety and precision of thesaurus terms;
- to illustrate once again the wide range of issues and areas that can be considered value-laden and stimulate your thinking in the process of formulating your research question;
- to serve as a source of search terms for your study

NB: this should not be your only source. Further research is required before a reliable list of values MeSH can be produced. More importantly, other databases are likely to have substantially different controlled vocabularies and may not recognise the majority of the words here. See the text under Generating search terms in the Quick guide box in this chapter for guidance on how to produce lists of search terms.

Abortion Applicants
Abortion, Eugenic
Abortion, Induced
Acculturation
Achievement
Activities of Daily Living
Adaptation, Psychological
Advance Care Planning
Advance Directive Adherence
Advance Directives
Advisory Committees
Affect
Altruism
Analytical Approach
Anger
Anomie
Anthropology
Anthropology, Cultural
Anxiety
Art Therapy
Aspirations (Psychology)
Assertiveness
Assisted Living Facilities
Attitude
Attitude of Health Personnel
Attitude to Computers
Attitude to Death
Attitude to Health
Authoritarianism
Autobiography
Awareness
Beauty
Beneficence

Bereavement
Bibliotherapy
Bioethical Issues
Bioethics
Bioethics and Professional Ethics
Body Image
Buddhism
Burnout, Professional
Career Choice
Caregivers
Catholicism
Ceremonial Behavior
Certification
Character
Charities
Child Welfare
Choice Behavior
Christianity
Civil Rights
Clergy
Clinical Competence
Codependency (Psychology)
Codes of Ethics
Coercion
Colonialism
Commitment of Mentally Ill
Communication
Communication Barriers
Communications Media
Community-Institutional Relations
Competitive Behavior
Comprehension
Confidentiality
Internal-External Control
Internationality
Interpersonal Relations
Interprofessional Relations
Interview, Psychological
Interviews
Interviews as Topic
Islam
Jealousy
Job Satisfaction
Judaism
Judgment
Judicial Role
Jurisprudence
Laughter
Leadership
Legal Approach
Legal Guardians
Leisure Activities
Liability, Legal
Life Change Events
Life Style
Life Support Care
Literature
Literature, Modern
Living Wills
Lobbying
Logic
Loneliness
Love
Malpractice
Mandatory Programs
Mandatory Reporting
Marriage
Mass Media
Maternal-Fetal Relations
Maternal Behavior
Medical Futility
Medicine in Art
Medicine in Literature
Medicine, African Traditional
Medicine, Traditional
Mental Competency
Mentors
Metaphor
Mind-Body and Relaxation Techniques
Mind-Body Relations (Metaphysics)
Minority Groups
Models, Educational
Models, Nursing
Models, Organizational
Models, Psychological
Models, Theoretical
Moral Development
Moral Obligations
Morale
Morals
Mother-Child Relations
Motivation
Multilingualism
Music
Music Therapy
Mythology
Narration
Needs Assessment
Negativism
Negotiating
Nonverbal Communication
Nurse’s Role
Nurse-Patient Relations
Nursing Education Research
Nursing Methodology Research
Nursing Research
Nursing Staff
Nursing Theory
Nutrition Policy
Observer Variation
Organizational Culture
Organizational Objectives
Organizational Policy
Organizations, Nonprofit
Paintings
Parent-Child Relations
Parental Consent
Parental Notification
Pastoral Care
Paternalism
Patient-Centered Care
Patient Acceptance of Health Care
Patient Admission
Patient Advocacy
Patient Compliance
Patient Dropouts
Patient Education
Patient Education as Topic
Patient Participation
Patient Rights
Patient Satisfaction
Patient Selection
Peer Group
Perception
Personal Autonomy
Personal Construct Theory
Personal Satisfaction
Personal Space
Personality
Personality Assessment
Personhood
Persuasive Communication
Philosophical Approach
Philosophy
Philosophy, Medical
Philosophy, Nursing
Physician's Practice Patterns
Physician's Role
Physician-Nurse Relations
Physician-Patient Relations
Portraits as Topic
Postmodernism
Power (Psychology)
Practice (Psychology)
Practice Guidelines
Practice Guidelines as Topic
Prejudice
President's Council on Bioethics
Principle-Based Ethics
Privacy
Problem Solving
Professional-Family Relations
Professional-Patient Relations
Professional Autonomy
Professional Competence
Professional Corporations
Professional Patient Relationship
Professional Role
Projection
Psychological Tests
Psychological Theory
Psychology
Psychology, Educational
Psychology, Social
Psychometrics
Psychosocial Deprivation
Psychotherapy
Psychotherapy, Brief
Psychotherapy, Group
Public Assistance
Public Opinion
Public Policy
Qualitative Research
Quality-Adjusted Life Years
Quality of Life
Questionnaires
Race Relations
Rationalization
Reality Testing
Reality Therapy
Recognition (Psychology)
Recreation
Reinforcement (Psychology)
Rejection (Psychology)
Relaxation Techniques
Religion
Religion and Medicine
Religion and Psychology
Religious Approach
Religious Philosophies
Remedial Teaching
Repression
Research Personnel
Research Subjects
Researcher-Subject Relations
Restraint, Physical
Resuscitation
Risk-Taking
Risk
Risk Assessment
Risk Management
Risk Reduction Behavior
Role
Role Playing
Scapegoating
Self-Care Units
Self-Help Devices
Self-Help Groups
Self-Injurious Behavior
Self Administration
Self Assessment
Self Care
Self Care Skills
Self Concept
Self Disclosure
Self Efficacy
Self Medication
Self Psychology
Self Stimulation
Semantics
Set (Psychology)
Shame
Sibling Relations
Sick Role
Sickness Impact Profile
Social Adjustment
Social Alienation
Social Behavior
Social Behavior Disorders
Social Change
Social Class
Social Conditions
Social Conformity
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Social Control, Informal
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<td>Supreme Court Decisions</td>
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<td>Value of Life</td>
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4.3. Values-related search filters – examples and sources

You can find the ‘brief values filter’ developed on the basis of the findings about keywords represented in the tables above in Chapter 5 (5.2).

There are a number of search filters concerning specific values topics developed or endorsed by major organisations specialising in systematic reviewing and/or information retrieval. Below are links to the websites of such organisations and examples of relevant filters. The majority of them focus on a single aspect of the broad concept of values as understood here and aim at enhancing sensitivity (i.e. at identifying as large a number of articles as possible at the cost of increasing the number of false positives). We have not yet assessed those filters against the empirical findings from our study.

You can find a comprehensive search filter resource compiled by the InterTASC Information Specialists’ Sub-Group (a group of information specialist supporting technology assessment research conducted for NICE) at: http://www.york.ac.uk/inst/crd/intertasc/about.htm.

The most relevant filters published on their website come under Public Views, Qualitative Research and Quality of Life. The filters whose intended coverage overlaps to the greatest extent with the field of health-related values as discussed in this manual are:

- **patient preferences in primary care** (http://www.york.ac.uk/inst/crd/intertasc/public1.htm) – developed by Rosalind McNally – based on permutations of client, patient, user, carer, consumer, customer and attitude, priority, perception, preference, expectation, choice perspective, view;
- **patient issues** (http://www.york.ac.uk/inst/crd/intertasc/public2.htm) – developed by Robin Harbour. A refined version can be found at: http://www.sign.ac.uk/methodology/filters.html#patient

You can also find a Performance of Filters section on the InterTASC website. There are currently four studies referenced there on the performance of filters for qualitative research.

Reviews and protocols of the Cochrane Consumers and Communication Group are also a good source on search strategies that target values issues. Here are some examples:

- **contracts between patients and health professionals** for improving patients’ adherence – includes keywords such as agreement, negotiation, goal setting, decision making, consumer participation, etc. The relevant systematic review is available at: http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004808/frame.html;
- **decision aids** – includes keywords such as choice behaviour, decision making, choices, preferences, consumer satisfaction, etc. Review available at: http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001431/frame.html;
- **disclosure of information** – includes keywords such as truth disclosure, confidentiality, communication, breaking bad news, psychological impact, choice, ethics, family relations, physician-patient relations, informed consent, etc. Review available at: http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003859/frame.html;
- **family-centred care** – includes keywords such as patient centred care, interpersonal relations, partnership in care, shared care, communication, negotiation, etc. Review available at: http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004811/frame.html;
• **patient involvement** – includes keywords such as *patient participation, empowerment, involvement, decision making, consent, directives*. Review available at: [http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004273/frame.html](http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004273/frame.html).

You can access further publications of the Cochrane Consumers and Communication Group at: [http://www.mrw.interscience.wiley.com/cochrane/cochrane_clsysrev_crglist_fs.html](http://www.mrw.interscience.wiley.com/cochrane/cochrane_clsysrev_crglist_fs.html).

As already mentioned in Chapter 2, comprehensive advice on searching for **bioethics** literature is offered by:


Some search platforms also have qualitative research and bioethics filters embedded within them (e.g. the bioethics subset of PubMed).

### 4.4. How to predict the usefulness of a values search term

You can never know for sure if a search term is ‘good’ before you have tested it, but you can make informed predictions using the considerations below. With values research, it is almost always the case that one and the same article can be retrieved by a number of search terms and as a result no word is irreplaceable. Unless you are doing a systematic review, you can safely avoid words that are likely to retrieve a large number of false positives. You will be able to reach the main topics, concepts and ideas through a number of routes. Here are some telltale signs of the likely ‘non-starters’:

- Many of the words which, out of context, appear appropriate search terms for values issues are used too frequently in contexts that are only weakly evaluative or not revealing of concerns at the core of a person’s identity. As a result, using such keywords in searches generates a large number of false positives or weakly informative true positives. For example, although *important* (to patients) may point to richly evaluative content, in many more cases it does not (e.g. as in *this is an important finding*). Examples of words that present the same sort of difficulty are *concern*, *difficulties*, *expect*, *individual*, *needs*, *prefer*, etc. One option is to search for those words in title only, or, in some cases, to search for the longest derivative (e.g. *expectations*, *preferences*).

- For other words that capture rich evaluative connotations in everyday language or in the language of the social sciences, there exist clinical or methodological concepts denoted by the same word. The most pertinent example in our case is *value*. Other examples are *independent* (*decision*, but also *variable*), *loss* (*emotional*, but also *of a function*), *norm* (*social*, but also *clinical*), *support* (*social*, but also *for a hypothesis*). Such words too generate a large number of false positives. In some cases, such a bifurcation of meaning is limited to a condition-specific context; the word may function well in other conditions (e.g. *personal* did not work for diabetes due to the interest of diabetes research in *personal insulin pumps*, but was a highly sensitive and precise keyword in the other test conditions).
**Key learning points**

After working through this chapter, you should have ...

» become aware of the wide range of keywords you can use in searching for values research, particularly the variety of thesaurus terms that can help you better target your searches;

» ideally, you should also have gained further conceptual clarity on the issues you are interested in, by coming across some more precise names for them in the lists of search terms.

**Key references**

**Books and articles:**


**Websites:**


www.sign.ac.uk/methodology/filters.html – for information on search filters, basic notations used in search strategies, and examples of search filters (this is a page from the website of The Scottish Intercollegiate Guidelines Network (SIGN), which develops evidence-based clinical practice guidelines for NHS Scotland).

http://www.york.ac.uk/inst/crd/intertasc/about.htm – the search filter resource of InterTASC.


**Key objectives of next chapter**

» to help you design highly efficient searches, which allow you to target the most information-rich and highly relevant articles.
How to run quick, easy and effective values searches?

CHAPTER 5

This chapter will ...

» discuss values searches under serious time and resource constraints or for scoping purposes;

» suggest ways of limiting your retrieval to the most information-rich and highly relevant articles, primarily through performing operations enabled by thesaurus term indexing. Most of the suggested techniques are generic, illustrated with values examples;

» offer a 22-line highly precise search strategy for identifying values topics, concepts and ideas across thematic areas within health research.

The Quick guide to expected background knowledge box will ...

» clarify terminology;

» outline techniques for improving relevance of search results through manipulating formal (rather than thematic) parameters of a search query.

This chapter focuses on operations at the level of search queries and on highly effective values search terms. Other chapters which may help with the efficiency and relevance of searches are Chapter 2, section 2.2 on formulating research questions, and Chapter 3, section 3.3 on database selection.

Quick guide to expected background knowledge

Limits

In a very general sense, limiting a search is any process of setting boundaries to a search that reduces its retrieval and may also make it more relevant to the core of your research interests. “Limits” and “applying limits” may be used to mean a wide range of decisions, including the exclusion of subtopics within your main topic or the decision to focus on a small number of databases.

In a more technical sense, which is usually the one implied in the context of database searching, “limits” is used in relation to the formal parameters of a search query. Limiting options available through most database interfaces include: year limits (“date range”), language or geographical region limits, publication type limits (e.g. research article, discussion paper, letter, etc.), record type limits (citations with/without abstracts, with/without links to full text), population group limits (e.g. specified according to age and gender), methodological limits. Limiting commands are often found on the main search page and are highly intuitive to use, usually through tick boxes or pull-down menus.
Some database interfaces allow you to select limits that have a stronger thematic component. For instance, the Ovid MEDLINE interface allows you to apply “clinical query” limits (clinical query filters retrieve high quality research on a particular aspect of a clinical question – e.g. diagnosis, prognosis, cost-effectiveness, qualitative research, see section 4.5. on search filters for more details). More typically, however, such filters can be found in separate features of the search interface (e.g. Clinical Queries and Special Queries on PubMed MEDLINE).

Whether you use the concept of limiting a search in a wider or narrower sense, make sure to report and justify your decisions, as each limiting decision can potentially bias your findings.

“Focusing”, “exploding” and “bypassing explosions”

Thesaurus terms allow you to perform several operations for improving the relevance of a search that cannot be performed with free text terms:

- You can instruct the search engine to pick only those appearances of a thesaurus term where it is used to indicate the primary focus of an article. This operation is called “focusing” a search. Focusing is enabled by a practice employed in the indexing of some databases where one thesaurus term (or a small number of these) is singled out as “major”, as reflecting the core issue discussed in the article. In the records which users of the database see, this may be indicated by an asterisk next to the term. Alternatively, such terms may be brought out in a separate field, e.g. the Major Descriptors on Ovid PsycINFO.

  The PubMed MEDLINE interface allows you to limit to major topic by adding [MAJR] after a MeSH term. The Ovid MEDLINE offers you the option of ticking a Focus box. For Ovid PsycINFO, you can use the Major Descriptors field. Using major topic or equivalent restrictions is not possible with all databases and/or providers. It requires that priority indicators have been assigned to records (database-dependent) and that these have been made searchable (provider-dependent).

- With thesaurus terms you can also search for a wide range of specific examples of a general concept, together with the general concept itself, by using a single word or phrase. This is achieved by “exploding” a thesaurus term. For instance, by exploding Emotion [MeSH], you will retrieve articles that discuss emotions more generally, but also articles on Fear, Anger, Anxiety, Happiness, Love, etc. (all of these are actual MeSH terms).

  This type of searching is enabled by the tree-like structure in which thesaurus terms are organised. Not all databases, however, are underpinned by a rich multilevel thesaurus, which is the first prerequisite for searching through explosions.

  If your aim is to run a maximally efficient search, you will generally want to avoid explosions. Most often this only means not selecting the “explode” option, but some providers have “automatic explosion” as the default setting for searching their databases (e.g. of PubMed MEDLINE). In such cases you may need to bypass the default setting.

  Whether or not a database is searched via automatic explosion depends on the vision of a particular provider of how the average search within the database can be made more relevant and efficient. If your main search page gives you the option of choosing to explode a term (e.g. through ticking a box, as on Ovid MEDLINE), then it means that explosion is not an automatic setting and you need not worry about it. As mentioned earlier, smaller databases underpinned by less complex classification systems and
The bullet points below present generic approaches to increasing the quality of your searches accompanied by values illustrations.

- **You may base your search strategy on thesaurus terms and add relevant free text words of high precision.** In the case of values research and MEDLINE in particular, we would suggest that developing a thesaurus terms-based strategy is an effective approach for the years after 2003-04. Our feasibility searches were performed at the end of 2003 – early 2004 and looked back towards 2000 or earlier. The indexing of values citations was quite limited and poorer than that of biomedical studies of the same period. In 2006 – 2007 we performed further searches, which covered the period after January 2004. The indexing of values citations has improved markedly – more, and more varied, values MeSH were used. The difference with biomedical research has also largely disappeared. This dramatic improvement in the indexing for values research seems to have started around 2004.

- **You may place “major topic” restrictions on most of your thesaurus terms.** With this approach, retrieval is likely to diminish several times. For instance, when MEDLINE is queried for publications indexed with Freedom as a MeSH term, approximately 14,000 citations are retrieved (Dec 11, PubMed interface, no limits). When the query is revised to Freedom as a
MeSH Major Topic, the retrieval falls to approximately 4,000. Similarly for Narration – the numbers go down from approximately 3,800 to 1,300 (Dec 11, PubMed interface, no limits).

- **If the default setting of the database is one of automatic explosion of thesaurus terms, you may try bypassing it.** The effect can be substantial. For instance, if you search Philosophy as a MeSH term in the PubMed MEDLINE, the engine searches for the general term Philosophy and for the more specific terms that come beneath it in the tree-like hierarchy (and which include terms like Esthetics; Ethics; Existentialism; Life; Logic; Metaphysics; Philosophy, Dental; Philosophy, Medical, etc.). In this way over 33,000 citations are retrieved for the period between January 04 and December 06. If you bypass the automatic explosion and run a search for Philosophy only (Philosophy [mh:noexp]), the retrieval goes down 55 times, to slightly over 600 citations (searches run Dec 11).

  This approach, of course, will be counterproductive if you are actually interested in the lower level concepts. It may also be irrelevant – when no concepts come below your main concept of interest. This happens relatively often with values terms.

- **You may choose to search for your concepts of interest only in the title.** Title-based searches are a quick and effective shortcut to identifying the main debates within a field. They are particularly effective with common free text words for values, which can take up a number of weak meanings (see Section 4.4 if this sounds unclear). For instance, if you are searching for comparisons of the perspectives of health professionals and patients, the retrieval of the following search string

  \[(\text{doctor}^* \text{ OR nurse}^* \text{ OR physician}^* \text{ OR health professional}^*) \text{ AND compar}^* \text{ AND patient}^*\]

  is approximately 37,700 citations (Dec 11, PubMed interface, no limits).

  However, if you run a search with the same parameters, but in title only:

  \[(\text{doctor}^* \text{ [ti]} \text{ OR nurse}^* \text{ [ti]} \text{ OR physician}^* \text{ [ti]} \text{ OR health professional}^* \text{ [ti]} \text{ AND compar}^* \text{ [ti]} \text{ AND patient}^* \text{ [ti]})\]

  retrieval will fall down to 442 (Dec 11). The most information-rich and relevant articles are highly likely to be part of it.

  Note: using a proximity operator would be another effective strategy in this case. It is not, however, available on PubMed.

- **You may try searching for MeSH terms with ‘dual scope’ only if they appear in combination with an ethics or psychology subheading.**

  We use the phrase ‘dual scope terms’ for terms which refer to a topic associated with a wide range of complex and conflicting values, but which can be explored from a strongly factual perspective, too – e.g. Terminal Care, Disabled Persons, Pain. For instance, there is abundant research on the lived experience of pain (the values perspective), but also on the drugs used in controlling it (the factual perspective). Our experience suggests that if such MeSH appear in values citations, they tend to be further qualified by at least one of the following subheadings – ethics, ethnology, nursing, and psychology. With less certainty, we can suggest that the ethnology and nursing association is spurious (as they themselves are dual scope subheadings) and that it may be safe to use only the ethics and psychology subheadings. Ovid allows you to tick boxes for subheadings you would like to search with. The syntax for PubMed is, for instance, MeSH term/psychology.
• Even more radically (and more likely to bias findings), you can try using *ethics* and *psychology* as “free-floating” subheadings and combine them with the health condition word (or organisational issue, health setting, etc. you are interested in). In the PubMed MEDLINE, the syntax for this will be:

\[(\text{psychology [sh]} \text{ OR ethics [sh]}) \text{ AND [condition word]}\]

Our impression is that this is an extremely effective approach, likely to retrieve the majority of articles which a comprehensive set of values search terms will return. We are in the process of testing this hypothesis.

• If you are searching social sciences databases, you may want to use their classification codes, which reflect wider thematic areas than thesaurus terms (if the term “classification codes” sounds unfamiliar, see the Quick guide box to Chapter 4). Combine your condition word (e.g. diabetes) or the health and illness codes of those databases (e.g. 2000 for ‘sociology of health and medicine’ in Sociological Abstracts) with the code for the area of social science knowledge in which you are interested (e.g. 0665 for ‘social network analysis’ in Sociological Abstracts).

As health is rarely a core topic in social sciences databases, searching by means of such wide areas can be quite effective. It saves you the need to identify individual keywords or thesaurus terms specific to a particular database, while retrieval is kept within manageable limits.

The classification codes for PsycINFO, Sociological Abstracts and Social Services Abstracts, three of the most popular social sciences databases, can be found here:


• As far as applying limits is concerned, the restrictions you place depend on the aims of your study. We would only suggest that in the case of values you avoid methodological limits (as found in “clinical queries”, for instance), as the majority of values research does not use methods that are generally seen to produce strong evidence.

### 5.2. Minimum words, maximum effect – a brief and highly precise values search strategy

The box on the next page offers a search strategy consisting of search terms (free text and MeSH) which, in the word frequency analysis study, demonstrated excellent performance parameters across the topics of diabetes, obesity, dementia and schizophrenia (Petrova, Sutcliffe, Fulford and Dale J, 2011).

Each of the words included in the search strategy had a precision >=90% and frequency >=30 (for the free text words) or >=20 (for the MeSH terms) in at least three of the four test conditions. A higher cut-off point was chosen for the frequency of free text words as their number was likely to exceed the number of abstracts in which they appeared.
By combining these 22 terms with the Boolean operator OR (to exclude duplicates) you will be able to retrieve the majority of values publications concerning a chosen health topic. In our study, they were able to retrieve 76.8% of the citations in the analysis datasets.

More research is needed to establish the extent to which this search strategy is generalisable across topics. We will be very interested to hear about your experiences of using it.

‘Brief values filter’ for MEDLINE

1. Attitude* (tw)
2. Perceptions (tw)
3. Qualitative (tw)
4. Coping (tw)
5. Counseling (tw)
6. Cultural (tw)
7. Ethics (tw)
8. Experiences (tw)
9. Interviews (tw)
10. Perceived (tw)
11. Personal (tw)
12. Professionals (tw)
13. QOL (tw) OR Quality of Life (mh)
14. Relations (tw)
15. Respondents (tw)
16. Satisfaction (tw)
17. Staff (tw)
18. Well-being (tw)
19. Adaptation, Psychological (mh)
20. Nurse’s Role (mh)
21. Social Support (mh)
22. OR/1-21

This search strategy has been developed on the basis of MEDLINE citations. The frequency of some of the free text words (e.g. “attitude”, “relations”) is as high as it is partly because they form part of compound MeSH terms (e.g. Health Knowledge, Attitudes, Practice [MeSH] or Attitude to Health [MeSH]). Further research is required on the adaptability of this search strategy to other databases underpinned by different thesauri.

We suggest that free text words are searched without being mapped onto thesaurus terms (on PubMed, you add a [tw] tag as above; on Ovid, you ignore the mapping option). This is because the mapping process will add new terms which may not be highly effective. The final line indicates that the terms are to be combined with an OR. The resulting retrieval can then be combined (with an AND) with topic-specific terms (e.g. for a disease; healthcare setting – e.g. general practice, hospital, public health; type of stakeholder – patients, professionals, carers, specific ethnic groups, etc.) to obtain an overview of the values research in relation to a particular condition, healthcare setting, type of stakeholder, etc.
Key learning points

After working through this chapter, you should have ...

» become familiar with a range of efficiency- and effectiveness-maximising approaches to searching for values publications;
» developed an understanding of their limitations;
» ideally, explored the interfaces of the databases you are using so that you can adapt the techniques suggested here to their characteristics;

If after applying the approaches suggested in this chapter the number of articles you need to process still appears daunting, you will need to narrow your research question (go back to Chapter 2 for help with that).

Key references


Key objectives of next chapter

» to prepare you for the major challenge in processing the retrieval of values searches – dealing with boundary cases.
Selecting publications – inclusion and exclusion criteria for values studies

CHAPTER 6

This chapter will ...

» prepare you for one of the main difficulties in processing values records – deciding on the true/false positive status of boundary cases;

» describe types of boundary cases; discuss why they represent a challenge of classification; illustrate them with abstracts of recent research studies; and suggest how to deal with them.

The Quick guide to expected background knowledge box will ...

» offer generic tips on processing large amounts of (bibliographic) information.

Quick guide to expected background knowledge

Selecting relevant records is part of a broader process of managing the publications you retrieve. The amount of information associated with literature searches has the reliable tendency to become overwhelming. As general principles, set up filing and recording processes that are consistent yet flexible; that enable you to locate items easily and precisely (sometimes this may mean having the same information under different categories); that are anticipatory of future needs; that allow you to easily filter in and out pieces of information; and that are reportable in great detail.

Allocating some time, e.g. a week, in preparation and planning (for instance to explore the more advanced options of your databases and prepare templates for your logs) is one of the best time-saving investments you can do in your research work. Here are some further tips:

» create a personal account – this is useful for saving searches, which helps with the logging of your progress (worth overcoming the inertia of “next time” ...);

» have your records displayed in a format including indexing terms – this will sensitise you to relevant search terms;

» learn how to export and import records from a database into a bibliographic software. The process is database- and bibliographic software-specific. It is generally quite easy, but you may need to identify information on appropriate formats and filters. For instance, if you want to export PubMed records into Endnote, you need to save your PubMed records in a MEDLINE format and then import them using the PubMed filter in Endnote, which is not immediately visible (go to File/Import/Import Option/Other filters.../PubMed);
» if available, make use of bibliographic or review management software – EndNote, ProCite, RevMan are some examples. They are usually available through an institutional subscription, so you might not have a choice of which one to use. They have amazing, often unsuspected features in making your work easier, giving you opportunities to look at data from a wide range of perspectives and to adapt it for specific uses (e.g. different journal requirements, self-generated templates, etc.);

» in saving your records, make sure you add information on: search strategy used, date search run, total number of records retrieved (you will often be saving only selected records – these are then given new numbers and you will have no indication of the total from which they were obtained). Give your files an information-rich name at first saving; automatically generated names may feel convenient there and then, but you tend to regret using them later. Sending emails to yourself may be convenient, but emailed records cannot be imported, which makes them more difficult to process. Try to import records directly into the bibliographic software, even if it is only in a temporary library;

» store and back up your records in the format generated by the bibliographic software, but also in text files. The bibliographic software files get corrupted more easily, so it is a good idea to have a simple text back-up (make sure though that they are in a format you can then re-export into a bibliographic software);

» make a habit of saving interesting records which are not directly relevant to your current purposes. If you find something interesting, record it there and then; do not think you will remember about it when the need arises. If you do this, you will be amazed by how rich and interesting your collections will be in a couple of years’ time. Temporary clipboards (which save information for the duration of your session) are a great help in this respect – you are not interrupting your main work for more than two clicks, and at the same time you have saved the record;

» make detailed logs of the progress of your searches and the organisation of your files and ideas – the more detailed the logs, the better, although it often feels tedious and unnecessary to articulate what you have just been doing. Things that you are mostly likely to forget to record are those that have not worked, e.g. words which have produced limited retrieval or a large number of false positives – and this is very useful and methodologically important information. Something we found helpful was recording the time it took us to screen articles. It helped us estimate the timeframe for subsequent work;

» automate processes that can be automated – use the opportunities of automatic alerts (most databases or journals will allow you to do this, as long as you create a personal account), but make sure to process them periodically rather than file them away. If you are doing the latter, ask yourself whether you no longer need (that many of) them or need to re-prioritise their processing. Managing your electronic alerts through ZETOC (a British Library service) is a convenient one-stop option if you are subscribing to a large number of alerts, with its coverage of over 20,000 journals (requires institutional subscription);

» for more effective and efficient retrieval of information, find out about the numerous ways in which your bibliographic software allows you to search for and display stored information;
How to approach this chapter

This chapter presents ideas concerning the grey areas between ‘values abstracts’ and ‘non-values abstract’. Readers coming from other theoretical frameworks, where values are not centre-stage, may still find elements of the discussion useful. What seem like grey areas from a values perspective are complex areas from a wide range of other perspectives.

It may take you much longer to go through this chapter than through other long chapters in the manual. It comprises many and varied examples interspersed with brief but information-dense theoretical sections. It covers complex issues which you may want to think through for yourself at greater length.

» become familiar with your library’s procedures for ordering publications from journals to which it does not subscribe. The relevant library services are usually called “interlibrary loans” or “document supply”. If you are a student, you may need a tutor’s signature. Consider the cost implications. Ordering articles may cost as much as a book (e.g. £7-£8), even more;

» learn to work wisely when performing literature searches:
  - you will be switching between moments of extreme excitement, utter boredom and efficient automatism. If you are in a tedious and bored phase, better take a break or switch to something else, as both the quality and speed of your work have diminished substantially. In phases of automatism and easy assignments, check if you are indeed processing the information or only going for superficial characteristics;
  - there seem to be days when you are more likely to be inclusive (be more permissive about what counts as a true positive) and days when you are more likely to be exclusive (be rather strict). Reconsidering your own choices (i.e. performing intra-rater reliability exercises) can help you see if this is within normal limits or whether your inclusion/exclusion criteria are too vague;
  - if you are consistently spending long periods of time perusing whether to classify certain records as true or false positives, you will most likely need to reconsider your selection criteria before continuing;
  - plan your literature searching session in a way that leaves you time to record the steps you have taken and process your temporarily saved records.

In summary:

» Know your software – it can usually do most of the things you would want it to do, and many more!

» Record meticulously – otherwise you will forget not some, but most of what you have done and found …
The chapter starts with examples of definite true positives and definite false positives. These are the endpoints between which most of the recent research retrieved by values search terms can be found (6.1).

It moves onto quantitative, intensity-related uncertainties. These can be experienced when classifying abstracts in which the values element (e.g. one sentence) is almost lost amidst factual elements (the text of the abstract as a whole) (6.2).

It then focuses on content-related difficulties of classification in three major areas:

- abstracts illustrating the value-ladenness of theories, frameworks, programmes, methods, etc. (6.3);
- abstracts of studies that explore values and evaluative processes from a reductionist perspective, e.g. research which is looking for the biological, evolutionary, environmental, computational, etc. determinants of certain evaluations (6.4);
- abstracts referring to psychology constructs that entail strong values elements (6.5).

Each of these cases is illustrated with abstracts from our searches on diabetes, obesity, dementia and schizophrenia.

Abstracts are, of course, only an indication of the contents and style of the full article. Some of the uncertainties may be resolved if the full text is accessed, but the majority of them are likely to reappear in the full texts.

### 6.1. The endpoints of the values continuum in recent research – definite true and definite false positives

The abstracts in the green box below are examples of texts which can be considered **definite true positives** from the perspective of Values-based Practice (Fulford, 2004; Woodbridge and Fulford, 2004). What makes them excellent examples is the possession of one or more of the following characteristics: their focus on a particular individual’s values; on eliciting differing or conflicting values and perspectives; on seeking solutions in a way that takes into account such differing and conflicting values; on making sense of illness experiences in the context of a particular values system.

Articles possessing such characteristics are very much in the minority. The reasons are likely to be varied. A concern with an individual’s perspective – with studies of n=1 – is untypical in research. A research reflex of exploring the perspectives of patients and providers in parallel has not yet been created. ‘Values’ and ‘value systems’ are hard to operationalise for empirical research purposes.

It may not be a good idea to be very restrictive in your values searches, as less perfectly fitting examples can be highly informative and more likely to be found in research-focused databases.
Relating with professionals.

Clarke C.

This paper addresses my difficulties as a carer in engaging with many professionals in mental health, both locally associated with my son's acute inpatient care, and nationally where policies are being developed and their implementation is pursued. All of us are affected by The Department of Health (DoH) Mental Health policies and their implementation by professionals has formed the way in which professionals relate with my son and myself. The way in which my son is impacted inextricably affects the way I relate to professionals.

I think my difficulty in engaging lies in the relationships we all have with each another. In focusing on the process within our relationships, I attempt to raise professionals' awareness of what constitutes a relationship when we dialogue. As it takes two to engage in a dialogue, I perceive my difficulty is also the difficulty of the professionals. Carers are becoming increasingly involved in the training of mental health professionals and our combined difficulty needs to be resolved, so that we all benefit. In order to achieve positive progression, there needs to be a radical change within our relationship to provide ease of engagement from all parties. In this paper I tentatively suggest how this process can be achieved.

MeSH Terms:
- Akathisia, Drug-Induced/etiology
- Akathisia, Drug-Induced/prevention & control
- Attitude of Health Personnel*
- Attitude to Health*
- Clinical Competence
- Communication
- Cooperative Behavior
- Empathy
- Health Knowledge, Attitudes, Practice
- Health Services Needs and Demand
- Humanism
- Humans
- Negativism
- Neuroleptic Malignant Syndrome/etiology
- Neuroleptic Malignant Syndrome/prevention & control
- Nursing Staff, Hospital/psychology*
- Parents/psychology*
- Patient Advocacy
- Power (Psychology)
- Practice Guidelines as Topic
- Professional-Patient Relations*
- Psychiatric Nursing/organization & administration
- Schizophrenia/drug therapy
- Schizophrenia/prevention & control*
- Stereotyping
- Trust
Life versus disease in difficult diabetes care: conflicting perspectives disempower patients and professionals in problem solving.

Zoffmann V, Kirkevold M.

Conflicts in problem solving are known from diabetes research on patients with good glycemic control but have rarely been studied in the care of patients with poor glycemic control. Equally, the different perspectives of health care providers and patients have not been a focus in previous studies. The authors studied the interactions between health care providers and 11 diabetes patients with poor glycemic control in a grounded theory study at a Danish university hospital. Keeping Life and Disease Apart was identified as a core category. It involved a pattern of conflicts both between and within patients and health professionals, which disempowered them in problem solving. Three approaches to problem solving were identified: A compliance-expecting approach kept the pattern unchanged, a failure-expecting approach deadlocked the pattern, and a mutuality-expecting approach appeared to neutralize the conflict.

MeSH Terms:
- Adolescent
- Adult
- Conflict (Psychology*)
- Denmark
- Diabetes Mellitus/physiopathology/*therapy
- Female
- Hospitals, University
- Humans
- Hyperglycemia/drug therapy/prevention & control
- Male
- Middle Aged
- Nurse-Patient Relations*
- Power (Psychology)*
- Problem Solving*
- Self Care
- Self Efficacy*

Making sense of dementia and adjusting to loss: psychological reactions to a diagnosis of dementia in couples.

Robinson L, Clare L, Evans K.

The current emphasis on early detection and disclosure of a diagnosis of dementia highlights the need to examine couples' shared constructions of, and responses to, the diagnosis, and to explore the appraisals that couples make about the illness at an early stage. While the experiences of carers and of people with dementia have mostly been considered separately, further investigation of the shared experience of couples where one partner is developing dementia is required. This study adopted a family systems perspective to investigate psychological reactions to a diagnosis of dementia in nine couples where one partner had received a diagnosis of either Alzheimer's disease or vascular dementia, with particular emphasis on the possible relevance of psychological responses to loss. Interpretative phenomenological analysis was used to explore participants' experiences of receiving a diagnosis of dementia, which were compared and contrasted across...
The abstracts in the box below are examples of **definite false positives** picked by values keywords (as highlighted).


**Phenotypic variability in familial prion diseases due to the D178N mutation.**

Zarranz JJ, Digon A, Atares B et al.

**BACKGROUND:** Between January 1993 and December 2003, 19 patients with familial prion diseases due to the D178N mutation were referred to the regional epidemiological registry for spongiform encephalopathies in the Basque Country in Spain, a small community of some 2,100,000 inhabitants. **METHODS:** Ten further patients belonging to the same pedigrees were retrospectively ascertained through neurological or neuropathological records. In four of the patients, the diagnosis was confirmed by analysing DNA obtained from paraffin blocks. In this article, we report on the clinical, genetic, and pathological features of the 23 patients carrying the D178N mutation confirmed by genetic molecular analysis. Haplotypeing studies suggest a founder effect among Basque born families, explaining in part this unusually high incidence of the D178N mutation in a small community. Only two patients (8%) lack familial antecedents. **RESULTS:** We have observed a phenotypic variability even among homozygous 129MM patients. Our findings challenge the currently accepted **belief** that MM homozygosity in codon 129 is always related to a fatal familial...
6.2. The grey area of intensity – small values islands in a vast factual sea

What is the dilemma? There is a substantial number of abstracts in which one or two values sentences can be identified, but the whole orientation of the abstract appears rather ‘factual’.

Papers represented in such abstracts clearly contain values elements and, ideally, should be included in the analysis. However, their number is substantial, while their likely contribution to our knowledge on values seems minor.

Arguments in favour of inclusion: theoretical consistency; contribution to knowledge may be small, but important (why not balance-tipping?).
**Cases in which inclusion may be advised:** if the study is on patient satisfaction with interventions. Our searches have shown that there is a large number of studies in which patient satisfaction with a treatment is the values element in an otherwise ‘factual study’.

**Arguments in favour of exclusion:** Generally, the constructs explored by such studies relate to values and evaluative processes that are far from being identity-defining, central to an individual’s personality. Also, the number of such studies is substantial and the information they contribute relatively easy to extract and synthesise. This combination of volume and clarity may obscure messages from research which is less frequent and more complex.

**Cases in which exclusion appears a safe choice:** if scoping searches suggest that the theme is well explored in studies with richer values contents.

<table>
<thead>
<tr>
<th>Subtypes and examples:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. One clearly identifiable subgroup of such studies concerns health technologies and treatments:</strong></td>
</tr>
</tbody>
</table>


**Improving website accessibility for people with early-stage dementia: a preliminary investigation.**

Freeman ED, Clare L, Savitch N, Royan L, Litherland R, Lindsay M.

This study, conducted collaboratively with five men who have a diagnosis of early-stage Alzheimer’s disease (AD), is the first stage of a formative research project aimed at developing a new website for people with dementia. Recommendations derived from a literature review of the implications of dementia-related cognitive changes for website design were combined with general web accessibility guidelines to provide a basis for the initial design of a new website. This website was compared with an equivalent site, containing the same information but based on an existing design, in terms of accessibility, ease of use, and user satisfaction. Participants were very satisfied with both sites, but responses did indicate some specific areas where one site was preferred over another. Observational data highlighted significant strengths of the new site as well as some limitations, and resulted in clear recommendations for enhancing the design. In particular, the study suggested that limiting the size of web pages to the amount of information that can be displayed on a computer screen at any one time could reduce the level of difficulty encountered by the participants. The results also suggested the importance of reducing cognitive load through limiting the number of choices required at any one time, the very opposite of the ethos of much website design.

**MeSH Terms:**
- Aged
- Cognition*
- Dementia/psychology*
- Humans
- Information Services
- Internet/standards*
- Male
Efficacy of risperidone for treating patients with behavioral and psychological symptoms of dementia.

Wancata J.

BACKGROUND: Large randomized controlled trials have shown that risperidone reduces the frequency and severity of behavioral and psychological symptoms of dementia (BPSD) in patients with dementia. Since such trials are obliged to use very strict inclusion and exclusion criteria, their information about the efficacy is limited by the criteria used. Thus, the aim of the present study was to investigate the efficacy of risperidone on BPSD in a sample of patients routinely treated by their primary care physicians. METHODS: A total of 938 elderly patients in Austria suffering from BPSD and routinely treated by their primary care physicians were included in this open-label prospective study. Patients received a flexible dose of risperidone, starting with 0.5 mg daily, for at least 6 weeks. Questionnaires were filled in before the start and after 6 weeks of treatment. RESULTS: Before starting treatment with risperidone, BPSD were severe in 36.6% of the patients, moderate in 49.3%, and mild in 14.1%. The overall efficacy of risperidone was judged as "excellent" by the general practitioners and caregivers in about half the patients. The treatment was judged as "not satisfactory" in only a very small proportion (3.3% and 4.3%, respectively). According to the physicians' judgement, the tolerability of risperidone was "excellent" in 81.5% of the patients and "satisfactory" in 17.8%. The tolerability was "not satisfactory" in only 0.7% and only 7.4% of the patients reported any adverse event. DISCUSSION: Overall, the results of this survey indicate that risperidone is both efficacious and well tolerated for the treatment of elderly primary care patients with BPSD.

MeSH Terms:
Aged
Antipsychotic Agents/administration & dosage
Antipsychotic Agents/therapeutic use*
Dementia/diagnosis
Dementia/drug therapy*
Dementia/psychology*
Humans
Mental Disorders/etiology*
Middle Aged
Prospective Studies
Questionnaires
Risperidone/administration & dosage
Risperidone/therapeutic use*
Severity of Illness Index


BMI affects presenting symptoms of achalasia and outcome after Heller myotomy.

Rakita SS, Villadolid D, Kalipersad C, Thometz D, Rosemurgy A.
BACKGROUND: Obesity has reached epidemic proportions in the United States and worldwide. The impact of obesity on health is increasingly recognized; however, its impact on achalasia has not been established. METHODS: The present study was undertaken to determine the impact of body mass index (BMI) on the symptoms of achalasia and outcome after myotomy. In our institution, 262 patients have undergone laparoscopic Heller myotomy and scored their symptoms before and after myotomy on a Likert scale (frequency: 0 = never to 10 = every time I eat/always; severity 0 = not bothersome to 10 = very bothersome). Patients were stratified by BMI > or = 30 kg/m2 or BMI < 30 kg/m2, and preoperative symptom scores and postmyotomy outcomes were compared. RESULTS: Patients with BMI > or = 30 had higher symptom scores for frequency of choking and vomiting before myotomy (p < 0.05). All symptom scores improved significantly after myotomy, except heartburn frequency and severity for patients with BMI > or = 30. By regression analysis, increasing BMI tended to exacerbate the frequency of choking and vomiting before myotomy and the frequency of heartburn after myotomy. Among the patients with BMI > or = 30 kg/m2, 73% reported excellent or good outcomes compared to 91% for patients with BMI < 30 kg/m2 (p = 0.02, Fisher's exact test). However, 96% of patients with BMI > or = 30 kg/m2, as well as 93% of patients with BMI < 30 kg/m2 would still elect to have the operation if they were asked to make the decision over again. CONCLUSIONS: Although some preoperative symptoms are exacerbated by elevated BMI, all symptoms of achalasia are improved with myotomy, even when undertaken for obese patients.

MeSH Terms:
- Adult
- Aged
- Body Mass Index*
- Digestive System Surgical Procedures/adverse effects
- Digestive System Surgical Procedures/methods*
- Esophageal Achalasia/complications
- Esophageal Achalasia/diagnosis
- Esophageal Achalasia/surgery*
- Esophagoscopy/methods*
- Female
- Follow-Up Studies
- Humans
- Male
- Middle Aged
- Muscle, Smooth/surgery
- Obesity/complications
- Obesity/diagnosis
- Patient Satisfaction
- Postoperative Complications/physiopathology
- Probability
- Prospective Studies
- Risk Assessment
- Severity of Illness Index
- Statistics, Nonparametric
- Treatment Outcome
B. Studies in another typical subgroup seek correlations between health-related behaviours and basic population characteristics, primarily demographic characteristics, with the occasional inclusion of data on specific beliefs, expectations, perceptions, etc. Again, discussion of the latter represents a very small proportion of the whole abstract, and potentially of the whole paper.


Eating at fast-food restaurants is associated with dietary intake, demographic, psychosocial and behavioural factors among African Americans in North Carolina.

Satia JA, Galanko JA, Siega-Riz AM.

OBJECTIVE: To examine associations of the frequency of eating at fast-food restaurants with demographic, behavioural and psychosocial factors and dietary intake in African American adults. METHODS: Self-reported data from a population-based cross-sectional survey of 658 African Americans, aged 20-70 years, in North Carolina. An 11-page questionnaire assessed eating at fast-food restaurants, demographic, behavioural and diet-related psychosocial factors, and dietary intake (fruit, vegetable, total fat and saturated fat intakes, and fat-related dietary behaviours). RESULTS: The participants were aged 43.9 +/- 11.6 years (mean +/- standard deviation), 41% were male, 37% were college graduates and 75% were overweight or obese. Seventy-six per cent reported eating at fast-food restaurants during the previous 3 months: 4% usually, 22% often and 50% sometimes. Frequency of eating at fast-food restaurants was positively associated with total fat and saturated fat intakes and fat-related dietary behaviours (P<0.0001) and inversely associated with vegetable intake (P<0.05). For example, mean daily fat intake was 39.0 g for usually/often respondents and 28.3 g for those reporting rare/never eating at fast-food restaurants. Participants who reported usual/often eating at fast-food restaurants were younger, never married, obese, physically inactive and multivitamin non-users (all P<0.01). Frequency of eating at fast-food restaurants was positively associated with fair/poor self-rated health, weak belief in a diet-cancer relationship, low self-efficacy for healthy eating, weight dissatisfaction, and perceived difficulties of preparing healthy meals and ordering healthy foods in restaurants (all P<0.05). Frequency of eating at fast-food restaurants did not differ significantly by sex, education, smoking, ability to purchase healthy foods or knowledge of the Food Guide Pyramid. CONCLUSIONS: Eating at fast-food restaurants is associated with higher fat and lower vegetable intakes in African Americans. Interventions to reduce fast-food consumption and obesity in African Americans should consider demographic and behavioural characteristics and address attitudes about diet-disease relationships and convenience barriers to healthy eating.

MeSH Terms:
- Adult
- African Americans/statistics & numerical data*
- Aged
- Attitude to Health*
- Cross-Sectional Studies
- Diet Surveys
- Dietary Fats/administration & dosage*
- Female
- Fruit
- Health Promotion
- Humans
- Male
- Middle Aged
C. Another typical subgroup includes research on the organisation of services that is done from a largely ‘factual’ perspective, but includes some (limited) data on acceptability, satisfaction, etc.


School nurse, family and provider connectivity in the FITE diabetes project.

Malasanos TH, Patel BD, Klein J, Burlingame JB.

The Florida Initiative in Telehealth and Education (FITE) diabetes project includes a system of remote blood glucose monitoring and online education for school personnel, families and providers. Forty-four patients with diabetes (100% of patients), six caregivers, six case managers and 18 school nurses were provided with secure email access, allowing blood glucose and other data transfer. In all, 50% of school nurses and 100% of case managers completed educational modules on the FITE Website. Over 90% of patients and all school nurses received equipment for transmitting blood glucose data to their computers. The data were discussed during clinic appointments. Inclusion of previously unavailable data from school nurses contributed to fine-tuning the diabetes management regimen. Those patients, families and school nurses who chose to transmit blood glucose data and participate in online education expressed satisfaction with the technology, the process and the improved communication.

MeSH Terms:
- Blood Glucose/analysis*
- Caregivers
- Child
- Diabetes Mellitus/blood*
- Health Education/methods
- Humans
- Internet
- School Health Services
- School Nursing*
- Telemedicine/instrumentation
- Telemedicine/methods*


The importance of knowledge transfer between specialist and generic services in improving health care: a cross-national study of dementia care in England and The Netherlands.

Kumpers S, Mur I, Hardy B, Maarse H, van Raak A.

Knowledge transfer (KT) between specialist and generic services is widely seen as an important
strategy for improving the quality of integrated dementia care. This article elaborates on intra- and inter-organizational features associated with successful KT. A provisional conceptual framework is suggested, based on literature about inter-organizational networks and knowledge management. Professional and organizational cultures, domain perceptions, perceived dependency and the availability of resources are suggested as significant influences upon the motivation and perceived capacity to engage in KT. Personal and organizational continuity is identified as an important process quality. Data from four local case studies in England and The Netherlands are used to develop and specify the provisional framework. A conceptual model is built to explain the relative success or failure of KT.

MeSH Terms:
- Delivery of Health Care, Integrated*
- Dementia/therapy*
- England
- Family Practice*
- Health Knowledge, Attitudes, Practice*
- Humans
- National Health Programs
- Netherlands
- Organizational Case Studies
- Quality Assurance, Health Care*
- Specialties, Medical*
- State Medicine

6.3. Grey area of contents 1 – the value-ladenness of theories, frameworks, programmes, methods, etc.

What is the dilemma? There is a certain type of articles which bring to the fore values embedded in theories, methodologies and conceptual frameworks, or in interventions, policies and service organisation.

On some occasions, the attention to such values is conscious – their exploration and questioning is the aim of the paper.

On other occasions, this is not so – the paper, or at least its abstract, does not show evidence of reflexivity. Yet a values-sensitive reader will find that certain words are too emotive, too prescriptive; that some initial assumptions are too biased; that some conclusions are reached with the help of tacit, strongly value-laden premises.

If values research is a window to the values of stakeholders in a health-related context, the values referred to here are the ones that are built into the window itself. If values interventions are tools for harnessing or modifying the values of stakeholders in a health-related context, the values referred to here are the ones designed into the tools themselves.

The understanding of values with which we are working makes such cases a definite true positive. However, this type of values is clearly of a different order to the one reflected in most of the keywords suggested in this manual. It is also more difficult to draw boundaries around – if one is overly sensitive to the values inherent in research and interventions, one can end up including virtually any true positive for a double reason (the values it explores and the ones underlying the exploration) as well as a large number of what would otherwise be clear false positives. In the extreme, all stable ground in working with research findings and practical and theoretical arguments may be lost.
Arguments in favour of inclusion: theoretical consistency, the importance of knowing what values have been embedded in frameworks so that findings/outcomes can be critically evaluated.

Cases in which inclusion may be advised: topics for which a number of alternative research traditions and/or practical approaches exist; issues with regard to which patients tend to be treated as passive subjects, as recipients of interventions only.

Arguments in favour of exclusion: this type of values is ‘different’. Also, the internal grey area – the number of boundary cases within the category itself – is very large and needs further exploration.

Cases in which exclusion appears a safe choice: such values are indeed very different and it seems almost natural to discuss them separately. They also tend to be subversive of our current knowledge and practices. It is thus ‘safer’ to leave them for later, for others. And continue to do productive, although inevitably imperfect work. Or continue to be ineffective and/or oppressive and self-deceive we are doing good.

Subtypes and examples:

A. The first subgroup of studies concerns scientific controversies, or reconceptualisations and new models offered as a better alternative to existing ones. Usually these are presented in a ‘here is a better approach’ style, with limited, if any, discussion of the assumptions and values underlying the new model.

The first example below is of a clear true positive, if articles of this type of values are treated as true positives. The second may itself be considered a borderline case (in addition to being one in a borderline category).


The debate on ethnicity and dementia: from category fallacy to person-centred care?

Iliffe S, Manthorpe J.

The concept of ethnicity remains attractive and meaningful to service developers and professionals, although research suggests that this disguises other facets of identity and difference. An epidemiological perspective on the relationship between ethnicity and dementia supports the idea that ethnicity (defined as particular shared cultural characteristics) is not likely to influence unduly the emergence of dementia in individuals. Cultural factors may protect against dementia, impeding its recognition and influencing its course and these deserve further investigation. Ethnicity is a general concept that subsumes and conceals the impact of migration, education, health beliefs and socio-economic status on health, and therefore is problematic. Empirical research on dementia and ethnicity reveals that intra-ethnic group variation is greater than inter-ethnic group variation; supporting the view that ethnicity as a category may not have great explanatory power and may foster a category fallacy. However, the experiences of people with dementia and their carers show that the important issues for service providers to consider are language, religious belief and observance, cultural practices (including food and personal care practices) and social support and coping mechanisms. In this position paper we argue that these issues are applicable to all individuals with dementia, independent of apparent ethnicity, and that
promotion of cultural competence in service provision should not be relegated to an ethnic minority agenda. The task for health and social care providers is therefore to recognise the diversity of users and to increase access to appropriate quality mainstream person-centred services, rather than to develop segregated or specialized services.

MeSH Terms:
- Adaptation, Psychological
- Aged
- Attitude to Health/ethnology*
- Cultural Characteristics
- Dementia/ethnology*
- Dementia/therapy*
- Great Britain
- Health Services Accessibility
- Health Status
- Humans
- Language
- Life Style/ethnology
- Mental Health Services/organization & administration*
- Patient-Centered Care
- Social Support
- Socioeconomic Factors


**Schizoaffective disorders are psychotic mood disorders; there are no schizoaffective disorders.**

Lake CR, Hurwitz N.

Schizoaffective disorder (SA D/O), introduced in 1933 by Dr. Jacob Kasanin, represented a first, modest change in our concept about the diagnoses of psychotic patients away from the beliefs of E. Bleuler, i.e., that hallucinations and delusions define schizophrenia, and toward the recognition of a significant role for mood disorders. SA D/O established a connection between schizophrenia and mood disorders, traditionally considered mutually exclusive, a connection that has strengthened progressively toward the diagnostic unity of all three disorders. A basic tenet of medicine holds that if discrepant symptoms can be explained by one disease instead of two or more, it is likely there is only one disease. The scientific justification for SA D/O and schizophrenia as disorders distinct from a psychotic mood disorder has been questioned. The "schizo" prefix in SA D/O rests upon the presumption that the diagnostic symptoms for schizophrenia are disease specific. They are not, since patients with severe mood disorders can evince any or all of the "schizophrenic" symptoms. "Schizophrenic" symptoms mean "psychotic" and not any specific disease. These data and a very low interrater reliability for SA D/O suggest that the concepts of SA D/O and schizophrenia as valid diagnoses are flawed. Clinically SA D/O remains popular because it encompasses both schizophrenia and psychotic mood disorder when there is a diagnostic question. We present a review of the literature in table form based on an assignment of each article assigned to one of five categories that describe the possible relationships between SA D/O, schizophrenia and psychotic mood disorders. We conclude that the data overall are compatible with the hypothesis that a single disease, a mood disorder, with a broad spectrum of severity, rather than three different disorders, accounts for the functional psychoses.

MeSH Terms:
- Affective Disorders, Psychotic/classification
- Affective Disorders, Psychotic/diagnosis*
B. The second subgroup of studies includes research that uses value-laden concepts and does not acknowledge or discuss this value-ladenness.


Reasoning, emotions, and delusional conviction in psychosis.

Garety PA, Freeman D, Jolley S et al.

The aim of the study was to elucidate the factors contributing to the severity and persistence of delusional conviction. One hundred participants with current delusions, recruited for a treatment trial of psychological therapy (PRP trial), were assessed at baseline on measures of reasoning, emotions, and dimensions of delusional experience. Reasoning biases (belief inflexibility, jumping to conclusions, and extreme responding) were found to be present in one half of the sample. The hypothesis was confirmed that reasoning biases would be related to delusional conviction. There was evidence that belief inflexibility mediated the relationship between jumping to conclusions and delusional conviction. Emotional states were not associated with the reasoning processes investigated. Anxiety, but not depression, made an independent contribution to delusional conviction. Copyright (c) 2005 APA, all rights reserved.

MeSH Terms:
- Adolescent
- Adult
- Anxiety/diagnosis
- Anxiety/psychology
- Awareness*
- Cognitive Therapy
- Cohort Studies
- Delusions/diagnosis*
- Delusions/psychology
- Delusions/therapy
- Depression/diagnosis
- Depression/psychology
- Emotions*
- Family Therapy
- Female
6.4. Grey area of contents 2 – research that explores values and evaluative processes from a reductionist perspective

**What is the dilemma?** There is a relatively small, but clearly identifiable group of studies of preferences, choices, judgements, decisions, etc. underpinned by evolutionary, physiological, computational and similar reductionist approaches. The focus of such studies is on values phenomena which can be explored without any reference to society, culture or idiosyncratic individuality.

These phenomena are clearly of a values nature under a broad understanding of values. However, the intuition is that they are not the type of values to be elicited by a health professional or accommodated in policies and service organisation. At the same time, learning about how biological, environmental, evolutionary and suchlike mechanisms determine the evaluations and choices of all human beings is one of the routes to a better understanding of the ‘other’ values – those that are, at least partially, a matter of conscious choice and reflective espousal.

**Arguments in favour of inclusion:** This is a fascinating and extremely important area. It holds the key to the limits and dangers of a values-based approach. It holds the key to the manipulation of health behaviours, to the ‘nudge’ that is controversial even when done with the best interests of individuals and populations in mind. It holds the knowledge that allows for such manipulations to be uncovered. It is also one of the areas which links the ‘mental’ and the ‘physical’, which is essential in understanding and improving both physical and mental health.

**Cases in which inclusion may be advised:** We would generally support inclusion, although such studies are likely to require analysis on their own terms before being pooled together with more typical values studies. It seems essential to include them in critical explorations of values, preferences, choices, etc. underpinned by strong consumerist elements and associated with superficial satisfaction.

**Arguments in favour of exclusion:** will be a serious challenge to combine this type of studies on values with the studies on more culturally and socially determined values.

**Cases in which exclusion appears a safe choice:** It seems that an interesting perspective will always be lost if such studies are excluded.
Subtypes and examples:

A. Studies in this subgroup explore how manipulating seemingly minor elements of the external environment brings about changes in people’s evaluations, choices, preferences, etc.:

Health Psychol 2002, 21(5): 505-512

Comparison of price change and health message interventions in promoting healthy food choices

Horgen KB, Brownell KD

This study examines the feasibility and effectiveness of an environmental intervention for improving diet by comparing the impact of health messages, lowered prices, and their combination on the purchase of healthy food items in a restaurant. Price decreases alone, rather than a combination of price decreases and health messages, were associated with a higher level of increased purchases of some healthy food items as compared with control items over a 4-month period. Price decreases may be a more powerful means than health messages of increasing consumption of healthy foods. Health messages may have paradoxical effects if foods labeled as healthy are assumed to taste bad.

MeSH Terms:
- Commerce
- Female
- Food Preferences/*psychology
- Health Behavior*
- Health Knowledge, Attitudes, Practice
- Health Promotion*
- Humans
- Male
- Motivation
- Nutritional Sciences/*education
- Obesity/*prevention & control/psychology
- Restaurants/*economics


Words matter: increasing the implementation of clinical guidelines.

Michie S, Lester K.

OBJECTIVES: To determine whether writing clinical guideline recommendations in behaviourally specified "plain English" language increases the likelihood of their implementation by service users (patients). DESIGN: Randomised controlled trial in which participants received either the original text of the National Institute for Clinical Excellence (NICE) public guidelines for the management of schizophrenia or a behaviourally specified text with the same content. SETTING: Mental health service user networks and voluntary sector organisations within two inner London boroughs. PARTICIPANTS: Eighty four mental health service users recruited by post or face to face contact at service user meetings. INTERVENTION: The section of the NICE public guidelines for schizophrenia concerning psychological and pharmacological treatments was rewritten to
improve style and behavioural specificity by applying evidence-based and psychologically informed principles of good written communication. OUTCOME MEASURES: Cognitive predictors of behaviour, as specified by the evidence based theory of planned behaviour, constituted the primary outcome as it was not possible to measure the actual behaviour of guideline implementation. The predictors were behavioural intentions to implement the guidelines, attitudes towards implementation, and perceived behavioural control over implementation. Satisfaction with the guidelines and perceived comprehension were also measured. RESULTS: Behaviourally specified “plain English” guidelines led to stronger intentions to implement the guidelines, more positive attitudes towards them, and greater perceived behavioural control over using them. There was no difference in satisfaction or perceived comprehension. CONCLUSIONS: Writing guidelines with high behavioural specificity in conjunction with the use of “plain English” may be a simple and effective method of increasing their implementation. Evaluation with a behavioural outcome is now needed.

MeSH Terms:
- Adult
- Attitude of Health Personnel
- Behavior Therapy
- Data Interpretation, Statistical
- Female
- Guideline Adherence*
- Humans
- Male
- Mental Health Services/manpower
- Mental Health Services/standards*
- Middle Aged
- Patient Compliance
- Patient Education
- Patient Satisfaction
- Practice Guidelines*
- Questionnaires
- Schizophrenia/drug therapy
- Schizophrenia/therapy*
- Writing

Deviant Behavior 2004; 25(1): 27-41

Exploring the purging behavior of Asian-Pacific adolescents in Guam: Does heavy television viewing make a difference?

Pinhey TK, Okinaka AM

This study explored the effects of heavy television viewing on the purging behavior of Asian-Pacific adolescents (grades 9 through 12) in Guam. We argue that Westernized television in Guam presents thin, tall, and athletic bodies as the only acceptable images for adolescents. Using logistic regression, we tested the television-purging connection using a probability sample of Asian-Pacific Islander high school students. The results of the analysis support the hypothesis that heavy television viewing is associated with male purging behavior, which is a form of self-directed deviance. Being overweight is also associated with purging for male and female adolescents. We discuss the implications of the findings for theory and future research. (PsycINFO Database Record (c) 2003 APA, all rights reserved)

KEY CONCEPTS: purging behavior; Asian Pacific ethnicity; television viewing
MAJOR DESCRIPTORS: *Purging-Eating-Disorders; *Racial-and-Ethnic-Attitudes; *Television-Viewing
B. Studies in this subgroup explore the “hardware” (biological, neurophysiological, neurocognitive, etc.) of values phenomena:


Neurocognitive correlates of therapeutic alliance in schizophrenia.

Davis LW, Lysaker PH.

Although therapeutic alliance in schizophrenia has been linked with treatment adherence and outcome, less is known about its clinical correlates. This study explored neurocognition as a possible predictor of perceived therapeutic alliance among people with schizophrenia in cognitive behavior therapy. Twenty-four participants with schizophrenia spectrum disorders and their therapists were administered the Working Alliance Inventory, Short Form after 3 months of therapy. Totals for clients and therapists were correlated with measures of verbal memory, premorbid intelligence, visual spatial reasoning, executive function, and attention, all obtained before beginning therapy. Poorer performance on verbal memory was significantly related to client report of stronger alliance, whereas better performance on visual spatial reasoning was significantly related to therapist report of stronger alliance. Client and therapist ratings of therapeutic alliance were significantly and positively related. Clients' abilities may differentially affect therapist and client perception of therapeutic alliance in schizophrenia.

MeSH Terms:
- Attitude of Health Personnel
- Attitude to Health
- Cognition Disorders/diagnosis*
- Cognition Disorders/psychology
- Cognitive Therapy*
- Humans
- Male
- Middle Aged
- Neuropsychological Tests/statistics & numerical data*
- Personality Inventory
- Professional-Patient Relations*
- Schizophrenia/diagnosis*
- Schizophrenia/therapy*
- Schizophrenic Psychology*
- Wechsler Scales


Mental health and diurnal salivary cortisol patterns among African American and European American female dementia family caregivers.

McCallum TJ, Sorocco KH, Fritsch T.

Using a sociocultural stress and coping model, this pilot study examines the influence of depressive symptoms and stress on diurnal salivary cortisol patterns among African American (N=30) and European American (N=24) female dementia caregivers and noncaregivers (African American, N=48; European American, N=15). Caregiving participants completed the Center for Epidemiological Studies Depression Scale (CES-D), Perceived Stress Scale (PSS), and Stress-Related
Growth Scale (SRGS) as respective measures of depressive symptoms, stress, and stress resilience. Participants also collected five saliva samples daily for two consecutive days. African American caregivers scored significantly higher than European American caregivers on the SRGS, but they did not differ on the PSS and CES-D scales. Regression analyses with age, ethnicity, caregiving status, and depressive symptoms as predictors, and cortisol slope as criterion, showed that only age and ethnicity predicted cortisol slope. African Americans had flatter slopes than the European Americans sampled, regardless of caregiving status. Findings highlight the role of cultural beliefs and of ethnicity in explaining cortisol function.

MeSH Terms:
- Adaptation, Psychological
- African Americans/psychology*
- Aged
- Caregivers/psychology*
- Circadian Rhythm
- Dementia*
- Depression/ethnology
- Depression/metabolism
- Depression/physiopathology
- European Continental Ancestry Group/psychology*
- Female
- Humans
- Hydrocortisone/metabolism*
- Mental Health*
- Middle Aged
- Pilot Projects
- Regression Analysis
- Saliva
- Stress, Psychological/ethnology
- Stress, Psychological/metabolism
- Stress, Psychological/physiopathology

6.5. Grey area of contents 3 – psychology research that entails strong values elements

What is the dilemma? The dilemmas discussed so far come together and crystallise, in various combinations, in a large number of psychological research studies. Most psychological research is heavily value-laden and this presents two major challenges.

First, if most psychological research is treated as true positive for values contents, it will overtake the pool of values studies. What is unique and potentially novel about the values-based practice approach may then be lost into the thinking of a well established discipline.

Second, if we begin to systematically unpack the values in psychological research studies, as a values-based approach would suggest, we may end up paying a high price: losing confidence in the substantive findings about values phenomena provided by psychological research. The question is again where to draw the dividing line.

Arguments in favour of inclusion: Such studies are a major source of findings about values, coming primarily in the shape of beliefs, attitudes, perceptions, expectations and suchlike phenomena. They are also a source of excellent techniques for working with values and value-laden phenomena.
(although the techniques are often used somewhat prescriptively, with the intention to change beliefs, perceptions, expectations, etc. in a predefined direction).

**Cases in which inclusion may be advised**: Such studies constitute a substantial part of the pool of potential values studies. A blanket exclusion is likely to be counterproductive. Finer inclusion/exclusion criteria may need to be developed.

**Arguments in favour of exclusion**: Many of those studies are based on strong assumptions and/or widely shared societal beliefs about functional and dysfunction beliefs, attitudes, perceptions, etc. As such, they may be relevant primarily in explorations of the values of a discipline, therapeutic approach, profession, society, etc. rather than of users' values. Also, an argument can be developed that dysfunctional values and evaluations are not to be considered on a par with other values, and that psychiatry and psychology are successfully working with those by conceptualising them as pathologies within their own frameworks rather than as dysfunctional values and evaluations in a values framework.

**Cases in which exclusion appears a safe choice**: Such studies should not be excluded by default, but finer inclusion/exclusion criteria may need to be developed.

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**Subtypes and examples:**

| A. Studies in this subgroup discuss value-laden cognitions (beliefs, perceptions, attitudes) which are considered, usually by patients and professionals alike, as dysfunctional/pathological. |


**Cognitive change in obese adolescents losing weight.**

Barton SB, Walker LL, Lambert G, Gately PJ, Hill AJ.

OBJECTIVES: To investigate how obese adolescents think about themselves in terms of exercise, eating, and appearance and whether these cognitions change over the course of a residential weight loss camp. RESEARCH METHODS AND PROCEDURES: Obese adolescents [N = 61; age, 14.1 (+/-0.2) years; BMI, 33.9 (+/-0.7) kg/m(2)] completed assessments of body weight and height and self-esteem and a sentence-completion test eliciting thoughts and beliefs about exercise, eating, and appearance at the start and end of the camp (mean stay, 26 days). They were compared with a single assessment of 20 normal-weight adolescents [age, 15.4 (+/-0.2) years; BMI, 21.8 (+/-0.5) kg/m(2)]. RESULTS: The obese adolescents lost 5.7 kg and reduced their BMI SD score by 0.25. Camp residence was associated with a significant reduction in the number of negative automatic thoughts and an increase in positive thoughts, especially related to exercise and appearance. There was no change in conditional beliefs, either functional or dysfunctional. Including BMI SD score change as a covariate took away all the main and interaction effects of time, showing that cognitive change was largely accounted for by the reduction in weight. Despite this improvement, campers remained cognitively more negative and dysfunctional than the normal-weight comparison adolescents. DISCUSSION: Obese adolescents not only lost weight, but they improved their self-representation, specifically in terms of automatic thoughts about exercise and appearance. Although these are short-term cognitive changes, they reflect positively on the camp experience and show the value of
psychological improvement in assessing obesity-treatment outcomes.

MeSH Terms:
Adolescent
Adolescent Behavior*
Adolescent Psychology*
Attitude to Health*
Body Image
Body Mass Index
Eating/psychology
Exercise/psychology
Female
Health Behavior
Health Resorts
Humans
Male
Obesity/psychology*
Self Concept
Weight Loss*


[Cognitive-behavioral therapy for auditory hallucinations resistant to neuroleptic treatment]

Favrod J, Pomini V, Grasset F.

The aim of this study is to test the feasibility and the efficacy of a cognitive and behavior therapy manual for auditory hallucinations with persons suffering from schizophrenia in a French-speaking environment and under natural clinical conditions. Eight patients met ICD-10 criteria for paranoid schizophrenia, 2 for hebephrenic schizophrenia and 1 for schizoaffective disorder. All were hearing voices daily. Patients followed the intervention for 3 to 6 months according to their individual rhythms. Participants filled up questionnaires at pre-test, post-test and three months follow-up. The instruments were the Belief About Voice Questionnaire--Revised and two seven points scales about frequency of hallucinations and attribution of the source of the voices. Results show a decrease of voices' frequency and improvement in attributing the voices rather to an internal than to an external source. Malevolent or benevolent beliefs about voices are significantly decreased at follow-up as well as efforts at coping with hallucinations. Results should be interpreted with caution because of the small number of subjects. The sample may not be representative of patients with persistent symptoms since there is an over representation of patients with benevolent voices and an under representation of patients with substance misuse.

MeSH Terms:
Adult
Antipsychotic Agents/pharmacology
Cognitive Therapy*
Drug Resistance
Female
Hallucinations/therapy*
Humans
Intervention Studies
Male
Middle Aged
Schizophrenia/complications*
Treatment Outcome
B. Studies in this subgroup discuss affective states which are considered dysfunctional/pathological, similarly to the cognitions illustrated above. These are different to the studies on ‘normal’ or typical emotions and feelings elicited in response to an illness experience and which seem to be definite true positives (not illustrated here).

*Eat Behav* 2003; 3(4): 341-347

**Emotional eating in overweight, normal weight, and underweight individuals**

Geliebter A, Aversa A

Emotional states and situations can affect food intake. We predicted that underweight individuals would eat less and overweight individuals would eat more during negative as well as positive emotional states and situations. Questionnaires to assess eating during emotional states and situations were distributed and collected in person in several major university and public libraries. Ninety questionnaires, representing for each gender the 15 most overweight, the 15 closest to normal weight, and the 15 most underweight, were analyzed. Gender had only minor effects on the eating ratings, and therefore the results are presented for the sexes combined. Underweight individuals reported eating less (P=.000) than both the normal and overweight groups during negative emotional states and situations. More surprisingly, underweight individuals also reported eating more (P=.01) than the other groups during positive emotional states and situations. Thus, part of the prediction was confirmed: the relative undereating by the underweight group, and the relative overeating by the overweight group during negative emotional states and situations. As compared to their usual eating behavior, undereating by underweight individuals during negative emotional states and situations was of a greater magnitude than their own overeating during positive states and situations (P=.01). Undereating by underweight individuals when experiencing negative emotions may contribute to their low body weight.


**Understanding suicidal ideation in psychosis: findings from the Psychological Prevention of Relapse in Psychosis (PRP) trial.**

Fialko L, Freeman D, Bebbington PE, Kuipers E, Garety PA, Dunn G, Fowler D.

**OBJECTIVE:** To examine the clinically important phenomenon of suicidal ideation in psychosis in relation to affective processes and the multidimensional nature of hallucinations and delusions. **METHOD:** In a cross-sectional study of 290 individuals with psychosis, the associations between level of suicidal ideation, affective processes, positive symptoms, clinical and demographic variables were examined. **RESULTS:** Forty-one per cent of participants expressed current suicidal ideation. Suicidal ideation was associated with depressed mood, anxiety, low self-esteem, negative illness perceptions, negative evaluative beliefs about the self and others and daily alcohol consumption. Frequency of auditory hallucinations and preoccupation with delusions were not associated with suicidal ideation; however, positive symptom distress did relate to suicidal thoughts. **CONCLUSION:** Affective dysfunction, including distress in response to hallucinations and delusions, was a key factor associated with suicidal ideation in individuals with psychotic relapse. Suicidal ideation in psychosis appears to be an understandable, mood-driven process, rather than being of irrational or ‘psychotic’ origin.
C. Studies in this subgroup present research on psychological therapies addressing cognitions and emotions as the ones discussed in A and B. In the majority of cases they point to values and evaluations which are believed to be dysfunctional, damaging to the people who hold them. Whether this is so may depend on the perspective taken. A decision about inclusion/exclusion can only be taken relative to the scope and aims of a particular search.

There is one further aspect in which such studies may be of interest – they may describe effective tools and techniques for identifying, discussing and negotiating values.

- **cognitive-behavioural therapy**


Early intervention for relapse in schizophrenia: impact of cognitive behavioural therapy on
negative beliefs about psychosis and self-esteem.

Gumley A, Karatzias A, Power K, Reilly J, McNay L, O’Grady M.

OBJECTIVES: The study aimed to test two hypotheses. Firstly, that participants who relapsed during the 12-month follow-up period of our randomized controlled trial, would show increased negative beliefs about their illness and reduced self-esteem, in comparison to the non-relapsed participants. Secondly, that cognitive behavioural therapy (CBT) for early signs of relapse would result in a reduction in negative beliefs about psychosis and an improvement in self-esteem at 12 months. DESIGN AND METHODS: A total of 144 participants with schizophrenia or a related disorder were randomized to receive either treatment as usual (TAU; N=72) or CBT (N=72). Participants completed the Personal Beliefs about Illness Questionnaire (PBIQ; Birchwood, Mason, MacMillan, & Healy, 1993) and the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965) at entry, 3 months, 6 months, and 12 months. RESULTS: At 12 months, relappers showed greater increase in scores for PBIQ entrapment compared with non-relappers. In addition, after controlling for baseline covariates (treatment group and PBIQ self versus illness), relappers also showed greater increase in scores for PBIQ self versus illness at 12 months. Furthermore, in comparison to treatment as usual, participants who received CBT showed greater improvement in PBIQ loss and in Rosenberg self-esteem. CONCLUSIONS: The study provides evidence that relapse is associated with the development of negative appraisals of entrapment and self-blame (self vs. illness). In addition, this is the first study to show that CBT reduces negative appraisals of loss arising from psychosis and improvements in self-esteem. Implications for future research and treatment are discussed.

MeSH Terms:
Adolescent
Adult
Aged
Attitude to Health
Cognitive Therapy/methods*
Culture*
Female
Humans
Male
Middle Aged
Psychotic Disorders/psychology*
Questionnaires
Recurrence
Schizophrenia/therapy*
Self Concept*
Time Factors


Cognitive therapy for command hallucinations: randomised controlled trial.


BACKGROUND: Command hallucinations are a distressing and high-risk group of symptoms that have long been recognised but little understood, with few effective treatments. In line with our recent research, we propose that the development of an effective cognitive therapy for command hallucinations (CTCH) would be enhanced by applying insights from social rank theory. AIMS: We tested the efficacy of CTCH in reducing beliefs about the power of voices and thereby compliance, in a single-blind, randomised controlled trial. METHOD: A total of 38 patients with command
hallucinations, with which they had recently complied with serious consequences, were allocated randomly to CTCH or treatment as usual and followed up at 6 months and 12 months. RESULTS: Large and significant reductions in compliance behaviour were obtained favouring the cognitive therapy group (effect size 1.1). Improvements were also observed in the CTCH but not the control group in degree of conviction in the power and superiority of the voices and the need to comply, and in levels of distress and depression. No change in voice topography (frequency, loudness, content) was observed. The differences were maintained at 12 months’ follow-up. CONCLUSIONS: The results support the efficacy of cognitive therapy for CTCH.

MeSH Terms:
Adult
Auditory Perception*
Cognitive Therapy/methods*
Female
Hallucinations/therapy*
Humans
Internal-External Control
Male
Middle Aged
Psychiatric Status Rating Scales
Schizophrenia/therapy*
Schizophrenic Psychology*
Single-Blind Method
Treatment Outcome

• other types of therapy that ask for stories, meaning, etc.


Psychotherapy in long-term care: A review.


Psychological distress in long-term care (LTC) settings is highly prevalent and crosses many conventional psychiatric diagnostic boundaries. Mental health professionals who consult in LTC facilities have experienced firsthand the impact of a variety of nonpharmacological therapeutic approaches on individual residents, yet these are rarely investigated in a systematic fashion, and even less commonly reported in the literature. The present report summarizes the state-of-evidence of "talk therapies" for depression and psychological well-being in LTC facilities by reviewing controlled trials of psychotherapy for LTC residents published in English-language peer-reviewed journals. We excluded studies of nonpharmacological approaches designed primarily to curb behavioural disturbances of dementia, and those psychosocial interventions using an approach other than "talk therapy" in individual or group format since they have been reviewed in detail elsewhere. A majority of the 18 studies that met our inclusion criteria reported significant short- and, in some cases, longer-term benefits on instruments measuring depression, hopelessness, self-esteem, perceived control, and a host of other psychological variables. However, these findings must be interpreted within the severe methodological limitations of many studies, including small sample sizes, variable study entry criteria, short duration of trials, heterogeneous outcome assessment methods, and lack of detail on intervention methods. Nevertheless, the positive efficacy of these approaches, when understood within the framework of potential serious complications of pharmacotherapy for frail elders with multiple comorbidities, polypharmacy, and a narrow therapeutic index, suggests a strong need for methodologically rigorous trials of psychotherapy in
the LTC setting, especially in combination with pharmacotherapy.

MeSH Terms:
Aged/psychology
Aged, 80 and over
Cost-Benefit Analysis
Dementia/complications
Depressive Disorder/etiology
Depressive Disorder/psychology
Depressive Disorder/therapy*
Evidence-Based Medicine
Female
Follow-Up Studies
Frail Elderly/psychology
Humans
Internal-External Control
Long-Term Care/economics
Long-Term Care/methods*
Long-Term Care/psychology
Long-Term Care/standards
Male
Mental Health
Nursing Homes*/organization & administration
Outcome Assessment (Health Care)
Program Evaluation
Psychotherapy/economics
Psychotherapy/methods*
Psychotherapy/standards
Randomized Controlled Trials
Research Design
Sample Size
Self Concept

D. Studies in this subgroup use constructs that are value-laden in a variety of ways. For example, constructs such as ‘self-esteem’ and ‘self-efficacy’ entail a process of evaluation of one’s own worth as a person, one’s resources, etc. A slightly different set of constructs includes ‘personality’, ‘character’, ‘personality traits’, ‘regulatory mechanisms’, ‘coping styles’, etc. With these the evaluative aspect is in the moral judgements associated with the specific types through which the construct is realised (e.g. active vs. avoidant coping styles).

It is interesting that healthcare research tends to give further reasons for such moral judgements, as some generally commended personality types and traits have been shown to be associated with better health outcomes and well-being.

Articles in this group can be considered values articles for yet another reason. The constructs they use describe something global about the person, determine or are determined by a certain values hierarchy and affect a large number of beliefs, perceptions, evaluations, etc.

J Black Psychol 2003; 29(4): 408-428

Body mass index, self-esteem and suicide risk in clinically depressed African American and White American females
Self-esteem and depression, as well as depression and body mass index (BMI), have consistently been found to be significantly associated for African American and White American females. The results are dissimilar when BMI and self-esteem are studied. Historically, the relationship between BMI and self-esteem is weak or nonexistent for African American females; however, for White American females, the relationship is usually significant. The goal of this study was to determine whether clinically depressed, healthy-weight, overweight, and obese females would differ significantly on self-esteem and suicide risk measures. In a voluntary hospital-based inpatient psychiatric unit, 165 clinically depressed females completed the self-esteem rating scale and the suicide risk scale. Healthy-weight, overweight, and obese African American females did not differ significantly on measures of self-esteem and suicide risk. However, depressed, obese White American females had significantly lower self-esteem and increased suicide risk than depressed healthy-weight and overweight White American females. Implications of the current results are discussed. (PsycINFO)

KEY CONCEPTS: body mass index; self-esteem; suicide risk; clinical depression; African American females; White American females
MAJOR DESCRIPTORS: *Body-Weight; *Major-Depression; *Racial-and-Ethnic-Differences; *Self-Esteem; *Suicide-
MINOR DESCRIPTORS: Blacks-; Risk Factors; Whites-


The influence of temperament and character on functioning and aspects of psychological health among people with schizophrenia.

Eklund M, Hansson L, Bengtsson-Tops A.

Research findings that link personality factors to functioning and symptoms in schizophrenia are inconsistent, and further studies are needed within the area. The purpose of this study was to investigate how personality, as measured by the Temperament and Character Inventory (TCI), was related to demographic factors, subtypes of diagnoses, level of functioning, and aspects of psychological health, including sense of coherence, perceived control, and self-esteem, among people with schizophrenia. Subjects were 104 individuals, aged 20-55 years, in psychiatric outpatient care. The results indicated that personality was not related to subtypes of diagnoses or demographic characteristics of the respondents, but to level of functioning and all aspects of psychological health. Especially self-directedness distinguished three groups of functioning and was highly correlated with the different aspects of psychological health. The article discusses how knowledge of schizophrenic patients’ personality structure might be used for tailoring psychiatric treatments.

MeSH Terms:
Adult
Character*
Diagnostic and Statistical Manual of Mental Disorders
Female
Humans
Male
Middle Aged
Personality Disorders/diagnosis
Personality Disorders/etiology*
Exploring the connection between self-efficacy and effective diabetes self-management

Krichbaum, Kathleen; Aarestad, Vivian; Buethe, Marie

PURPOSE: The purpose of this study was to review the existing empirical evidence about factors that contribute to effective diabetes self-management as indicated by healthy outcomes in persons with the disease, with a specific focus on self-efficacy, to determine the link between learned self-efficacy and effective diabetes self-management in adults. METHODS: A systematic review was conducted of the extant literature from 1985-2001 that described factors related to effective self-management of diabetes. The review included theoretical and empirical articles. The search engines included CINAHL, MEDLINE, PUBMED, and COCHRANE. RESULTS: Empirical evidence suggests that the goal for educating people with diabetes should be to improve their individual self-efficacy and, accordingly, their self-management ability. CONCLUSIONS: Education sessions need to involve fewer lectures and more practical, interactive exercises that focus on developing specific skills.

MeSH Terms:
- Adaptation, Psychological
- Adult
- Aftercare
- Attitude to Health
- Diabetes Mellitus/prevention & control*
- Diabetes Mellitus/psychology
- Health Behavior
- Health Knowledge, Attitudes, Practice
- Holistic Health
- Humans
- Life Style
- Models, Psychological
- Needs Assessment
- Nursing Assessment
- Patient Education as Topic/methods*
- Patient Education as Topic/standards
- Self Care/psychology*
- Self Care/standards
- Self Efficacy*
- Treatment Outcome
Key learning points

After working through this chapter, you should have ...
» become aware of the types of dilemmas you are likely to encounter in processing values records. You should also have begun to articulate the pros and cons of applying different demarcation criteria in the context of your own study.

Key references


PETROVA, M., SUTCLIFFE, P., FULFORD, K. W. M. B. & DALE, J. (2011) Search terms and a validated brief search filter to retrieve publications on health-related values in Medline: a word frequency analysis study. J Am Med Inform Assoc, doi:10.1136/amiajnl-2011-000243 – this paper also includes instructions and numeric data from an inter-rater reliability exercise concerning the classification of values abstracts into true and false positives.


Key objectives of next chapter

» introduce you to the main challenges and approaches to analysing and synthesising values research.
Analysing and synthesising values research

CHAPTER 7

This chapter will ...

» introduce you to some of the main challenges in analysing and synthesising values research;
» offer initial suggestions on how to handle these challenges based on our experience of four pilot studies;
» refer you to relevant theoretical and methodological debates, e.g. concerning the synthesis of heterogeneous (qualitative and quantitative) evidence;
» begin to outline some possibilities for using non-research, ‘alternative’ materials on values (such as personal narratives, mass media materials, literature and art work, etc.).

Quick guide to expected background knowledge

This chapter assumes a basic understanding of the differences between quantitative and qualitative research. Opinions diverge as to the extent to which research of these two types can be meaningfully brought together. Effects of the so-called “paradigm wars” of the 70s and 80s persist, and some authors see fundamental, unbridgeable differences between quantitative and qualitative research. In recent years, however, the field of mixed methods research, which attempts to integrate quantitative and qualitative approaches (as well as research and the arts), has grown dramatically. Communication between diverse groups of health researchers and types of data, method and theory has improved. Nevertheless, numerous practical and theoretical difficulties of integration remain.

If you are unfamiliar with the debate on the quantitative-qualitative divide, you can read about it in almost any textbook on qualitative research methods and mixed methods research. Qualitative research often defines itself in opposition to quantitative research, while the reverse is rare. Mixed methods research justifies its existence against a perception of incommensurability of the qualitative and quantitative ‘paradigms’. The following website is an excellent source of information on mixed methods research in a health context, including suggestions for further reading:

http://www2.warwick.ac.uk/fac/med/research/hsri/primary_care/research_/centrepatexp/complexityhealth/mixedmethods/ (accessed Dec 11)

In the context of this chapter, experienced readers are those who are familiar with issues of mixed methods research and non-statistical research synthesis (through approaches such as meta-ethnography, meta-study, critical interpretive synthesis, realist synthesis, etc.). You will find that many of the difficulties and dilemmas encountered in these fields resurface in the field of values research.
The analysis and synthesis of values research are underexplored, theoretically and practically complex territories. In this chapter, we begin to outline relevant issues. Its main focus will be on the synthesis (integration) of findings from values research. The analysis of values research will be of interest primarily as preparation and part of the process of research synthesis.

### 7.1. Main challenges in appraising the quality of values studies

One of the most basic ways of analysing a study is by appraising it against a set of quality criteria. In recent years, a wide range of checklists for assessing the methodological quality of studies has been devised (see references at the end). There are no such checklists for values research and we are not aware of a debate on the topic. Generic checklists are appropriate for assessing the quality of values research, yet values-specific criteria still need to be developed.

Below we share observations on the quality of recent values research (the set of 2001-2008 studies on obesity, diabetes, dementia and schizophrenia used for the purposes of the search strategies work). We are also giving initial practical suggestions on how to address the associated difficulties.

- **explicit use of theory and definition of concepts**

  *Impressions from recent values research:* A high quality study employs, among other things, explicit theoretical postulates and clearly defined concepts and operationalisations. Many of the studies we screened used little, if any, theory concerning the values issues explored. Values concepts (e.g. attitudes, preferences, perceptions, etc.) are often treated as having self-evident meanings. In some cases, this may be appropriate in view of the aims of the study. It may also be claimed that the nature of the findings is more important than the way in which they have been named, e.g. whether they came under the heading of ‘perception’, ‘experience’ or ‘attitude’. The problem is nevertheless significant: the standard of values research, in terms of its theoretical and conceptual quality, is generally low.

  *Suggestions for practice:* If you are analysing and synthesising values research, make sure to define and operationalise the concepts you are using, even if their meaning appears self-evident (e.g. attitudes, preferences), and continue to refine your definitions and operationalisations as you go along. At the very least, this will help you solve many dilemmas concerning the inclusion and exclusion of studies. Going beyond dictionary definitions and identifying relevant theoretical work (most likely it will come from psychology and philosophy) will add substantial depth and clarity to your work, but may be a research study in its own right.

- **methodological quality**

  *Impressions from recent values research:* If values research is assessed using standard methodological quality checklists, our experience suggests that a large proportion of it will come out as low-quality. Sample sizes are often too small, sampling procedures are suboptimal or poorly described, the instruments used have not been validated, etc. Rigorous, well thought-through values studies are available and highly informative, but they are very much in the minority.

  *Suggestions for practice:* This may be a controversial suggestion and its implications need to be considered carefully, but we would suggest that you do not exclude studies on the basis of poor quality. Firstly, your pool of studies will be reduced dramatically. Secondly, and more importantly, if you intend to synthesise values research, you will be using only selected elements of your studies on which the overall quality of a study may have had little effect. This is discussed in greater detail below.
• **richness of information and explanatory potential**

*Impressions from recent values research:* Generally, qualitative studies have the ‘highest concentration’ of values topics. Quantitative and experimental studies, however, are more informative if you are interested in the effects of values on health-related decisions and behaviours or in their relationship to clinical parameters. As far as values constructs with high explanatory or heuristic potential are concerned, at this stage we can say relatively little. Some suggestions are offered in Chapter 2 on values questions (2.2.1 and 2.2.2).

*Suggestions for practice:* We would suggest that you do not select only studies that focus on your parameter of interest. Studies in which this parameter is present as a relatively marginal concept can enhance substantially your understanding of it by placing it in a wider context. It may also be counter-productive to exclude early on studies that seem to have little to contribute. Your ideas will change and it may be precisely obscure studies providing the elements that complete the whole.

• **values awareness**

*Impressions from recent values research:* Unsurprisingly, most studies we have screened have an awareness of the importance of values issues, even if it is only of the class of phenomena to which their specific concern belongs. In a small number of studies, values considerations feel as an add-on, only included in response to the call of the Zeitgeist. There is also a number of studies which mention no values issues in a context where, to a values-sensitive reader, their exploration appears essential. Interestingly, even those researchers who explore values issues show relatively little awareness of their own underlying values and how these may have affected what they have found about the values of others.

*Suggestions for practice:* This lack of awareness and inadequate control for researchers’ values introduces biases and ‘noise’. Discarding studies, however, may not be the best choice. A more informative approach might be to develop methods for exploring the effect of researchers’ values – through identifying them, developing conjectures about how they might have influenced findings, and proposing alternative interpretations to those arrived at by taking findings at ‘face value’. Easier said than done – how to approach such a project is a serious research challenge.

7.2. Difficulties in synthesising values studies

The extreme variety and heterogeneity of values studies presents serious problems in bringing them together into a meaningful summary picture. The process of synthesising values research is a new territory and the experience we can share (outlined below) is still limited.

7.2.1. Existing integrative methodologies

The problem of combining heterogeneous studies is not new in health research and the respective research field is quite lively. It is not, however, part of the mainstream of health research and still lacks a coherent research programme. High quality comprehensive resources on its theory and practices are also scarce. The reviews of Dixon-Woods et al. (2004); Pope, Mays and Popay (2007) and Barnett-Page and Thomas (2009) are amongst the most detailed reviews of integrative methodologies we have found (see end of the chapter for references).

1 “Heterogeneous” is understood here in a broad sense, as arising from a large diversity of theoretical frameworks, methods, fundamental assumptions about the world and knowledge, key constructs, etc.
Below are some examples of new and emerging methods for research integration that go beyond the mainstream systematic review and meta-analysis:

- Bayesian meta-analysis
- Comprehensive decision modelling
- Content analysis
- Critical interpretive synthesis
- Cross-design synthesis ("grouped meta-analysis")
- "EPPI-approach"
- Framework synthesis
- Grounded theory
- Meta-ethnography
- Meta-interpretation
- Meta-narrative
- Meta-study
- Multiparameter evidence synthesis
- Qualitative comparative analysis
- Qualitative meta-analysis
- Qualitative metasummary
- Qualitative metasyntthesis
- Realist synthesis
- Textual narrative synthesis

7.2.2. Main challenges in the synthesis of values research – our experience so far

Our experience in the synthesis of values research comes from the following pilot studies:

- Synthesising findings and ideas from recent values research on overweight and obesity (as collected for the purposes of the search strategies study). The aims of this work were to identify: 1) values constructs with high explanatory potential in thinking about overweight and obesity; 2) the most promising directions for values research on overweight and obesity; 3) issues on which communication and mutual understanding between stakeholders, primarily patients and health professionals, needs to be improved; and 4) values issues that need to be taken into account when developing weight reduction interventions.

- Comparing the findings and ideas from the research discussion on overweight and obesity, as outlined above, with messages coming from alternative, non-research sources, primarily web-published personal narratives.

- Synthesising ideas and findings concerning self-perceptions as overweight or obese. The aims of this work were to identify: 1) the value-laden determinants of this phenomenon (itself a value-laden one), 2) its impact on weight loss behaviours, 3) the mechanisms through which this impact is effected.

- Thematic analysis, for major issues and key messages, of recent values research on diabetes, obesity, dementia and schizophrenia (2004-2006), again as collected for the purposes of the search strategies study.

Some of our most salient impressions from the above studies are summarised below.

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2 The list is only illustrative and is based on methods identified in the above publications. The methods have not been appraised on their own terms or in terms of their suitability for synthesising values research.
Research synthesis concerning a wide area

- **If you would like to draw a detailed values picture of a wide area** (e.g. the values implicated in breast cancer), our experience with overweight and obesity research suggests that you plan for a medium-term, analysis-intense and creative project that is properly resourced and supported by experts in a range of thematic and methodological areas. If this is unrealistic, we would suggest that you synthesise studies on a specific and narrow question rather than perform a synthesis of ‘salient messages’. We found the main messages from an overview phase to be rather different from the main messages after an in-depth analysis. To a great extent this is because intense research interest, which comes through as salient messages, does not necessarily reflect importance and explanatory potential.

- **What worked for us** in synthesising values research on a wide area was mapping research topics, findings, claims, data and ideas onto a very general schema of a decision-making process (in this case of deciding to engage in weight loss behaviours). Parameters within this schema included, for instance, identifying oneself as overweight or obese, perceptions of the goal of weight loss, barriers to achieving it, etc.

  We can strongly recommend using a basic schema of a decision-making process. It is general and adaptive enough to provide a place for virtually any topic, finding, claim, etc., but also specific enough to circumscribe meaningful areas and draw useful boundaries between issues. It is dynamic enough to help elicit relationships and mechanisms of interaction and effect, yet open to different conceptualisations of how these ‘work’. The latter feature allowed us to explore a range of ‘models’ for the functioning of the system. This, in the case of a framework which asserts a wide variety and legitimacy of differing values, is an important asset.

- **What did not work for us** in synthesising values research on a wide area was using a broadly grounded-theory type of approach of letting a meaningful framework emerge from the data. In experimenting with such an approach, we categorised values along a wide range of parameters. Some examples of the many categories we experimented with are negative-positive values; age-related, gender-related, culture-related values, etc.; differences in values; conflicts of values; determinants of values; modifications as a result of experiences, etc. This grounded-theory type of approach of being completely open to the data may not have worked for spurious reasons, e.g. having been done relatively early in the analysis process. With the benefit of hindsight, we think it failed to work as our codes did not have enough process and dynamics within them and links with behaviours and decisions that are important from a practical point of view. To what extent this was our failure, and to what – a consequence of the nature of the research field and its data, is difficult to tell.

- **If you would like to draw the values picture of a wide area, but in less detail, as a bird’s eye view of key themes and major findings**, our experience with diabetes, dementia and schizophrenia research suggests that the outcome is interesting, but of limited practical usefulness. It can raise awareness of available research and offer a slightly new perspective towards a condition, but it does not provide sufficient substantive information to support decision making or practical changes. This may be slightly more useful if you are comparing conditions: it may make visible differences in research interest that are not justified by the nature of the conditions.

Research synthesis concerning well specified and relatively narrow questions

Our experience with narrow research questions on values comes from a study concerning self-perceptions as overweight or obese and their impact on weight loss behaviours. As much as the
research question of this study was much more specific than that of the larger study (see bullet points one and three under 7.2.2), the number of concepts and subtopics revealed by the process of operationalisation was still substantial. It may be the case values synthesis questions can be kept only relatively narrow.

The study involved synthesis of primarily qualitative and quantitative research and a small number of experimental studies. We did not find any fundamental difficulties in bringing them together arising from conflicting philosophical orientations and worldviews. Conflicting findings, non-matching concepts and diverse theoretical positions were found as much within methodological groups as between them. Our observations concerning the qualitative-quantitative divide are briefly outlined below.

Many other effective frameworks and approaches to performing informative values syntheses are likely to exist, as well as many ways of making the ineffective ones work. We would be very interested to hear about your experiences and both successful and unsuccessful attempts.

**Expect a process which is intense in interpretation and critique**

Our experience suggests that it is hard, if at all possible, to identify a large enough number of homogeneous studies to subject to either a quantitative synthesis (meta-analysis), or a qualitative synthesis that is not interpretation- and critique-intense. Even if you do manage to come up with a question and studies that allow this, the findings are likely to be of limited value. The reasons for this have been mentioned at various points throughout the manual, but here is a summary of them from the point of view of research synthesis.

A synthesis study of values research which involves limited interpretation and critique of its source studies is likely to be difficult to devise or of limited value if indeed performed because: the issues and constructs within the values studies are: 1) many; 2) either highly specific and narrowly defined, functioning within a very specific theoretical context, or vague and unspecified, functioning as concepts from the language of everyday life; 3) overlapping – to degrees and in ways awaiting description; and 4) explored in the context of highly dissimilar – theoretically and methodologically – studies. As a result, findings and ideas about values can neither be combined directly and effortlessly, nor keeping them separate appears justifiable. Any values synthesis work will thus require a high level of analysis, interpretation and critique, and there is limited guidance on how to proceed with these.

**Main concerns associated with high levels of interpretation and critique in integrating primary studies**

There seem to be two main concerns associated with high levels of interpretation and critique in integrating primary studies. The first is that one is ‘cherry-picking’ data from studies in a biased way, or can be seen as so doing. The second is that one is mis- or over-interpreting studies, or can be seen as so doing. Such concerns are somewhat unusual in mainstream research synthesis methods (e.g. systematic reviews), but are fundamental in primary research. We will only focus on some differences from a primary research context. They tend to arise from the fact that in integrative studies your data – other researchers’ studies – are widely available and that study authors will have expert opinion on the adequacy of their re-use.

Below we describe briefly these two main concerns in the context of the values synthesis work. We also include questions we have found helpful in reflecting on our decisions and judgements.
• **The need to be selective and the danger of bias**

In a synthesis study of a large number of primary research reports you are only using a fraction of their contents. You only select elements that are relevant to the question you are asking (although you may need to extract much additional information to guide your decisions about the elements of interest). It is also likely that what are key units of knowledge for you are only secondary for the source study. There is thus a serious danger of bias. In a new territory like values synthesis, it is difficult to know how to guard against it.

One recommendation we can make is to pay particular attention to studies that do not fit. Make sure you are not excluding them because you do not know how to deal with them, while using the argument that they are not ‘proper’ values studies. Trying to accommodate difficult to fit studies and elements gives you the stimulus to refine your ideas and concepts, even if in the end you decide that they are of no use to your current study.

• **The need for interpretation and the danger of interpreting past recognition**

In using findings from research which is clearly relevant but may not quite match your research question and working concepts, you may need to modify the statements in which the authors have expressed their findings. This change of context may, however, make them sound like different findings: their level of importance may diminish relative to that in the original study; the strength of the assertions may also be questioned; and the interpretation may alter the implications of the claim. The dangers of such a process, as in primary research, are of misinterpretation and over-interpretation.

Using a highly transparent translation process – for instance, providing a table illustrating how claims in the original study have been translated into claims in the values synthesis study – is one way of controlling for such dangers. You may also try contacting study authors to discuss interpretations. Establishing a referencing convention may too be helpful (e.g. adding an asterisk to references where one has diverged substantially from the authors’ interpretation). Keep checking that your starting framework is a lighthouse rather than a Procrustean bed. Can you defend each step in the ‘translation’ process? If this were your study, would you be happy with the re-interpretation?

**Observations on the quantitative-qualitative divide**

As mentioned above, our synthesis work did not present uniquely intractable problems in integrating qualitative and quantitative studies generated by their conflicting philosophical and theoretical underpinnings. Overall, the two broad methodological types seem interested in different values topics and constructs or in different, but complementary, angles to them. Contradictions and conflicts within the two groups are probably more and stronger than ones between them. Nevertheless, there are serious practical difficulties of integrating heterogeneous health research. The focus on differences along quantitative-qualitative lines may in fact be becoming counter-productive in exploring and handling these.

**Techniques we have found particularly useful**

These are standard research techniques we have found particularly useful in values synthesis work:

- Concept mapping;
- Tabulating of summary statements from the studies concerning the parameters we were exploring;
• Multiple classification of the same piece of information – not restricting claims to what appears to be their ‘most natural’ category.

Observations on analysing non-research, ‘alternative’ materials on values

In another pilot study we tried to compare the research discussion on values in overweight and obesity with the wider social discussion (primarily from web-published personal narratives, but also from other sources such as newspaper articles, TV programmes, artwork – literature, films, etc.). We also collected non-research materials on the other conditions from the search strategies study (diabetes, dementia and schizophrenia). The scope of this study was relatively limited, but such work appears promising and exciting. Below are our most distinct impressions:

• The ‘alternative’ materials on values offer a wide range of opportunities in two directions:
  - direct use of such materials, with no or minimal processing, for educational purposes. Many alternative materials have substantial potential in fostering empathy (towards patients); improving understanding (between patients and health professionals, patients and carers, etc.); creating a feeling of a shared burden, of control and hope; in providing advice of the type that is needed and in a way that feels most supportive (when patients share their experiences with other patients, carers with carers, etc.). Such materials can be highly valuable both for professional medical education and health education of the public, patients and carers (e.g. videos patients can watch in surgeries);
  - indirect use of such materials as raw data for research. They can be used to study the range and variety of individual values (as found, for instance, in web-published personal stories) or the nature of societal values upheld in a certain culture, at a certain time (as underpinning, for instance, mass media reporting). Interestingly, our pilot study did not find substantial differences in the values issues raised in research and in alternative materials. The language, emotional impact, the relative frequency of certain positions are, unsurprisingly, very different. The concerns, ideas and explanatory styles are, however, shared to a surprisingly high level.

• Alternative materials, however, present some specific difficulties, at least relative to the arsenal of typical healthcare researchers’ knowledge and skills. These are some examples:
  - what makes a good piece of ‘alternative material’? How will this differ depending on its primary use? For instance, emotional impact and ability to provoke insight may be criteria for materials to be used in medical education; ability to engender a sense of control, empowerment and support may be criteria for materials on patient education; ability to capture the typical and mundane along with the extreme and dramatic may be important for research, but what else?
  - what are appropriate techniques and methods to analyse such materials? To what extent are techniques from, for instance, media studies appropriate for health research studies?

7.3. Research priorities in developing the analysis and synthesis of values studies

The analysis and synthesis of values research, and the use of alternative materials on values, are a challenging new territory that requires much creative and innovative work. We see the following areas as research priorities:
• Experimenting with new approaches to the synthesis of values research and adapting existing approaches, such as the ones for qualitative and quantitative research integration;

• Refining our understanding of what makes important and answerable values questions;

• Theoretical and conceptual work on the wide variety of values concepts in health research (e.g. attitudes, preferences, perceptions, beliefs, expectations, satisfaction, quality of life, self-efficacy, etc.) – exploring their definitions, boundaries, relationships, etc.;

• Development of quality criteria for values research;

• Exploration of the potential of alternative materials to contribute to teaching and research.

Chapter 9 discusses priorities for future research in greater detail.

Key learning points

After working through this chapter, you should have …

» developed an understanding of the main challenges in appraising, analysing and synthesising values studies;

» planned to familiarise yourself with some of the currently available approaches for integrating heterogeneous research, if these are new to you.

Key references

Books and articles:

Review articles on methods of research synthesis


On methods of quality assessment applicable to a broad range of study types


**Websites:**

http://www2.warwick.ac.uk/fac/med/research/hsri/primary_care/research_/centrepatexp/complexityhealth/mixedmethods/ – an extensive and up-to-date collection of resources (including bibliography) of mixed methods resources for health research.

http://www.york.ac.uk/inst/crd/systematic_reviews_book.htm – the systematic reviews guidance of the Centre for Reviews and Dissemination. Quality assessment is discussed in relation to each specific type of review question.

http://www.cochrane-handbook.org/ – the Cochrane handbook for systematic reviews is another authoritative source on quality assessment of health research.

http://www.phru.nhs.uk/Pages/PHD/resources.htm – appraisal tools developed by the Critical Appraisal Skills Programme (CASP).

**Key objectives of next chapter**

» to help you in writing up sections of reports and papers which describe the process and outcomes of your literature searching.
CHAPTER 8

This chapter will ...

» suggest what information to include in search strategy sections of papers;
» suggest how to fine-tune the most widely disseminated pieces of information of any study (title, abstract and keywords) so that your work becomes easier to retrieve by your target audience.

This chapter will contain mostly generic advice, as we wanted to extend the advice suggested by available generic sources (relevant references are given at the end). The values-specific recommendations are in italic.

Quick guide to expected background knowledge

The quality of reporting the process and outcomes of literature searching tends to vary widely and is often suboptimal, even in systematic review articles. There are no consensual criteria of what needs to be reported about a search strategy. Cochrane systematic reviews are usually seen as being highly transparent about their search strategy, but on closer inspection the need for further detail becomes apparent in them, too.

The most detailed reports of search strategies we have seen (almost prohibitively detailed) are in the appendices to guidelines of the UK National Institute for Health and Clinical Excellence (NICE) (see end of chapter for an illustrative reference). These reports are highly transparent in terms of final search strategies: they tend to offer the complete searches for all databases which have been searched, even if differences are primarily of syntax rather than search terms. However, they give little information on the conceptualisation behind searches and on their performance parameters.

8.1. What information about a literature search process needs to be reported?

Box 8.1 lists questions and prompts to help you describe your search process in ‘review-heavy’ papers. Such high level of detail is necessary if you are reporting studies whose primary aim is to review the literature, or propose something new on the basis of a literature review (e.g. recommendations for policy changes). The list can also serve as a reminder of what is expected of a high quality search process.
Box 8. 1. What to report?

**Aims, in terms of coverage**

Have you described clearly the thematic coverage of your search? More specifically,

Have you identified the aspects of the topic in which you are interested and those in which you are not? Have you justified the exclusions?

*Detailed specification of the thematic coverage of your search is essential in all cases where you cannot rely on shared perceptions and expectations of what is to be included. Searches on values are a prime example.*

If not implicit in the thematic coverage, have you made clear the disciplinary perspective(s), primary audience and primary uses for which you will be exploring the issue in question? (This will have implications for the databases you choose.)

**Aims, in terms of performance priorities**

Have you described the performance parameters you have prioritised in developing your search strategy? For instance,

Has your aim been to develop a comprehensive search strategy for a systematic review (which will prioritise sensitivity)? Or have you tried to develop a highly precise search strategy (e.g. by utilising ‘major topics’)?

**Design, in terms of words and operators**

Have you described clearly the methods you have used to derive your search terms? Is a critical reader likely to be convinced that those methods were reasonable and that they were the most effective ones in the circumstances? More specifically,

Have you referenced search strategies on the same or similar topics which you have used as a starting point? Have you reported whether these were validated? Have you described their strengths and weaknesses? Have you explained in what ways you have attempted to improve on them? Have you explained (if not self-evident) why you think the changes you have introduced are likely to be improvements?

What other methods of search term generation have you used? (See the *Quick guide* box in Chapter 4 for a list of the main methods.)

If you have received advice from a library and information specialist, have you stated it? (Ideally, you should develop your search strategies with the support of a library and information specialist.)

If you have searched some of the words in selected fields (e.g. title) rather than all fields, have you justified it?
Have you made the core search strategy available? Have you indicated how it has been adapted for the other databases you have used? In particular, how have the thesaurus terms been changed?

**Design, in terms of sources of information**

Have you made it clear what sources of information you have used and why you have used them in preference to others?

For instance, in the case of values it is a good idea to try to combine databases which are very different from one another (e.g. the type of studies you are likely to retrieve from MEDLINE and Embase will be more similar to each other than those you are likely to retrieve from MEDLINE and Sociological Abstracts).

Have you justified your decision not to include certain expected databases or types of databases (e.g. grey literature)?

Have you listed all databases and other sources of information you have used?

Have you described additional approaches you have used? (E.g. citation tracking, hand searching of selected journals – systematic reviews are a good source of ideas for additional approaches.)

If you have used databases of alternative materials in your values searches, have explained your choice? Have you provided sufficient detail about them (as they tend to be less familiar to readers of health research)?

**Design, in terms of limits**

Have you reported what limits you have applied and justified your choices? For instance,

Have you indicated the month and year when you performed the search? Have you justified the choice of time period? (Ideally, your year limits should not be arbitrary but follow a natural benchmark, e.g. change in policy, changes in database indexing and nomenclature, or take up from the most recent comprehensive work on the same topic.)

Have you specified the other limits you have applied (e.g. languages, “humans”, etc.)? Remember that some limits may appear more innocuous than they actually are. For instance, by excluding articles not indexed by “humans”, you are also excluding non-indexed articles, which are the most recently added ones.

If you have applied a limit for a negative reason (e.g. limitations of resources that will not allow you to have non-English papers translated, rather than a positive reason – better focus, more relevant retrieval), have you described briefly the impact this may have had on the findings?
Retrieval *(performance of the strategy)*

Have you given detailed information on the performance of your search strategy? More specifically,

Have you specified total retrieval, number of articles excluded at the level of title (if first selection was done at the level of title), number of articles excluded at the level of abstract, total number of full text articles obtained, number of full text articles that were relevant?

Have you given information on inter-rater agreement regarding the selection process and how disagreements were dealt with?

(Providing the following information is *not* standard practice in studies that do not aim specifically at search filter development, but it may be highly valuable. You may wish to consider adding it in an appendix.) Have you shared any salient and interesting observations concerning the performance of your search strategy, such as appropriate words for a quick, scoping search (if yours was extensive) or for a systematic search (if yours was a quick, scoping one)? Have you shared observations on level of overlap between databases?

Limitations

Have you discussed the limitations of your search strategy? For instance,

Have you discussed the limitations in terms of coverage of issues, of potential bias introduced during the process of search term generation, limitations of suitability for different time periods (e.g. because of changes in indexing and nomenclature), of transferability to other areas, etc.?

8.2. How to make it easier for your target audience to find your work?

Before reading through our suggestions about making your work easier to find, try to come up with answers to the questions on the next page:
Now think of the title and abstract of your latest paper, published or unpublished. How does it fare relative to the parameters you have identified?

The advice in Box 8.2. attempts to accommodate the behaviours of both competent and intuitive searches. Many searchers will be using keywords that are inefficient, but highly intuitive. It is thus a good idea to choose words onto which both competent and intuitive searchers can latch.

While scanning the list, think again of the last abstract you have written.
Box 8.2. How to make your own work reach its intended audience?

1. Write a detailed and dense abstract. Short, general abstract may feel like the only thing you have energy for when they are the last step towards a paper submission, but remember that they are the face of your work, and one that is hastily judged.

2. Use varied vocabulary. Include words that are synonymous to the term you use for your main concept.

3. Consult the natural language terms statistics offered in this manual and, if possible, use terms with high precision.

4. Use some core words that may not work well, but are highly intuitive and likely to be used by many searchers. Words reappearing in published search strategies on your topic may be a useful guide.

5. If you decide to follow the suggestions in 3 and 4, don’t overdo it. Be creative. Do not contribute to a vicious path of a repetitive and impoverished vocabulary.

6. Many journals ask authors to provide controlled vocabulary terms describing their study. Again, it is often one of the last hurdles before you submit an article. You are likely to be impatient. Yet choose your terms carefully, as indexers will be guided by the terms you are offering. The number of competent searchers is increasing and they tend to use controlled vocabulary terms. The number of citations in databases is also increasing, which forces searchers to be more selective and rely on well chosen controlled vocabulary terms.

7. Familiarise yourself more closely with controlled vocabulary terms. Consult the lists offered in this manual; explore database thesauri; notice the terms indexing the articles you are retrieving. Many thesaurus terms are unintuitive, are used rarely, but give apposite names to phenomena. If you like a term, help it spread. If it is a good (and lucky) term, it will gain momentum. Even if it may not work particularly well now, it will work for you in the future.

8. Indicate your methodology – many search filters use methodology terms.

9. Choose an informative title – a popular way of limiting retrieval is by searching ‘title only’. Metaphorical or quotation-based titles, which are not unusual in qualitative research and discussion papers, may prevent your work from being identified easily. Make sure to include some more typical keywords, too.

10. If you are offering an alternative to an approach, theory, framework that carries a very different name to the one it critiques, mention ‘the opponent’ in the abstract or keywords – this may help searchers from the ‘enemy camp’ learn from you, too.

We will be very interested to hear your tips for making one’s work more easily retrievable by its target audience, or thoughts on practices that are likely to be counterproductive. Concerns about unintended consequences that may result from following the suggestions given above will also be much appreciated.
Key learning points

After working through this chapter, you should have ...

» developed a better understanding of what makes transparent reporting of a search process. This will improve not only the transparency of your reporting, but also the rigour of your searches;

» developed a better awareness of how to improve the chances of your work reaching its target audience, through careful attention to the vocabulary of your title, abstract and keywords.

Key references

Books and articles:


Websites:


http://www3.interscience.wiley.com/cgi-bin/mrwhome/106568753/HOME?CRETRY=1&SRETRY=0 – link to the Cochrane Library. Cochrane reviews set a standard for search strategy reporting.

Key objectives of next (and final) chapter

» to summarise what you (should, may) have learnt by working through this manual;

» to outline priority directions for research on identifying and utilising values research – i.e. the way forward for future versions of this manual.
Where are we now and what comes next?

CHAPTER 9

This (brief) chapter will ...

» summarise what you (should, may) have learnt by working through this manual;
» outline research priorities concerning the identification and utilisation of knowledge on values. These reflect issues which the manual has not been able to address in depth.

9.1. Looking back at what you have learnt

Take some time to answer the following questions:

» Do you feel your thinking about health-related values has changed? Do you think you have become more sensitive to the presence of values around you?

» Do you feel your understanding of how databases and search engines work has improved? If so, has this had an effect on the way you conduct literature searches?

» Do you feel you are able to select appropriate keywords for your searches?

» If you are given 3 hours and an unfamiliar area of health research, do you think you will be able to identify the main values debates in it as well as some core papers?

» Do you feel you have developed an awareness of the main challenges in selecting, analysing and synthesising values studies?

» Will you be able to describe a literature search process in a research paper?

» Do you think you would be able to perform a more effective and efficient literature search on a values topic compared to the one you would have done before you have read this manual?

If you have answered “yes” to most of the above questions, the manual has served its current aims. If not, go back to the relevant chapters and/or let us know what has been missing from them! Our intentions for improving the manual are described below.
9.2. **Priority issues for future research**

We would suggest the following four issues as research priorities in the field of literature searching for values publications. Expanding our knowledge and thinking on them and developing appropriate tools and methods is crucial in providing stable foundations for values searches.

- **What makes a good values question?**
  We began exploring this issue in Chapter 2, by suggesting a typology of values questions and some initial considerations on what makes a good values question. A major challenge to be met is the difficulty of drawing boundaries between and/or integrating different values concepts and topics. These overlap and interact in complex and unexplored ways. Work on values questions will also help resolve dilemmas of relevance (inclusion/exclusion criteria for values research), as addressed in Chapter 6.

- **Quality criteria for values research**
  Standard methodological checklists may need to be expanded to include items on the definition and operationalisation of values concepts, and on recognition of the potential biasing effects of one’s own values.

- **Adapting currently available approaches to synthesising heterogeneous evidence** (such as approaches for integrating qualitative and quantitative evidence) to the specifics of values research.

- **Developing values-specific approaches to research synthesis.**

9.3. **Next steps in developing the manual**

Below are priorities for empirical research which will help enhance the quality of the advice offered in the current version of the manual, particularly in relation to keywords and databases:

- Developing and applying alternative methodological approaches to identifying effective search terms;

- Performing tests on other conditions, longer time periods and larger datasets;

- Further work on exclusions (NOT-ting);

- Identifying further databases that cover relevant issues (specialised databases, grey literature and non-English sources are a particular priority);

- Exploring in greater depth how the databases identified so far cover values issues – in terms of thematic areas they are particularly strong/weak on, relevant thesaurus terms and relevant free text terms (the work so far has focused on MEDLINE). A particular priority is to explore the values coverage in Cinahl, in view of findings that it markedly outperforms other databases (MEDLINE, Embase, PsycINFO, ASSIA, etc.) in the retrieval of qualitative research (FLEMMING, K. & BRIGGS, M. (2007) Electronic searching to locate qualitative research: evaluation of three strategies. *J Adv Nurs*, 57, 95-100).

- Comparing the degree of overlap of values coverage between databases. The research tradition in this area seems to be to compare retrieval on a particular topic across databases.
In the case of values research more generally, a more informative approach might be to compare the journal lists of the databases of interest for face-valid journal titles and estimate the extent of overlap/exclusive coverage;

- Developing ‘star-term’ lists for narrower topics;
- Expanding reference lists and the number of links to high quality publications and sources, including relevant search filters;
- Evaluating relevant search filters in light of the findings from our research and suggesting revisions, if appropriate;
- Expanding the work on alternative sources (e.g. personal narratives, mass media materials, art work).

9.4. **A radically new approach?**

So far, our work on search terms has been negotiating current classification systems, thesauri and vocabulary. A more effective, but also quite radical approach might be to rethink and refine current classification systems. This will require much conceptual work and highly specialised expertise in areas like library and information sciences, database engineering, classification theory and biomedical ontologies. The future will tell if such an approach is feasible. For the moment, we hope that the research summarised in this manual serves you well.

**Good luck with your searches!**

You can contact us on:
Mila Petrova
mp320@exeter.ac.uk
This is a list of acronyms used at a number of points throughout the Manual. It excludes acronyms that have become established as proper names (e.g. MEDLINE) and acronyms used only once (their meaning is given in the text as they appear). We will greatly appreciate if you advise us of any omissions that impede understanding.

**ASSIA** – Applied Social Sciences Index and Abstracts

**CINAHL** – The Cumulative Index to Nursing and Allied Health Literature

**ESRC** – Economic and Social Research Council (UK)

**IBSS** – International Bibliography of the Social Sciences

**LSE** – London School of Economics and Political Science

**MeSH** – medical subject headings

**NHS** – National Health Service (UK)

**NICE** – National Institute for Health and Clinical Excellence (UK)

**PPI** – patient and public involvement

**PROMs** – patient-reported outcome measures

**SA** – Sociological Abstracts

**SSA** – Social Services Abstracts

**VaST** – Values Search Tools

**WMS** – Warwick Medical School