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Ethnographic evidence

The value of applied ethnography in healthcare

Jan Savage PhD, BSc(Hons), RN

Anthropologist in Residence

EGA/UCL Institute for Women's Health, London

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Abstract The move towards evidence-based healthcare across the industrialised world has raised questions about the nature of evidence, and how good evidence is determined. In response to a hierarchy of evidence in which findings from qualitative research are deemed to be the lowest form, qualitative researchers have underscored the different agendas of qualitative and quantitative research, and the potential for qualitative inquiry to explore complex problems, including the experiential components of healthcare. This paper, which provides a context for the other papers on ethnography in this journal issue, looks at ethnography in the context of this debate. It first offers an overview of what is meant by ethnography, its different forms of practice, and how it relates to qualitative research more broadly. It then looks at how ethnography has been applied in organisational and healthcare settings, before considering the nature of evidence that qualitative inquiry, and particularly ethnographic inquiry, can provide. It argues that, within the qualitative paradigm, ethnography is particularly valuable because of the attention it gives to context and its synthesis of findings from different methods. Moreover, ethnography offers a holistic way of exploring the relationship between the different kinds of evidence that underpin clinical practice.

Key words qualitative research, ethnography, evidence, context, evidence-based healthcare

Introduction

One of the main planks of recent NHS policy, the promotion of evidence-based healthcare, has prompted debate about the most credible forms of evidence and the most appropriate methodologies for its acquisition. Until recently, it was usually only studies that used an experimental methodology (such as randomised controlled trials) that were afforded scientific credibility. There is now growing recognition of the value of other, more qualitative kinds of evidence (Mays and Pope, 2000) and, as discussed more fully below, increasing interest in ethnographic evidence indicated, for example, by a move towards increased funding for ethnographic studies in the field of healthcare.

However, despite this, there remains considerable confusion about what ethnography is or is not, and limited understanding of how ethnography can be applied to

healthcare issues (Brink and Edgecombe, 2003). This paper, which provides a context for the other papers on ethnography in this issue, will first briefly outline what is meant by ethnography and how it relates to qualitative research more broadly. It then provides examples of the application of ethnography in both commercial and public sectors, before moving on to look at the nature of evidence that ethnography can provide and its relevance to healthcare issues.

The place of ethnography within qualitative research

Qualitative research is difficult to define with any precision. Very broadly, it is concerned with the study of social life in naturally occurring settings. This naturalistic approach tends to be contrasted with positivist social research, which assumes that it is possible to use the principles and methods associated with natural science to measure social phenomena. Traditionally, such quantitative approaches have been more widely accepted than qualitative research in the healthcare context.

Qualitative research is informed by one of a range of methodologies or broad theoretical and philosophical frameworks. The choice of methodology then influences the kind of methods chosen for a particular qualitative study: in other words, the method and methodology are inseparable (Brewer, 2000). Some researchers argue that qualitative research involves the use of multiple methods in an attempt to secure an in-depth understanding — a form of triangulation that provides an alternative to validation (Denzin and Lincoln, 1994). While a multi-method approach is characteristic of ethnography, much qualitative research, particularly in the health services, relies on a single method such as the use of focus groups. What is characteristic of all qualitative research, though, is that researchers study phenomena in their everyday context, and attempt to make sense of these phenomena in terms of the meanings that research participants bring to them.

Ethnography sits like a chameleon within the tradition of qualitative research. It is a form of naturalistic enquiry that may, if appropriate to the research problem and chosen methodology, incorporate quantitative as well as qualitative methods. For some, the term 'ethnography' is synonymous with fieldwork (what Brewer (2000) calls 'the little tradition'), while others use it to refer to the whole spectrum of qualitative research ('the big tradition'). To confuse matters further, the term 'ethnography' is sometimes mistakenly used interchangeably with 'participant observation' (Savage, 2000).

What is ethnography?

The absence of a single, fixed understanding of ethnography has probably contributed to its under-utilisation in healthcare research. At its simplest level, 'ethnography' can refer to a way of collecting data (a set of research methods); the principles that guide the production of data (a methodology); and/or a product (the written account of a particular ethnographic project).

Yet, at another level, ethnography can be understood as a composite of theoretical principles, method and written account: these different elements of ethnographic research are generally closely interwoven, as is made evident by the features that characterise ethnography. These features — not all of which are necessarily present, or given the same emphasis, in all ethnography — include recasting everyday understandings and practices that are taken for granted, or turning the familiar into the strange (Dixon-Woods, 2003). Ethnography is also typified by the priority placed on

gaining an emic perspective: the ethnographer tries to gain the insider's view of a particular group or community (or what Ong (1993) has referred to as 'getting under the skin of participants'). More recently, ethnographers have also been concerned with gaining the perspectives of numerous and differently positioned individuals, giving attention to questions of power, inequality and how some voices are heard above others. Historically, ethnographic research has tended to focus on 'culture' and to explore what people say, what they do, and the relationship between these. In doing so, the ethnographer draws on a number of methods, traditionally involving immersion in the life of research 'subjects' over a prolonged period of time. Typically, the researcher acts as the primary tool for data collection, although there is some dispute as to whether he or she needs to employ some form of observation for the study to be deemed ethnographic (Bloor, 2001). What, for many ethnographers, is centrally important is that findings are presented in a way that conveys a sense of 'being there', or indicates the nature of the relationship/s between the researcher and the researched, and how this may affect the research process and findings. Fieldwork may focus on a single, bounded community or explore the connections and relationships between different sites (Marcus, 1998). Usually, data collection does not follow a detailed, pre-determined study design, but is responsive to what is found in the field, while analysis is primarily concerned with understanding meaning or providing detailed description: there is generally little emphasis on quantification.

Yet, while all ethnographic research will incorporate some of these features, it is arguably the way in which ethnography makes links between the micro and macro, between everyday action or interaction and wider cultural formations through its emphasis on context, that most clearly distinguishes ethnography from other approaches (and makes it particularly valuable for researching healthcare issues). The ethnographer's approach can therefore be described as

a curious kind of cross-eyed vision, one eye roving ceaselessly around the general context, any part of which may suddenly reveal itself to be relevant, the other eye focusing tightly, even obsessively, on the research topic.

(Hirsch and Gellner, 2001: 7)

Just as there is no single understanding of ethnography, the use of an ethnographic approach is not limited to one disciplinary field. Sociologists, for example, have a long tradition of ethnographic work. In the United States, the Chicago School was hugely influential during the 1920s and 1930s in developing the use of ethnography to study small communities (such as street gangs) at the margins of industrial society, and later in exploring complex organisations, work practices and collective behaviour such as labour strikes.

However, ethnography is widely regarded to have originally sprung from social anthropology, at a time when the discipline was concerned with creating a comparative archive of the cultures of pre-industrial societies or groups, particularly those made subject to European and American colonialist rule (Marcus, 2003). Within anthropology, ethnography was initially characterised by long-term participatory fieldwork in small-scale and often remote communities, followed by an intensive period of writing, during which fieldnotes were transformed into a monograph. This provided a supposedly authoritative and unbiased account of the beliefs and practices of the group under study, preferably before these were contaminated by Western influences. Significantly, in a post-colonial age, ethnographers have become more

aware of their ambiguous political and ethical position, and of the need to give more attention to the relationships between knowledge, society and power. This awareness, together with changing views about the nature of knowledge, has led to both new areas of focus (such as healthcare) and new forms of ethnographic practice.

Different forms of ethnographic practice

A number of different types of ethnography have emerged in recent years, largely differentiated by the epistemology (theory of knowledge) and ontology (theory of being) that inevitably inform an ethnographer's approach. A useful but not exhaustive typology of these is provided by Skeggs (2001), who draws out the distinctions between naturalist, realist, modernist, social constructionist and postmodernist ethnography. Much of the ethnography carried out by anthropologists, Skeggs suggests, has been naturalist ethnography, which is underpinned by an ontological assumption that people can only be known through observing them in their 'natural' or everyday world. Realist ethnography is in many ways similar, but is perhaps more clearly premised on the belief that there is a single reality that can be discovered and described, and in which community, coherence and structure are key features. Rather differently, Hammersley (1992) proposes a more subtle form of realism, premised on an acceptance that research does not aim to reproduce reality, but merely to represent it. Moreover any representation will inevitably arise from a particular perspective in which some things are assumed to be pertinent and others extraneous.

Other forms of ethnography, while still shaped by assumptions regarding the nature of reality, also focus on issues of power, knowledge and identity. For example, Skeggs (2001) suggests that modernist ethnography is less concerned with community, and more with the construction of identity and what, or who, controls identify formation. While naturalistic ethnography has tended to report on those it studies, critical ethnography generally aims to speak on behalf of research participants, with a view to lending more authority to their voice (Thomas, 1993: 46) and, in some contexts, leading to the development of new ethnographic methods such as Participatory Rural Appraisal (Spencer, 2001). Along similar lines, feminist ethnography is concerned with questions about power and interests, although it may focus particularly on the way these shape women's experience. A more consistent focus of feminist ethnography, however, has been on the nature of the research process, how the ethnographer can best ensure that this is informed by a feminist ethics of care, and that knowledge is elicited in ways that can be used by research participants to change the exploitative conditions of their society (Skeggs, 1994).

These different approaches to ethnography can be understood to reflect a succession of phases, marked by changing assumptions about the relationship between researchers' aims and the knowledge they may produce, and changing mores governing the relationship between the researcher and the researched (Denzin, 1997). Yet, as Taylor (2002) has argued, these phases continue to exist, and often co-exist, in current research practice and might therefore be more accurately depicted as competing ideas that can shape social research.

The application of ethnography

Ethnography has long been used to study the everyday, such as organisational life or industrial relations. Wright (1994), for example, identifies three periods — the 1920s, the 1950s and 1960s, and the present time — when anthropologists have

made significant contributions to organisational studies. However, these sorts of ethnographic studies were still largely rooted in academic departments and, although they may have provided insights for the managers of various institutions or corporations, at heart they were generally concerned with the development of ideas about social organisation and culture, or with developing research methodology. Traditionally, those who plied their trade as ethnographers beyond the academy have been regarded by their colleagues as beyond the pale, and ethnography applied to the problems or requirements of industry and the public sector has often been viewed as 'impure' (Roberts, 2004).

Such a derogatory view of applied ethnography is, however, under review. To some extent, this change of heart within disciplines such as anthropology comes at a time of upheaval and uncertainty for university departments, indicated for example by declining student enrolment and course closures (Mars, 2004). At the same time, there is growing interest in the potential that ethnography offers amongst those outside the social sciences. Ethnography, it seems, has become something of a 'buzz word' and many businesses, institutions and organisations are now commissioning ethnographic research or employing anthropologists on their staff (Roberts, 2004). However, in the world of applied ethnography, academic debate on issues such as representation, multiple voices and so on tends to be set aside (Marcus, 2003). In other words, there is a new approval for ethnography, but generally in its more conventional or pragmatic forms.

The trend towards increased acceptance of ethnography is also driven in part by a growing resistance on the part of many key informants to continued co-operation with more traditional research procedures. Chapman (2001), for instance, suggests that there is particular disenchantment with the research questionnaires employed in business studies, partly because of the huge numbers of these that managers are asked to complete, as well as doubt about the quality of the data that these generate. There is a feeling on the part of participants that questionnaires ask the wrong questions, and as a result, response rates are low. In contrast, according to Chapman, an ethnographic approach can have the advantage of allowing managers a rare, and often highly valued, opportunity to talk about the complexity of what they do and to formulate and pursue problems in their own terms through discussions with someone who is genuinely interested. The value placed on this kind of opportunity can be evident, in Chapman's experience, in the way that interviews are not quickly terminated by participants, but often last longer than intended and sometimes only end because of exhaustion on the part of both parties.

Ethnography is useful in many contexts. For example, it is widely recognised as a form of pilot testing for a broader survey, or for clarifying hypotheses. It is particularly useful where information is new and unfamiliar, or when the information required is too subtle or complex to be elicited by questionnaires or similar techniques (Brewer, 2000). Ethnographic methods have been used to understand how people negotiate the sometimes competing demands of efficiency and quality (Smith, 2001). In addition, ethnographic research has been effective in uncovering the tacit skills, decision rules and subtleties in jobs labelled as routine, unskilled or deskilled, or even trivial (Smith, 2001). One area in which the value of ethnography is often overlooked is in helping programme developers (that is, those who introduce interventions with the aim of bringing about change) and programme evaluators (those who assess the effectiveness of an intervention programme) to improve the quality of their programmes. Nastasi and Berg (1999), for instance, claim that ethnography can

contribute to all stages of a programme, as well as facilitating the involvement of stakeholders. They argue that ethnography is crucial in describing and monitoring the process of change, and can help to describe the evolution of an intervention and its effect both on individuals and their social context. Moreover, ethnography is characterised by an iterative process of continuous data collection, analysis and reflection that makes it possible to strengthen or otherwise adapt interventions in a continuous manner and ensure a close relationship between intervention and assessment.

However, the application of anthropology to non-academic fields such as the worlds of business, or indeed healthcare — if traditional in terms of its epistemology — has involved a certain amount of adaptation and responsiveness on the part of ethnographers. Chapman (2001), for example, did not carry out classic fieldwork, but relied instead on long, unstructured and much-repeated interviews that he claimed remained within the ethnographic tradition, partly because of maintaining a focus on context, and because there was sufficient involvement to develop sustained and relatively 'close' relationships with participants.

With applied ethnography, the time available for fieldwork tends to be briefer than usual in ethnographic research; the nature of the relationship between the researcher and study participants may be differently structured (for example, informed by commercial interests rather than the pursuit of knowledge for its own sake); and there is often more, possibly multidisciplinary, collaboration on projects (Ortleib, 2004). In response to new types of research opportunities and new audiences, ethnographers have expanded their traditional tool kit of methods. These include techniques for rapid appraisal, and the development of 'quick ethnography' that integrates conventional methods of data collection and analysis with more novel approaches, such as successive pile sorts or multivariate statistical procedures (Handwerker, 2001). A further way of adapting ethnography to the tight deadlines of applied research is through team ethnography, rather than the employment of the traditional, solitary ethnographer or 'Lone Ranger' (Erickson and Stull, 1998). For example, some team ethnographers use the methods and iterative process of ethnography, albeit in a retracted way, together with the triangulation of findings to carry out rapid assessments for policy-makers and programme planners (Beebe, 2001). In addition, ethnography may be 'focused' in that it deals with a relatively narrow field of inquiry: in contrast to traditional ethnography, fieldwork may be premised on clearly formulated research questions (Kleinman, 1992). Yet while there may be differences between traditional and applied ethnography, these differences have been described as differences of degree, rather than of kind, with key features of an ethnographic approach, such as the focus on context, still central (Hart, 2004).

The application of ethnography to healthcare

Classic ethnographic studies of illness, health and healthcare include Goffman's (1961) exposition of patients' experiences of mental health institutions, Roth's (1963) study of how patients renegotiated treatment regimens in a TB sanatorium, and Strong's (1979) work identifying the tacit rules governing clinical interactions. A more recent example is provided by Lawton's (2000) study of patients' experiences of palliative care. Lawton carried out fieldwork in both a day care service and a hospice providing respite care, pain or symptom control, and 'terminal care' for patients with advanced disease (mostly cancer). One of the main findings concerned the way that patients' conception of self changed once they lost their physical ability to act for themselves and, more fundamentally, once the physical boundaries of their

bodies were irreversibly eroded. The findings thus make a significant contribution to understandings of the modern, Western self as well as providing important insights into the experience of terminal illness.

Although the findings from 'mainstream' sociological or anthropological studies can be made use of by healthcare practitioners, the nature and purpose of these studies — rather like the early ethnographic studies of organisations — have been shaped to a large extent by a social science agenda, particularly the development of social theory, and reported in the sociological or anthropological literature.¹ However, the usefulness of ethnography, either as the sole research approach or as an adjunct to others, is increasingly recognised within the field of healthcare research, with ethnography more and more applied to essentially practical concerns that have been identified, for the most part, by policy-makers, managers or practitioners, and reported primarily in professional rather than academic journals.² For example, ethnography has been recognised to be useful in the study of safety and quality in healthcare, being well suited to identifying conditions of risk, particularly where these are rooted in organisational dynamics, human performance or interactions between staff and technology, and in complex areas where there are long chains of causation (Dixon-Woods, 2003). As Dixon-Woods (2003: 326) puts it, ethnography 'can capture the winks, sighs, head shaking, and gossip that may be exceptionally powerful in explaining why mistakes happen, but which more formal methods will miss' (Dixon-Woods, 2003: 326).

The value of ethnographic evidence

Despite its potential, however, those who fund healthcare research, for the most part, have continued to shy away from ethnography. This is partly because, along with other qualitative approaches, it attempts to explain rather than measure, offers insight rather than generalisable findings, and generates rather than tests hypotheses (Jones, 1995). There remains scepticism about the usefulness of ethnography in the healthcare context, endorsed to some extent by controversy over whether or how qualitative research in general can be rigorously assessed, and a belief that ethnography, as a form of qualitative inquiry, inevitably provides a lower order of evidence than more quantitative types of research.

For example, whether or how qualitative research can be evaluated is highly contested, even amongst researchers in this field, with some arguing that qualitative research is premised on anti-realism (that is, that there is no reality that exists independent of our awareness of it), and therefore cannot be evaluated by any standardised set of criteria. Conversely, others suggest that, if qualitative research is to have any practical application, criteria need to be developed in order to allow evaluation, but because qualitative and quantitative research are located in essentially different research paradigms, the criteria they use will necessarily be different (Mays and Pope, 2000). Murphy et al. (1998), however, suggest that, whilst a rigid set of checklists is inappropriate, certain practices are helpful in ensuring the validity of qualitative findings³ and help readers to assess the trustworthiness of qualitative evidence. These practices include providing a clear account of how data has been collected, analysed and interpreted, with sufficient display of the data to allow the reader to assess whether the researcher's interpretation is supported, and an indication that researchers have not discounted data that contradicts their interpretation. In addition, there should be signs of in-depth reflection on the ways in which the research data are influenced by the research process.

Despite arguments that there are ways of evaluating qualitative research, the findings produced by ethnography, along with the findings of qualitative inquiry more generally, tend to be assigned an inferior position in the hierarchy of evidence that increasingly shapes decision-making in the health services. In industrialised economies, evidence-based practice has become one of the central means of assuring that clinicians base their clinical decisions on the 'best' available evidence, to the point that it has become a key factor in the allocation of healthcare resources (Forbes and Griffiths, 2002). However, what is agreed as 'evidence' is contentious: as Larner (2004) has noted, who controls the definition of evidence is a political matter. Evidence-based practice, which has emerged from the tradition of clinical epidemiology, has been accused of focusing only on variables that can be easily measured, and of recognising only certain kinds of evidence, predominantly evidence generated by experimental studies such as randomised controlled trials (RCTs). While RCTs represent a powerful method of testing which treatments have the greatest effect, they have certain limitations. For example

the constraints on the patients entered into trials are often very tight, which means that the result of the trial may not be applicable to the population from which they are drawn, or at least to the patients seen in the clinic or hospital ward.

(Goodman, 2000: 38)

As Goodman (2000) points out, although evidence-based medicine is now widely regarded as the safest form of practice, there is a lack of evidence that it is reliable or testable. Nonetheless, the emphasis placed on the findings of experimental research means that alternative forms of evidence arising from qualitative inquiry — evidence, for example, that may still contribute to the reduction of morbidity and mortality, or demonstrate efficacy (Morse, 2005) — has been largely overlooked. Moreover, although 'evidence' is often interpreted as information concerning the best course of treatment, decision-making in the healthcare context is also informed by other forms of knowledge (for instance, knowledge about the nature of health beliefs, the impact of organisational and cultural issues, or patient experiences that impact on treatments or services) that is more likely to be derived from qualitative rather than quantitative research (Pope and Mays, 1995).

On a more positive note, there are signs of a new openness to the various forms of evidence beyond that provided by experimental research with, for example, growing acceptance of the contribution that qualitative inquiry can make to systematic reviews (Dixon-Woods and Fitzpatrick, 2001). Indeed, recent guidance concerning systematic reviews of research on effectiveness (NHS Centre for Reviews and Dissemination, 2001) includes a consideration of qualitative research and recognises the range of different types of evidence that can be included in research synthesis. In addition, the remit of evidence-based practice topics has recently been extended to include phenomena such as 'experience' and 'perceptions' (Forbes and Griffiths, 2002), topics amenable to ethnographic inquiry.

However, research synthesis is a contentious issue for many qualitative researchers as qualitative inquiry appears incommensurate with the traditional rules of evidence and with the hierarchy of research designs advocated by evidence-based practice. For example, the principles informing qualitative inquiry are concerned with induction rather than deduction, subjective perceptions rather than objective quantification, and description and interpretation rather than inferential testing (Giacomini, 2001). Moreover, the synthesis of qualitative studies assumes that it is possible to generalise

beyond individual qualitative studies, an assumption that many in the qualitative research community do not accept (Campbell et al., 2003). Thus many take the stance that, rather than attempting to apply the conventional processes for synthesis to qualitative evidence, or trying to reconcile the different standards of evidence associated with quantitative and qualitative traditions, the kinds of findings generated by qualitative and quantitative approaches to synthesis are generally considered complementary rather than commensurate in nature, and cannot therefore be incorporated into the same reviews (Morse, 2005).

It is still early days in exploring whether, or how, it is possible to develop a system for synthesising qualitative research findings that remains true to the tenets underlying qualitative inquiry. As Morse (2005) has pointed out, there has been considerable effort to 'shoehorn' qualitative inquiry into the framework of evidence-based practice, despite the awkwardness of the fit. The danger remains of trying to stretch qualitative inquiry to meet the criteria developed for other types of research design that are considered more scientific or more objective, at the expense of the alternative kinds of evidence that qualitative inquiry can generate. The contribution of qualitative inquiry to healthcare lies in its potential to explore complex issues, such as those shaping the context of care, or the nature of care provided (Morse 2006). Within the paradigm of qualitative inquiry, ethnography, with its multi-method approach and attention to context, is particularly well suited to tackling such complexity.

In addition, the scope of ethnography means that it can make an important contribution to the debate about evidence itself, and, for instance, the extent to which protocols based on evidence arising from systematic reviews may impact on practice. For example, Smith et al. (2003) used an ethnographic approach to study the nature of anaesthetists' expert practice, and the role of different kinds of knowledge in accomplishing this. They found that varying and sometimes competing forms of knowledge were learned and employed in anaesthetic practice, namely knowledge of the patient as a person; knowledge derived from case notes; knowledge from direct observation and indirectly from electronic monitors; formal theoretical knowledge; and knowledge from experience. Findings suggested that instructional knowledge (that is, knowledge from sources such as textbooks or protocols) did not help practitioners to address the uncertainties they faced in practice, and did not lead to expertise. Deciding what was happening and how to respond to any particular situation was a matter of interpretation based partly on experience and what felt 'normal'. Indeed, in relation to a specific patient, experience could suggest that the most appropriate course of action ran counter to what protocols might propose, even though protocols are now the 'tool of choice' for clinical decision-making.

Conclusion

Curiously, the scope for ethnographic inquiry within healthcare research is currently shaped both by increasing receptiveness on the part of funders and others towards its potential and dismissal of its findings on the basis that it offers low-order evidence. While this contradictory stance is particularly noticeable towards ethnography, it is also experienced by qualitative researchers more generally. Those who resist this approach to evidence argue that qualitative research has inherently different aims, subjects and methods to quantitative research, that it can reach the areas that quantitative research cannot reach, and moreover, that continuing refusal to accept the kind of evidence that qualitative research provides will undermine improvements in

healthcare. Ethnography is especially suited to advancing the cause of qualitative inquiry within healthcare research. Its particular strengths, such as its multi-method approach (including its capacity to incorporate a varying range of methods to address research aims) and its attention to context, while giving voice to individual experience, provide a counter for the totalising tendencies of evidence-based practice. Finally, ethnography offers a holistic way of exploring the concept of evidence itself, or the interaction of different kinds of evidence, within the various contexts in which evidence-based practice is promoted.

Notes

- 1 For an overview of ethnographic research in medical sociology, for example, see Charmaz and Olesen (1997).
- 2 Indications of this include tendering by the National Patient Safety Agency (www.npsa.nhs.uk) for an ethnographic study of the practice of recycling single-use medical devices, and the commissioning of an ethnographic study of violence in the accident and emergency setting by the Service Delivery and Organisation Research and Development panel (www.sdo.lshtm.ac.uk).
- 3 Although 'validity' may have a slightly different meaning for quantitative researchers.

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Correspondence should be addressed to:

Jan Savage
 EGA/UCL Institute for Women's Health
 c/o Gynaecological Cancer Research Unit
 University College London
 Maple House
 1st Floor
 149 Tottenham Court Road
 London
 W1T 7DN
 Email: jansavage@ucl.ac.uk

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