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Authors in this issue

David Ross: I am a third year Adult Nursing student. I enjoyed a variety of clinical, acute and community placements during my nurse training. I am particularly interested in thoracic nursing as it entails investigation and treatment of diseases of the heart and lungs. The article I have written represents my experience during my nurse training.

Padraig O Hara: I studied Adult Nursing at Liverpool John Moore's University (LJMU) and graduated with a first class honours degree. My first clinical placement was in a hospice, which initiated my interest in palliative care. Following this placement, I joined the bank in the hospice and worked as a healthcare assistant and currently as a registered nurse. My full time post is in nephrology where I work closely with patients with end stage renal failure. At times, some of the patients and their families decide to opt out of treatment and require palliative intervention. The article I have written represents my current experience and interest in palliative care and highlights the challenges faced by patients, families and health care professionals.

Clare Henry: I am a student nurse currently in my third year of adult nursing. I am enjoying the course and the variety of learning opportunities on placement. I have developed a keen interest in wound management, in particular management of chronic wounds. I have written a synopsis review, which looks at Negative pressure wound therapy (NPWT) as a treatment option for diabetic foot ulcers.

Sarah Simons: I am a student nurse in the final year of my training to become an adult nurse. I have had twelve clinical placements thus far in a variety of settings including hospitals, community and independent sectors. I am currently choosing options for my negotiated management placement and am keen to seek out further experience of acute areas such as A&E or Intensive Care. My background prior to commencing my nursing degree was in sexual health where I worked as a health care assistant carrying out STI screening, pregnancy testing, condom teaching and general advice work. The area of sexual health and psychosocial factors affecting health interests me greatly and I enjoyed researching this further whilst writing this piece.

Susan Hopkins: At the time of writing this article, I was a registered adult and child nurse working as a Senior Lecturer. I had worked in nurse education since 1983.
My main interests have included mentorship and student nurse education, particularly study skills. For my Masters in Advanced Educational Practice (MAEP) dissertation I wanted to carry out research to explore if embedding study skills sessions in a module of study had any positive effects on students' learning and achievements. As part of my MAEP, I studied a research module, which involved experiencing different methods of collecting data for research, to help me to decide which methods I might eventually choose. This article is my reflection on the experience of one of these data collection methods.

Guest Editorial

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Health and social care research: a way of pragmatically addressing societal challenges

As a pragmatic philosopher and mental health nursing academic I passionately believe that health and social care research, which that is embedded within the real-life world of the service user, can assist us in addressing the big societal challenges. One such challenge is the challenge a rapidly ageing society poses. The UK population is rapidly ageing and by 2050, the number of people over 65 years old will have potentially doubled to 20 million, of that figure 8 million will be aged 80 or over. There is no doubt an ageing population will have a significant impact upon future health and social care delivery. Health and social care services are already responding to these predicted changes by focusing on providing care, which is more efficient and more effective. In addition, work-force planning initiatives are focusing on producing health and social care practitioners who will be technologically smart and adaptive to new ways of working (Smith 2015).

Research will play a pivotal role in ensuring these proposed changes are fit for purpose. However, due to the real-life context of care delivery different types of research approaches will have to be utilised, moving away from a one-size fits all approach. This pragmatic approach, using theory for utility sake rather than for theory sake, will move research methods away from just answering abstract questions to addressing real-life need, a user-centric focus to research. Using research in this way enables the practitioner to embed different sources of knowledge within their everyday decision-making activities while acknowledging that knowledge is not static, it is constantly interacting with the real world. Being adaptive to this fast-pace of knowing is a feature of expert practice it is also a feature of the innovator. This does not mean traditional methods are not valued; they are valued where they have utility and where they assist the practitioner to understand the real-life meaning and experiences of the service user (Greenop and Smith 2016).

Research as innovation can take many forms; a living lab approach will robustly structure this activity, an approach used at the Centre for Collaborative Innovation in Dementia. This approach, accredited through the European Network of Living labs (ENoLL), provides; “a user-centred, open innovation ecosystem based on a systematic user co-creation approach integrating research and innovation processes in real life communities and settings.” (ENoLL, 2017). The Centre’s participation within a European funded project called Innovate Dementia has systematically developed this living lab approach. This activity involved the Centre working with project partners to explore ways of developing innovative approaches to dementia care across North West Europe. The Centre worked with 5000 people with dementia in Liverpool, the business sector – SMEs and multinational companies, other academics, and commissioners and providers of services including clinical commissioning groups, NHS Trust, and diverse providers of services. Transnationally ‘over 15 innovations were brought to the market’. Furthermore, the Centre is now widening its reach by working with co-creation groups across health and social care, this work is not always condition specific, it can be international; however, the real-life needs of the user always drive this work.

Pre-qualifying programmes for aspiring health and social care professionals play a critical role in the development of the research-innovators of the future. These programmes such as the programmes at Liverpool John Moores assist the student to work with knowledge in way that is suitable for today’s and tomorrow’s health and social care challenges. Students who work alongside a research team or an active researcher will accelerate their development especially where a systematic approach is used. Outcomes should include writing a scholarly paper on a chosen the research topic, which is the aim of this journal (Jukkala et al., 2016). Students who participate in this type of activity will grow professionally and personally, other benefits include developing robust teamwork and communication skills. In addition, motivation and enthusiasm levels for research will increase particularly where this activity reflects the real world of practice (Stanford and Shattell, 2010).

References

European Network of Living Labs (ENoLL): http://openlivinglabs.eu/; accessed May 2017

Greenop, D & Smith, G (2016) Research in Smith, G (Editor) (2016) Dementia Care: A Practical Approach. Boca Raton, CRC Press

Jukkala, A.M., Miltner, R.S., Morrison, S.L., Gisiger-Camata, S., Todd, A., Moneyham, L.D. and Meneses, K.M., 2016. A team approach to enhance scholarship among honors students in nursing. *Nursing Education Perspectives*, *37*(3), pp.178-180.

Smith, G. (2015) The ageing society and its potential impact on health and social care provision: Editorial, Working Papers in the Health Sciences, Autumn 2015, pp.1-4

Stanford, D. and Shattell, M., 2010. Using an honors program to engage undergraduate students in research. *Nursing education perspectives*, *31*(5), pp.325-326.

Challenges for Men in a Female Dominated Environment

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Abstract

Florence Nightingale’s perception and feminisation of nursing into a female only profession has resulted in fewer men pursuing nursing as a career, with men in contemporary society making up only 10% of nursing professionals. Stereotyping and gender bias of men has helped create a less than inclusive, sometimes isolating and challenging experience for men in nursing, who are frequently treated differently to their female counterparts. It is important particularly for male nursing students to learn about men’s contribution to the history of nursing.

Keywords

History, Perceptions, Nursing, Men, Gender

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Introduction

Florence Nightingale's perception and feminisation of nursing into a female only profession has resulted in fewer men pursuing nursing as a career, with men in contemporary society making up only 10% of nursing professionals. Stereotyping and gender bias of men has helped create a less than inclusive, sometimes isolating and challenging experience for men in nursing, who are frequently treated differently to their female counterparts. It is important particularly for male nursing students to learn about men's contribution to the history of nursing.

Florence Nightingale

Florence Nightingale's perception of nursing as a career for women only is decreasing as more men enter the nursing profession. However, her 19th century 'feminisation of nursing' into a caring female only profession is still prevalent in contemporary society (Masters, 2009). There is a widespread assumption that while female nurses are suitable to provide intimate care for both male and female patients it is deemed inappropriate for male nurses to provide intimate care, such as inserting a catheter on a female patient (Harding, North and Perkins, 2008). Florence Nightingale perceived men to lack the capacity to be caring and empathic and saw nursing as suitable for women. It was an 'extension of their domestic roles' as nurturers and caregivers: theorising that nursing was not a place for men because their rough hands were 'not fitted to touch, bathe and dress wounded limbs' (Brown, Nolan and Crawford, 2000). This type of prejudice and gender stereotyping helped establish the discrimination of men in nursing which persists today.

Many in modern society view men who enter nursing as unmanly because they think male nurses don't conform to the traditional, heterosexual, patriarchal role. According to (How, 1995; Brown, 2010) prejudice has its roots in individual and social psychology, concealed until they surface in the process of furthering tradition. Consequently, male nurses continue to be discriminated against on the basis of 'socially constructed gender roles and norms' which initially prevented and now deter men from entering what many in society still consider a female only profession (Evans, 1997; Meadus, 2000).

History

Historically nursing has not always been a predominately female career. Prior to the 1800s and Florence Nightingale men significantly represented the nursing profession, mainly because of the association between nursing and the military (Office of Medical History, OMH, 2016). The first nursing school in the world, which included men only, was established as far back as 250 B.C. in India, were only men were considered 'pure' enough to become nurses (Vallano, 2011). Men's long history of being involved in nursing carried on to 330 A.D., in the Byzantine Empire (Bullough, 1994). During this era hospitals were one of the major institutions where nursing emerged as a separate occupation, primarily for men (Bullough, 1994; White, Duncan and Baumle, 2011). Male nurses also cared for the sick and injured during the Crusades in the 11th century and they staffed field hospitals during the Franco-Prussian War (1870-1871) where it was noted that the mortality rates amongst the troops were kept 'abnormally low' (Evans, 2004).

In World War I (1914 – 1918) male nurses served on the front line caring for the injured. They were known as 'orderlies' even though they had the same training and held the same diplomas as their female counterparts. They were paid about half of the salary of a female nurse (OMH, 2016). In Great Britain, the Nurses Registration Act was passed in 1919 (Sweet and Dougall, 2008). Although this act granted legal recognition to male nurses only female nurses were granted full membership on the registry. Male nurses were placed on a separate registry. Female nurses were often hostile to male nurses, re-enforcing negative stereotypes of men in nursing and often creating obstacles to their employment (Mackintosh, 1997). Consequently the Society of Registered Male Nurses was formed, in the 1930s, to encourage the professional training, conduct and tradition of men in nursing (O'Lynn and Tranbarger, 2007).

During World War II (1939 – 1945) many male nurses worked on the battlefield where female nurses were not allowed. In 1947, the sex segregation of nurse registries ended and men were allowed education and employment equity by the 1960s. In the US, to meet the needs of army personnel, the Army Nurse Corps (ANC) actively recruited male nurses, a segment of the nursing population that had previously faced stringent restrictions to stop them joining the ANC. Male nurses became a vital part of the ANC and in some cases military officials tried to maintain men only medical staff.

Male nurses in Vietnam worked alongside their female counterparts treating massive trauma injuries, displaying immense skill, compassion and professionalism. Few records of valour and dedication to duty by male nurses were kept and another part of the history of men in nursing was lost (Combs, 2012); leaving male nurses with little information about their professional background and historical position.

Barriers to men entering the nursing profession

The biggest barrier to men entering nursing is gender itself (Keogh and O'Lynn, 2007). Over the last 60 years or more many barriers to men entering the nursing profession have been removed. In 1951, the relaxation of registration laws which excluded men from entering nursing were removed and male nurses were allowed to join the main nursing register (O'Lynn, 2004). Worldwide the numbers of men entering the nursing profession remains generally low, with men, in the UK, comprising 10.6% of the nursing workforce (Regan, 2012). Hodes (2005) and Stanley (2012) argue that aspiring male nurses have few role models to look up to on television or in films where they are mainly portrayed as gay or comical characters.

As well as being viewed as unmanly, male nurses also have to challenge the stereotypical view that they are unsuitable caregivers, incapable of providing compassionate and sensitive care. Prevailing definitions of masculinity and the questioning of their ability to provide appropriate care have undoubtedly acted as powerful barriers to men crossing the gender divide and entering the nursing profession (Halloran and Welton, 1994).

While the use of touch is even more challenging for male nurses because of the feminization of touch (Evans, 2002). Society has normalized touch as a caring behaviour in women while sexualizing it in men. The result is that men feel vulnerable and cautious about providing intimate care, particularly to women, as their care runs the risk of being misinterpreted. This is undoubtedly one reason why men move away from direct care. The fact that male nurses are faced with the reality of defending their career choice, their contribution to nursing and their sexuality is reflected in the specialties male staff choose to work in (Black, 2014).

Management, education and technology dominated roles attract much larger numbers of male nursing staff thereby allowing them to distance themselves from the feminine image of nursing by moving into 'high tech, low touch' specialties (Evans, 1997). Unfortunately this also takes men away from the caring aspect of nursing.

Women overcoming prejudice and discrimination

Women have successfully overcome the widespread stereotypical belief that many professions are suitable only for men. Medicine was a male only profession until campaigning and lobbying of Parliament by Sophia Louisa Jex-Blake (1840-1912) resulted in the first female medical students entering the University of Edinburgh between 1869 and 1874 (Murdoch, 2014). However, the University refused to award female medical students degrees and it was not until 1876 when Russell Gurney's Bill was accepted by Parliament that British examining bodies were permitted to include women (Crowther, 2002). According to the latest statistics the overall increase in women joining the profession means that in just a few years there will be more female than male doctors on the medical register (General Medical Council, GMC, 2016). Compare this to the to the latest figures for men in nursing which shows that just over one in ten nurses are men; compared with one in a hundred in the earliest days of the National Health Service (NHS) more than 60 years ago (Walsh, 2016).

Common perceptions regarding male nurses

A common perception regarding male nurses is that they earn more money than their female counterparts. Newly qualified male and female nurses earn the same starting salary, with London nurses getting an increased cost area supplement (Prospects, 2016). As nurses advance in their careers and apply for more senior positions in a hospital or out in the community there is naturally an increase in salary. Male nurses who work in the private sector generally earn a higher salary then their female counterparts. One reason may be that men unlike women do not take career breaks; to have children or have to work part-time to accommodate their family (Vallano, 2011). Men are assumed to be leaders and can be judged negatively when they do not hold a senior position. However they can also be judged negatively when they do hold a senior or management position as their peers perceive that they got the position on gender rather than merit. This is supported by McMurry (2011), who argues that men are given preferential treatment in hiring and promotion decisions. I disagree with this point of view as there is a strong evidence base to show that men in nursing do not make up a disproportionate number of higher positions of authority (Villeneuve, 1994; Anthony, 2006; Nelson and Belcher, 2006).

Male nurses are usually perceived to fall into one of four roles: the ladder-climber, because two thirds of the top jobs in nursing are occupied by men (Randstad UK, 2016); the trouble maker, with men supposedly socialized to be more assertive; the he-man, because of their greater physical strength men are expected to do all the heavy lifting, when in reality male nurses use lifting aids as often as female nurses (Evans, 1997); and the homosexual, if a man displays empathy and caring, he is assumed to be gay. The first three roles are imposed by their female counterparts, the dominant group in nursing, and the fourth is imposed from outside nursing by men rather than women (Neighbours, 2016).

Patients’ perceptions of male nurses

Patient perception of being cared for by male nurses refutes the belief that patients prefer female nurses to male nurses. Patients in a study by Landry and Tillman (2000), said they saw no significant difference in the care provided between male and female nurses. They also said that they had no problem with male nurses providing intimate care and that they actually preferred male nurses because they were ‘more gentle, concerned and compassionate’ than their female counterparts who could be ‘moody, harsh and didn’t always take their time’. Further research showed that most of the time patients seem to be open and non-discriminatory towards male nurses (Cude and Winfrey, 2007). A positive view of male nurses by patients is very important to men in nursing. Rochlen, Good and Carver (2009), supports this view arguing that social support is positively correlated to work and life satisfaction, particularly for men.

Patients often mistake male nursing students and qualified male nurses for doctors, based solely on their gender (Meadus and Twomey, 2011). This can be disconcerting to men as they have to explain that they are not doctors but nurses and very annoying to female nurses. Similarly, some patients direct questions at the male student or nurse bypassing the female nurse, which can also be a bit awkward and embarrassing as most often the senior nurse is female.

Personal Experience

In my experience, as a student nurse, I have occasionally felt discriminated against because of my gender, not by patients but staff. The fact that male nurses face gender-based barriers, even during their training was highlighted in research by Keogh and O’Lynn (2007). On my previous placement, I had just finished recording a patient’s observations in a bay when a female student, returning from refilling a patient’s water jug, called me over and asked me to get the female staff nurse. I informed the nurse and followed her back into the bay to carry on with the observations. The student then asked the staff nurse to help her put the female patient on a commode. Later on I asked the student nurse why she didn't ask me to help and she replied that it was 'personal care' and walked away. I felt I got on well with her so I don't think it was personal. This action may be linked with some deep-rooted prejudice and preconceptions (Davidson, 1996) about males providing personal care influenced the way she acted. A view supported in research by Robertson (2008), who theorised that there does seem to be an undercurrent amongst female colleagues as to what is and isn't appropriate for male nurses.

I understand that personal care can have an intimate, psychological, emotional or spiritual element to it and that it is extremely important for all nurses carrying out personal care to be aware of this and to pay close attention to the effect this has on the patient. I appreciate that we must abide by patients' wishes and I would never want a patient to feel uncomfortable by my presence and I would never be offended if a patient said she preferred a female nurse to attend to her as that is the patient's choice, according to NMC Code (2015), to avoid assumptions, recognise diversity and individual choice. However, the patient had never objected to me helping her onto the commode before and I never heard her object on that occasion. It is surprising that this type of culture still persists in nursing, amongst colleagues. I have heard qualified nurses ask patients, do you mind the male student staying in while you are examined. Patients generally look puzzled that they are asked such a question. I feel this is an example of double standards as male patients are not given the option to refuse nursing care from a female nurse.

The only time I was asked to step out of the room was for cultural reasons. The patient was a Muslim lady and both the female staff nurse and I were asked, in a very courteous manner, to leave the room while a family member provided personal care. Perhaps I have been fortunate but no other patient has ever asked me to leave or refused help from me. I have never heard a nurse ask a patient if they object to being attended to by a doctor of the opposite sex and doctors provide much more intimate care than nurses yet they always ask if it is alright for a male student or nurse to attend to them. My experience is supported by Kermode (2006) who used quantitative research methods to explore discriminatory attitudes and behaviours toward male nursing students.

Men's experience of nursing

Men's experience of nursing differs from their female counterparts (O'Lynn, 2004). Florence Nightingale, although she made major contributions to the development of modern nursing, effectively removed men from nursing by affirming that nursing was a female only profession. As a consequence, men in nursing encounter challenges such as, being stereotyped and gender biased. According to research by Evans (2004), male nurses compromise their reputation and social status in patriarchal culture. The main stereotype they encounter is about their sexuality, with the assumption that they are gay or sexual predators but the majority of men in nursing are heterosexual (Davies, 1995). However, public perception is that most male nurses are gay. The stereotypical prejudice that nursing is a profession for women only and that it is somehow abnormal persists, but only in general nursing whereas in mental health nursing it is deemed an acceptable occupation for men (Harding, 2007).

According to Evans (2002), this type of preconception can make it difficult for men to interact with patients and inevitably makes them cautious care givers. According to Leidner (1991), men in nursing struggle looking for ways to reconcile the work they do with an identity they can accept and that is why many men moving into administrative or technical roles. Uhlimann and Cohen (2005) offer a slightly cynical view of why men enter female dominated occupations such as nursing: either they assume they will succeed in terms of obtaining jobs and faster promotion than their female counterparts or, although not intentionally seeking this by virtue of being men, it happens anyway. Sargent (2005) offers an alternative view; that men who enter occupations such as nursing experience the same prejudice as women in male dominated careers and they must learn ways to manoeuvre through the gender environment. I think men enter the nursing profession for the same reasons as women do; mainly because they have a caring nature and want to help people. It is also a relatively secure job that offers job diversity, career advancement, job satisfaction and the chance of earning a good salary. The challenges men experience in a female dominated profession are different to those experienced by women, in a male dominated profession, because unlike male nurses, the sexuality of female engineers, bankers and doctors is not questioned and they are not perceived as inferior when they do the same job as men.

Conclusion

In conclusion, the perceptions of men in nursing shows that overall, although negative societal, stereotypical views still persist these views are slowly changing. Men continue to face challenges in nursing but perhaps as more men assume positions of leadership it will help start the reversal of the gender bias found in nursing among the dominant gender.

Patients, especially when they have been cared for by a male nurse, have proved much more accepting of male nurses than their female counterparts. In order to address the future healthcare needs of UK residents it is important that nursing is representative of the people it cares for.

References

Anthony, A. S (2006) ‘Retaining men in nursing - Our role as nurse educators’ [Online] *Annual Review of Nursing Education* 4: 211 – 234 https://www.researchgate.net/publication/286678085_Retaining_men_in_nursing_-_Our_role_as_nurse_educators (Accessed 18 April 2006)

Black, P. M. (2014), ‘Professional Nursing: Concepts & Challenges’, (7th ed) Missouri, Elsevier.

Brown, R. (2010), ‘Prejudice: Its Social Psychology’ (2nd ed), Chichester, Wiley-Blackwell

Brown, B., Nolan, P. and Crawford, P. (2000) ‘Men in nursing, ambivalence in care, gender and masculinity’. [Online] *International History Nursing Journal*, 2000, 5(3):4-13 http://www.ncbi.nlm.nih.gov/pub med/1162473 (Accessed 4 May 2016)

Bullough, V. L. (1994) ‘Men, women and nursing history’. [Online] *Journal of Professional Nursing*, 10 (3), 127. http://www.professionalnursing.or g/article/8755-7223(94)90002-7/references (Accessed 10 May 2016)

Combs, J. (2012) ‘*Mercy Warriors: Saving Lives Under Fire’*, Bloomington, Trafford Publishers.

Crowther, A. M. (2002) "Why Women should be Nurses and not Doctors." [Online] Centre for the History of Medicine, Glasgow University http://www.ukchnm.org/ (Accessed 11 May 2016)

Cude, G. and Winfrey, K. (2007), ‘The hidden barrier: Gender bias: fact or fiction’, [Online] Nursing Women’s; Health 11(3), 254-265. http://www.whjournal.org/article/S1751-4851(15)30191-4 (Accessed 14 May 2016)

Davidson, M. (1996) ‘Not a Male Nurse, A Real Nurse’, Nursing Forum, 31 (4) 28. October-December, 1996. [Online] http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1744-6198 (Accessed 14 May 2016)

Davies, C. (1995) ‘Gender and the Professional Predicament in Nursing’, Buckingham, Open University Press.

Evans, J.A. (1997) ‘Men in nursing: Issues of gender, segregation and hidden advantage’. [Online] Journal of Advanced Nursing, 26(2) 226-231. http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.1997.1997026226 (Accessed 10 May 2016)

Evans, J. A. (2002) ‘Cautious caregivers: gender stereotypes and the sexualisation of men nurses' touch'. [Online] *Journal of Advanced Nursing*, .40 (4), 441-448. http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.2002.02392 (Accessed 14 May 2016)

Evans, J. A. (2004), 'Men nurses: a historical and feminist perspective'. [Online] *Journal of Advanced Nursing* 47(3), 321-328. http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2648.2004.03096.x/abstract (Accessed 11 May 2016)

General Medical Council, (2016), 'List of Registered Medical Practitioners-statistics [Online] http://www.gmc-uk.org/doctors/register/search-sats.asp (Accessed 11 May 2016)

Halloran, E. J. and Welton, J. M. (1994) '*Why aren't there more men in nursing*?' 4th Edition, St. Louis, Mosby Publishing

Harding, T. (2007), 'The construction of men who are nurses as gay', [Online] *Journal of Advanced Nursing*, 60(6), 577–719 http://onlinelibrary.wiley.com/wol1/doi/10.1111/j.1365-2648.2007.04447.x/full (Accessed 11 August 2016)

Harding, T. North, N. and Perkins, R. (2008), 'Sexualizing men's touch: male nurses and the use of intimate touch in clinical practice', [Online*] Research and theory for nursing practice*, 22(2) 88-102 http://www.ncbi.nlm.nih.gov/pub med/18578219 (Accessed 01 June 2016)

Hodes, B. (2005), Men in Nursing Study. [Online] Bernard Hodes Group. http://aamn.org/docs/meninnursing2005survey.pdf (Accessed 1 June 2016)

How, A. (1995), '*The Habermas-Gadamer Debate and the Nature of the Social*, Aldershot, Avebury Publishing.

Keogh, B. and O'Lynn, C. (2007), 'Male Nurses' Experience of Gender Barriers, [Online] *Nurse Education*, 32(6) 256-9. http://journals.lww.com/nurseeduc atoronline/2007/11000/Male_Nurs es-Experiences-_of-Gender-Barriers-.9.aspx (Accessed 22 May 2016)

Kermode, S. (2006). Is nurse education sexist? An exploratory study. [Online] Contemporary Nurse, 22(1), 66–74. http://www.ncbi.nlm.nih.gov/pub med/16863412 (Accessed 10 August 2016)

Landry, T. and Tillman, K. (2000) 'Patients Perceptions of Being Cared for by Male Nurses' [Online] http://www.aamn.org/docs/Landry _Perceptions.pdf (Accessed 9 May 2016)

Leidner, R. (1991), 'Serving Hamburgers and Selling Insurance: Gender, Work and Identity in interactive Service [Online] Gender and Society, 5(2), 154-177 http://www.jstor.org/stable189482 (Accessed 21 May 2016)

Mackintosh, C. (1997), 'A History of Men in Nursing', [Online] *Journal of Advanced Nursing* (JAN), 26, (2), 232 – 236 http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.1997.1997026232.x (Accessed 3 June 2016)

Masters, K. (2009) '*Role Development in Professional Nursing Practice'* (2nd ed), London, Jones and Bartlett

McMurry, T. B. (2011), 'The Image of Male Nurses and Nursing Leadership Mobility', [Online] Nursing Forum, 46(1), 22-28 http://onlinelibrary.wiley.com/doi/10.1111/j.1744-6198.2010.00206.x/pdf (Accessed 24 May 2016)

Meadus, R. J. and Twomey, J. (2011) 'Men Student Nurses: The Nursing Education Experience', [Online] *Nursing Forum*, 46(4), 269-273. http://onlinelibrary.wiley.com/doi/10.1111/j.1744-6198.2011.00239.x/epdf (Accessed 22 May 2016)

Meadus, R. J. (2000), 'Men in Nursing: Barriers to Recruitment', [Online] *Nursing Forum*, 35(3) 5 – 12 http://onlinelibrary.wiley.com/doi/10.1111/j.1744-6198.2000.tb00998.x/full (Accessed 18 April 2016)

Murdoch, L. (2014), 'Daily Life of Victorian Women', Greenwood, London.

Neighbours, C. (2016), 'Male nurses, men in a female dominated profession: the perceived need for masculinity maintenance.' [Online] http://studentnurse.tripod.com/m en.html (Accessed 3 June 2016)

Nelson, R. and Belcher, D. (2006), 'Men in Nursing: Still Too Few: Discrimination and stereotypes still keep many from joining nursing ranks' [Online] *American Journal of Nursing* 106(2) 25 – 26 http://journals.lww.com/ajnonline/Citation/2006/02000/Men_in_Nursing__Still_Too_Few__Discrimination_and.16.aspx (Accessed 18 April 2017)

Nursing and Midwifery Council (NMC) (2015), The Code incomplete title https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf (Accessed 18 April 2017)

O'Lynn, C. E. (2004) 'Gender based barriers for male students in nursing education', [Online] *Journal of Nurse Education* 43(5), 229-236. http://www.ncbi.nlm.nih.gov/pubmed/15152800 (Accessed 18 May 2016)

O'Lynn, C. E. and Tranbarger, R. E. (2007) '*Men in Nursing'*, New York, Springer Publishing.

Office of Medical History, (OMH, 2016), 'The Evolution of Male Army Nurse Corps Officers' [Online] http://history.amedd.army.mil/ancwebsite/articles/male.nurses.html (Accessed 30 May 2016)

Prospects, (2016), 'Adult Nurse'. [Online] https://www.prospects.ac.uk/job-profiles/adult-nurse (Accessed 31 May 2016)

Randstad UK (2016), 'Female nurses struggling to fill the top posts because of a 14% pay gap.' [Online] https://www.randstad.co.uk/job-seeker/career-hub/archives/female-nurses-struggling-to-fill-the-top-posts-because-of-a-14-pay-gap_1011/ (Accessed 3 June 2016)

Regan, H. (2012), 'Male Nurses Worldwide', REALMANSWORK. https://realmanswork.wordpress.com/2012/05/05/male-nurses-worldwide/ (Accessed 04 June 2016)

Robertson, S. (2008), 'Why so Few Men in Nursing? [Online] *Nursing Times* http://www.nursingtimes.net-why-so-few-men-in-nursing/849 (Accessed 30 May 2016)

Rochlen, A. B., Good, G. E., and Carver, T. A. (2009), 'Predictors of gender-related barriers, work, and life satisfaction among men in nursing' [Online] Psychology of Men and Masculinity, 10(1), 44-56 http://www.researchgate.net/profile/Glenn-Good/publication/232557670.pdf (Accessed 25 May 2016)

Sargent, P. (2005), 'The Gendering of Men in Early Childhood Education', [Online] *Journal of Research*, 52(3) 251-259 http://link.springer.com/article/10.1007/s11199-005-1300-x (Accessed 14 June 2016)

Stanley, D. (2012), 'Celluloid devils a research study of male nurses in feature films'. [Online] *Journal of Advanced Nursing*, 68(11), 2526-2537. http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1744-6198 (Accessed 2 May 2016)

Sweet, H. M. and Dougall, R. (2008), '*Community Nursing and Primary Healthcare in Twentieth-Century Britain*', Oxon, Routledge

Uhlmann, E. L. and Cohen, C. L. (2005) 'Constructed Criteria: Redefining Merit to Justify Discrimination'. [Online] *Psychological Science* 16(6), 474-480. http://pss.sagepub.com/content/1 6/6/474 (Accessed 22 May 2016)

Vallano, A.T. (2011), ‘*Your Career in Nursing’*, Chicago, Kaplan Publishing.

Villeneuve, M. J (1994) ‘Recruiting and retaining men in nursing: a review of the literature’ [Online] *Journal of Professional Nursing* 10(4) 217 – 228 http://www.professionalnursing.org/article/8755-7223(94)90023-X/pdf (Accessed 18 April 2017)

Walsh, B. (2016) ‘More men than ever work as hospital nurses’, [Online] MailOnline, Tuesday, May 10th, 2016 http://www.dailymail.co.uk/health/article-145183/More-men-work-hospital-nurses.html (Accessed 10 May 2016)

White, L. Duncan, G. and Baumle, W, (2011), ‘Medical Surgical Nursing: An Integrated Approach’, (3rd ed), New York, Delmar Publishing.

The management of nutrition for palliative care patients

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Abstract

In order to improve quality of life, nutrition in palliative care must be one of the main goals when managing a patient's care. Malnutrition is a predominant factor for the palliative patient. Poor nutrition can have an impact on the patient as well as their families, as they see changes in their loved ones. The main aim of nutrition is to maximise food enjoyment and minimise food related discomfort. Guidelines are available for health care professionals. Nurses and other healthcare professionals have a vital role in the management of nutrition by providing both physical and emotional support for both the patient and their families. It can lead to ethical dilemmas and puts professionals, patients and family members in difficult positions.

Keywords
Palliative Care, Nutrition, Malnutrition, Cancer Cachexia,

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Introduction

The National Institute for Health and Care Excellence (NICE, 2004, p.20) defines palliative care as; "…the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families." Many patients who are terminal generally experience weight loss, loss of energy and loss of appetite (Hanks et al, 2011). A study conducted by Hopkinson, Wright and Corner (2005) revealed that weight loss was a common concern highlighted by family members and carers. Patients who have cancer often are malnourished and lose weight due to a variety of mechanisms involving the tumour, the host's response to the tumour and anticancer therapies (Meyenefelt, 2006). The National Cancer Institute (NCI, 2015) suggest the close links between weight loss and poor prognosis. It has also been revealed that 80% of patients with upper gastrointestinal cancer and 60% of patients with lung cancer have already experienced substantial weight loss (NCI, 2015). Barakat, Markman and Randall (2009) explain how malnutrition can impact patients with a cancer diagnosis including increased hospital stay, poor response to treatment and decreased survival rate.

Weight loss does not just affect the patient physically but also psychologically. Patients can become conscious of their altering body image often leading to depression, anxiety and conflict between family members, which will be explored in this article (Kinghorn and Gaines, 2007).

Nutritional Assessment

Nutritional screening and assessment is a fundamental aspect of nursing which is used to identify and treat patients who are malnourished or underweight (Best, 2008). Johnstone (2006, p28) stresses the importance of nutritional screening and denotes how, "failure to address the issue of malnutrition is a failure of the duty of nurses to protect the health of patients." Early identification of patients who are underweight or malnourished benefits the patient as it improves their nutritional status and avoids additional deterioration (Perry, Potter and Ostendorf, 2014).

There are various nutritional measuring tools which can be adopted. Screening tools are generally based on the patient's weight, any changes, disease, changes in food intake and symptoms (Shaw and Eldridge, 2015). Santarpia, Contolado and Pasanisi (2011) articulates how using only a body mass index (BMI) is not effective for determining a palliative patient's nutritional status as it can present normal results in patients with ascites or oedema. These screening tools, however, do not always adapt well in the palliative settings as they do not distinguish between malnutrition and cachexia (Shaw and Eldridge, 2015).

Many screening tools require the patient's weight over a period of weeks or months to identify a change, however, a barrier to this is staff attitudes. Watson et al (2010) conducted a study which explored the attitudes of staff regarding weighing patients in both a hospice and a hospital outpatient setting within the UK. The results found that 66% of patients attending hospices were rarely weighed as staff thought that it would be too upsetting for the patient. What was interesting about this study is that 96% of patients with advanced cancer did not find getting weighed upsetting. Additionally, 74% weighed themselves at home and 89% wanted to know if their weight was changing. Weighing palliative patients is beneficial as it can determine how fast they are losing weight and whether the interventions used are effective (Ferrell and Coyle, 2010). However, sensitivity is paramount and if a patient is in the terminal stage of their disease, immobile or demented then undertaking such an assessment may be inappropriate (Cherny et al, 2015).

A full assessment should be conducted which is tailored to the patients individual needs. In palliative care the focus of eating should be based on pleasure rather than the patient getting the nutrients they need (NCI, 2015). The patient may also be referred to the dietician and the speech and language therapists who will identify the factors hindering the patient's quality of life. From this, an individual care plan can be drawn up highlighting the appropriate interventions. It is the responsibility of the entire health care team to ensure the patient's nutritional needs are met. Nurses, however, are in a unique position to ensure this as they are at the forefront of patient care (Coxall, 2007).

Social and Psychological Issues

Food beliefs and eating habits stem from childhood and are associated with family and culture. Food can be highly regarded by families as it is a time where they can gather and socialise (Dillon, 2006). A palliative patient may find meal times a burden as they may feel too weak, too tired or just simply just do not have an appetite. This can cause them to feel isolated as they cannot participate which can lead to exclusion from the people they love (Holmes, 2011a). An altered body image can also hinder the patient's confidence which can cause them to feel anxious. This makes the thought of socialising and interacting with people too overwhelming (Carr and Steel, 2013). Cherney et al

(2015) explains how this can cause patients to develop a low self-esteem and potentially depression.

Food has various meanings to different people, some find hope in eating as it is the fuel that drives our body and can provide strength to battle their illness. On the other hand, some patients may resent meal times as food can cause pain and discomfort through the symptoms of their illness (Shaw and Eldridge, 2015). Families can have an active role in preparing meals for their loved ones which makes them feel like they are contributing to the healing process (Shaw and Eldridge, 2015). Martin (2010) agrees and comments on how family members are in an ideal position to help their loved ones meet their nutritional needs and assist them with eating if required. Food presentation is key, therefore, meals should be made attractive and portions should be small so the patient doesn't feel overwhelmed. The atmosphere during mealtimes remain normal to the individual family's dynamics. The family could use attractive tableware, background music or perhaps offer a small amount of alcohol to compliment the meal (Oneschuk, MacDonald and Hagen, 2012).

The Priorities of Care for the Dying Person outlines how patients should be supported to eat or drink as they wish and their choices be respected (Leadership Alliance for the Care of Dying People, 2014). However, Shaw (2011) explains how some families may advise the patient on what they should be eating to increase survival rather than focusing on food which the patient enjoys. For families food and drink can symbolise hope, strength and prosperity, therefore, the inability to eat or drink can be associated with despair (Holmes, 2011a). Oneschuk, MacDonald and Hagen (2012) explains that patients may be unable to eat or drink due to side effects of treatment or the actual illness itself, leading to a real sense of guilt as they feel they are letting their family down. On the other hand, the patient may avoid food as a means of regaining control over their own life or to hasten death (Shaw, 2011). This can cause tension, anger and frustration between family members and the patient (Preedy, 2011). Nevertheless, the Nursing Midwifery Council (NMC, 2015) denote how professionals must respect and support a person's wishes to refuse treatment or care. Wheeler (2013) states that health care professionals cannot force a patient to eat, drink or accept medical treatment. Nurses can offer encouragement to patients and educate their families on how their illness can affect their loved ones appetite (Burton and Ludwig, 2010).

Nutritional Goals

The Ambitions for Palliative and End of Life Care highlight's how goals should be clear from the beginning of treatment and should be tailored to each individual's preferences (National Palliative and End of Life Care Partnership, 2016). In harmony, the leadership alliance for the care of dying people (2014) articulate how the patient's wishes must be supported alongside the patient's choices. In order to deliver high quality palliative and end of life care a person centred approach should be adopted (Block et al, 2015).

The goals of nutrition in cancer and palliative care alter during the different stages of a patient's disease. In the early stages, during treatment, nutritional intervention is needed to help patients cope with the metabolic demands of illness, preventing infection, tissue repair and general wellbeing (Watson et al, 2009). Towards the end of life the goal is to maximise food enjoyment and diminish food related discomfort (Acreman, 2009). The rationale for this is so that patients can enjoy a higher quality of life (Cherney et al, 2015). Conflict can arise between families and the multi-disciplinary team regarding the patient's minimal food intake, resulting in some families wishing to force feed the patient (Chochinov and Breitbart, 2009). Forcing the patient to eat does not allow the patient to live longer or feel stronger but instead may cause them to feel discomfort rather than pleasure (Arnella, 2010). Carr and Steel (2013) concur and explain how force feeding can lead to aspiration and cause the patient's condition to deteriorate. This can be an exceptionally difficult time for family members as they may have felt like it was out of love in which they were feeding their relative (Arceman, 2009).

Nurses can provide emotional support to family members and encourage them on other methods of expressing their love to their relative. The National Institute for Health Care Excellence (NICE, 2015) provide guidelines which suggest that the families of the dying person could be encouraged to provide comfort by maintaining mouth care or assisting with drinks. Nurses can also provide the necessary aids such as fluid thickener, beakers, straws and mouth care trays whilst educating and advising the families on maintaining safety (Coyle and Paice, 2015).

Cancer Cachexia

Cancer cachexia can be classed as a wasting disease whereby the individual suffers from uncontrollable, unintentional weight loss and muscle wasting which is caused by abnormal metabolism and reduced diet (Del Fabbro, Inui and Strasser, 2015). Cancer cachexia increases the risk of morbidity and mortality and occurs in around 80% of patients with advanced cancer (Reid et al, 2010). Patient's families may feel like their loved one is being 'starved' by health care professionals, therefore, it is important to distinguish the difference between cachexia and starvation (Ferrell, Coyle and Paice, 2015). Cachexia and starvation is similar in that weight is lost due to a reduction in calorie intake. However, the difference is that resting energy expenditure, protein syntheses and protein degradation are reduced in starvation whereas, in cachexia, they are all increased (Gorrol and Mulley, 2011). The configuration of weight loss is different, within starvation weight is lost preferentially from fat whereas cachexia affects skeletal muscle and connective tissue, including fat and protein (Holmes, 2011b).

The European Palliative Care Research Collaboration (EPCRC) provide recommendations in treating cachexia for patients with advanced cancer (Del Fabbro, Inui and Strasser, 2015). Conversely, Suziki et al (2013) suggests that there is limited cachexia specific research to determine the effectiveness of these recommendations due to the life expectancy of palliative patients. The management of cachexia also needs to take into consideration the patient's prognosis. Treatment for cachexia in patients with a short life expectancy may add to the disease burden without providing symptom relief and therefore be inappropriate (Suziki et al, 2013). Additionally, Del Fabbro, Inui and Strasser (2015) suggests a need for increased cachexia awareness and assessment in clinical practice which should be integrated into mainstream oncology education for health professionals.

Reid et al (2010) conducted a study in the UK on both inpatient's and outpatient's experience of cancer cachexia. The study discovered that many patients and their family members found that healthcare professionals did not give them any information or explain why the patient was losing weight. This made them feel anxious, isolated and concerned about their loved ones weight loss. The results are contrary to the guidelines suggested by the Royal College of Nursing (2015) which states how sensitive communication should take place between staff, the patient and their family. A study by Reid, Santin and Porter

(2012) revealed similar findings and family members recall feeling like nobody cared. The family members also felt like someone should have spoken to them, as a family, regarding what to expect from their loved one with cancer cachexia. Both studies, however, did not incorporate the views of healthcare professionals, therefore, this may be an area for future research.

In terms of nursing staff, a study by Millar, Reid and Porter (2013) revealed it was a lack of knowledge or outdated knowledge on cancer cachexia that led to a lack of recognition of cachexia patients in clinical practice. Similar findings were reported in a study by Churm et al (2009), suggesting it compromised professional's ability to care for patients and their families. In order to enhance practice and the experience of patients and their families more training could be arranged for nurses on cancer cachexia. Effective communication and partnership working is vital to deliver high quality end of life care. It furthermore ensures that this partnership working improves the outcomes and experience for the patient and their families (Laycock, 2011).

Nursing Interventions

Symptom control in palliative nutrition is vital to enhance the patient's quality of life (Watson et al, 2009). In order to improve the patient's nutritional status the nurse can attempt to alleviate symptoms which affect a patient from eating. However, a person centred approach needs to be adopted and nurses symptom control should be individualised to the each patients' needs and wishes (Coyle and Paice, 2015). Cherney et al (2015) highlights the importance of a multi-disciplinary approach, where nurses work alongside doctors, dieticians and speech and language therapists in order to deliver safe nutrition. During a time of such vulnerability nurses hold an important role in acting as an advocate through advising doctors on appropriate pain management and dosage to alleviate symptoms (Becker, 2009).

Kinghorn and Gaines (2007) draws attention to patients who under report their level of pain and explains how nurses can use their observational skills and their initiative to recognise and manage this. By working together the multidisciplinary team can reduce/eliminate the symptom's which prevent the patient from eating, therefore allowing them to enjoy food while improving their nutritional status (Dahlin, Coyne and Ferrell, 2016).

An audit led by the Marie Curie Palliative Care Institute Liverpool in 127 hospital trusts discovered that 91% of palliative patients had written prescriptions available to alleviate palliative symptom's including nausea and vomiting and pain, and in some trust's 100% was achieved (Royal College of Physicians, 2011). This shows that effective communication and partnership working is fundamental to delivering high quality palliative care.

Protected mealtimes is a local initiative introduced to help patients maintain and improve their nutritional status (Reed, Clarke and Mac Farlane, 2012). Results from a study conducted by Ullrich, McCutcheon and Parker (2011) highlighted that since the implication of protected meal times the nutritional status of the patients had improved. Also, a study by Taylor (2008) revealed that patients and families actually preferred protected mealtimes compared to open visiting hours. Ullrich, McCutcheon and Parker (2011) based their study on a residential care setting with a small sample making it difficult to generalise these results. The researchers could consider conducting a study based on different settings to get a deeper understanding of the impact of protected mealtimes.

Nevertheless, nurses face challenges and tensions can arise as doctors do not recognise the value of them (Tolson, Booth and Schofield, 2011). Nurses need to be assertive to ensure the focus at mealtimes is on the patient and their meal in order to maintain and improve their nutritional status (Mallik, Hall and Howard, 2009).

Methods of Delivering Nutrition

There are various methods of delivering nutrition and hydration to patients. The oral route is the preferred method of delivering nutrition and patients should be advised to eat frequently and eat foods high in protein and energy (NCI, 2016). Doctors and nurses working in palliative care believe that the non-oral route for hydration and nutrition has very limited benefits at the end of life (Dean, Harris and Regnard, 2011) On the other hand, Skipper (2012) denotes how families believe that this withdrawal will cause further distress and therefore lead to an uncomfortable death. Such decisions should be based on an individual assessment, in some patients reversing dehydration can help manage symptom control in the earlier stages of the illness (Dean, Harris and Regnard, 2011).

Nasogastric tubes are effective in the short term for delivering nutrition and can be inserted during radiotherapy so long it is not painful for the patient (Bernstein and Luggen, 2010). However, it is argued that nasogastric tubes can be inserted incorrectly which could lead to aspirational pneumonia, they can also cause distress to the patient (Durai, Venkatraman and Phillip, 2009). Unlike nasogastric tubes, percutaneous endoscopic gastrostomy (PEG) tubes are for a long term basis and host less of risk of aspiration (Bernstein and Luggen, 2010). PEG tubes can be beneficial in patients with gastrointestinal cancers to provide nutritional or decompress the upper gastrointestinal tract in patients with distal bowel obstruction. It is unclear however that patients will become totally independent of total parental nutrition, additionally it is uncertain that PEG tubes coincide with the goal of palliative care, to provide comfort (Mobily and Patel, 2015). Furthermore, Malhi and Thompson (2014) explain how nutrition through PEG tubes can cause pain, discomfort and infection, although these can be dealt with through good nursing management and care.

Doctors hold no legal obligation to provide futile treatment (General Medical Council, 2016). However, Howard and Pawlik (2009) states that doctors do have an obligation to discuss the rationale of this decision with the patient and their families whilst also advising them of the wide range of supportive care options available. A study by Efstathiou and Walker (2014) revealed that nurses lacked confidence in treatment withdrawal and felt like it impacted their ability to care for the patient. In this study however, the participants were self-selected and their motives for taking part may suggest very positive or negative experiences which can affect the accuracy of these results. Nevertheless, to improve practice training could be offered to nurses on the process of treatment withdrawal. This would be beneficial as families recall in a study by Wiegand (2008) how the decision to withdraw treatment was horrific and one of the hardest things they have ever done. Training could enable nurses to provide better support and information to patients and their families.

Ethical Considerations

The most fundamental ethical aspect of nursing is the principle of respect for patients (Matzo and Sherman, 2014). This is also highlighted by the Nursing Midwifery Council (NMC, 2015, p.4) as it calls professional's to "treat people with kindness, respect and compassion." The patient's right to autonomy should be respected particularly if they need artificial nutritional support. The patient should be educated on the benefits and the potential risks so that they can make an informed decision and give consent (Purtillo and Have, 2010). The option for artificial support may be withdrawn or withheld for some patients if it was deemed ethical for that patient. It should be effectively communicated to the patient and their families if treatment was to be withdrawn or withheld following a review of the Liverpool Care Pathway which suggested withdrawal of fluids and food was to hasten death. (Neuberger et al, 2013).

Conclusion

A diagnosis of cancer or a life limiting condition can be exhausting both emotionally and physically and palliative patients and their loved ones. Nurses and the multidisciplinary team play an vital role in the management and support of palliative patients and their nutritional status. In absence of a specific screening tool to determine a palliative patient's nutritional status, a full individual assessment should be conducted and appropriate referrals made. Nutritional intervention is necessary in the early stages of palliative care, whereas, at the end of life stage the aim is to maximise food enjoyment and diminish discomfort. There needs to be effective communication between health care professionals, the patient and their families to determine the best plan of care.

References

Acreman, S. (2009) 'Nutrition in palliative care', *Brittish Journal of Community Nursing.* 14(10), pp. 427-430.

Arenella, C. (2010) *Artificial Nutrition and Hydration at the End of Life: Beneficial or Harmful?,* [online] Available at: *http://americanhospice.org/caregiving/artificial-nutrition-and-hydration-at-the-end-of-life-beneficial-or-harmful/* (Accessed: 21 January 2015).

Barakat, R., Markman, M. and Randall, M. (2009) *Principles and Practice of Gynecologic Oncology*, 5th ed., Baltimore : Lippincott, Williams & Wilkins .

Becker, R. (2009) 'Palliative care 2: exploring the skills that nurses need to deliver high-quality care.', *Nursing Times ,* 105(14), pp 18 - 20

Bernstein, M. and Luggen, A. (2010) *Nutrition for the Older Adult*, Canada : Jones and Bartlett Publishers, LLC.

Best, C. (2008) *Nutrition: A Handbook for Nurses*, West Sussex: Blackwell Publishing.

Block, L., Albers, G., Onwuteaka-Philipsen. B., Pereira, S., Pasman, R. and Deliens, L. (2015) *Palliative Care for Older People: A Public Health Perspective*, Oxford: Oxford University Press .

Burton, M. and Ludwig, L. (2010) *Fundamentals of Nursing Care: Concepts, Connections & Skills*, 2nd ed., Philadelphia : F. A. Davis Company .

Carr, B. and Steel, J. (2013) *Psychological Aspects of Cancer*, New York: Springer

Cherny, N., Fallon, M., Kassa, S., Portenoy, R. and Currow, D. (2015) *Oxford Textbook of Palliative Medicine*, 5th ed., Oxford : Oxford University Press .

Chochinov, H. and Breitbart, W. (2009) *Handbook of Psychiatry in Palliative Medicine*, 2nd ed., Oxford : Oxford University Press .

Churm, D., Andrew, I., Holden, K., Hildreth, A. and Hawkins, C. (2009) 'A questionnaire study of the approach to the anorexia-cachexia syndrome in patients with cancer by staff in a district general hospital', *Supportive Care in Cancer,* 17(5), pp. 503-507.

Coxall, K. (2007) 'Applying the key principles of nutrition to nursing prac-tice', *Nursing Standard,* 22(36), pp. 44-48.

Coyle, N. and Paice, J. (2015) *Oxford Textbook of Palliative Nursing*, 4th ed., Oxford: Oxford University Press .

Dahlin, C., Coyne P. and Ferrell, B. (2016) *Advanced Practice Palliative Nursing*, New

York: Oxford University Press.

Dean, M., Harris, J. and Regnard, C. (2011) *Symptom Relief in Palliative Care*, 2nd ed., Oxon: Radcliffe Publishing Ltd.

Del Fabbro, E., Inui, A. and Strasser, F. (2015) *Cancer Cachexia*, London: Springer Healthcare Ltd.

Dillion, P. (2006) *Nursing Health Assessment: A Critical Thinking, Case Studies Approach*, 2nd ed., Philadelphia: F. A. Davis Company .

Durai, R., Venkatraman, R. and Phillip, C. (2009) 'Nasogastric tubes 2: risks and guidance on avoiding and dealing with complications', *Nursing Times ,* 107(17), pp 14 - 16

Efstathiou, N. and Walker, W. (2014) 'Intensive care nurses' experiences of providing end-of-life care after treatment withdrawal: a qualitative study', *Journal of Clinical Nursing,* 23(5), pp. 3188–3196.

Ferrell, B. and Coyle, N. (2010) *Oxford Textbook of Palliative Nursing*, Ox-ford University Press: Oxford .

Ferrell, B., Coyle, N. and Paice, (2015) *Oxford Textbook of Palliative Nursing*, 4th ed., Oxford: Oxford University Press .

General Medical Council (2016) *End of life care: Legal Annex,* [online] Available at: *http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_legal_annex.asp* (Accessed: 7th March 2016).

Goroll, A. and Mulley A. (2011) *Primary Care Medicine: Office Evaluation and Management of The Adult Patient*, 6th ed., Philadelphia : Lippincott Williams & Wilkins

Hanks, G., Cherny, N., Christakas, N., Fallon, M., Kaasa, S. and Portenoy, R. (2011) *Oxford Textbook of Palliative Medicine*, 4th ed., Oxford : Oxford University Press .

Holmes, S. (2011a) 'Importance of nutrition in palliative care of patients with chronic disease.', *Primary Healthcare ,* 2(6), pp. 31-38.

Holmes, S. (2011b) 'Nutrition in the care of patients with cancer cachexia', *British Journal of Community Nursing,* 16(7), pp. 314-323.

Hopkinson, J., Wright, D. and Corner, J. (2005) 'Exploring the experience of weight loss in people with advanced cancer', *Journal of Advanced Nursing ,* 54(3), pp. 304-12.

Howard, D. and Pawlik, T. (2009) 'Withdrawing Medically Futile Treatment', *Journal of Oncology Practice,* 5(4), pp. 193–195.

Johnstone, C. (2006) 'Nurses' role in nutritional assessment and screening - Part one of a two-part series', *Nursing Times ,* 102(46), pp. 28.

Kinghorn, S. and Gaines, S. (2007) *Palliative Nursing: Improving End-of-life Care*, 4th ed., Missouri : Elsevier .

Laycock, W. (2011) 'Think about it: a prompt to discuss end-of-life choices.', *Nursing Times ,* 107(18), pp. 19-20.

Leadership Alliance for the Care of Dying People (2014) *Priorities of Care for the Dying Person ,*[online] Available at: *http://www.nhsiq.nhs.uk/media/2485900/duties_and_responsibilities_of_health_and_care_staff_-_with_prompts_for_practice.pdf* (Accessed: 7 March 2016).

Malhi, H. and Thompson, R. (2014) 'PEG tubes: dealing with complications ', *Nursing Times ,* 110(45), pp. 18-21.

Mallik, M., Hall, C. and Howard, D. (2009) *Nursing Knowledge and Practice*, 3rd ed., London: Elsevier Limited .

Martin, G. (2010) *Palliative Care Nursing: Quality Care to the End of Life*, 3rd ed., New York: Springer Publishing Company, LLC .

Matzo, M. and Sherman, D. (2014) *Palliative Care Nursing* , 4th ed., New York: Springer Publishing Company .

Meyenefelt, M. (2006) 'Cancer-associated malnutrition: an introduction.', *European Journal of Oncology Nursing,* 9(2), pp. 35-38.

Millar, C., Reid, J. and Porter, S. (2013) 'Healthcare Professionals’ Response to Cachexia in Advanced Cancer: A Qualitative Study', *Oncology Nursing Forum,* 40(6), pp. 393-402.

Mobily, M. and Patel, J. (2015) 'Palliative percutaneous endoscopic gastrostomy placement for gastrointestinal cancer: Roles, goals, and complications', *World Journal of Gastrointestinal Endoscopy,* 7(4), pp. 364–369.

National Cancer Institute (NCI) (2015) *Nutrition in Cancer Care–for health professionals,* [online] Available at: *http://www.cancer.gov/about-cancer/treatment/side-effects/appetite-loss/nutrition-hp-pdq* (Accessed: 1st December 2015).

National Cancer Insitute (2016) Nutrition in Cancer Care–for health professionals, [online] Available at: http://www.cancer.gov/aboutcancer/treatment/side-effects/appetite-loss/nutrition-hppdq#section/_49 (Accessed: 4 February 2016).

National Institute for Health Care Excellence (NICE) (2004) *Improving supportive and palliative care for adults with can-cer,* [online] Available at:

https://www.nice.org.uk/guidance/csg4/resources/improving-supportive-and-palliative-care-for-adults-with-cancer-pdf-773375005 (Accessed: 20th November 2015).

National Institute for Health Care Excellence (2015) *Care of dying adults in the last days of life,* [online] Available at: *https://www.nice.org.uk/guidance/ng31* (Accessed: 7th March 2016).

National Palliative and End of Life Care Partnership (2016) *Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020,*[online] Available at: *http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf* (Accessed: 7 March 2016).

Neuberger, J., Gurthrie, C., Aaronovitch D., Hameed, K., Bonser, T., Pentregarth, P., Charlesworth-Smith, D., Jackson, E., Cox, D. and Waller, S. (2013) *More Care Less Pathway; A Review of the Liverpool Care Pathway,* [online] Available at: *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf* (Accessed: 10 February 2015).

Nursing and Midwifery Council (2015) *The code Professional standards of practice and behaviour for nurses and midwives,* [online] Available at: *https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/revised-new-nmc-code.pdf* (Accessed: 15 February 2016).

Oneschuk, D., MacDonald, N. and Hagen, N. (2012) *Palliative Medicine: A Case-based Manual*, 3rd ed., Oxford: Oxford University Press .

Perry, A., Potter, P. and Ostendorf, W. (2014) *Clinical Nursing Skills and Techniques8: Clinical Nursing Skills and Techniques*, 9th ed., Missourri : Elsevier .

Preedy, V. (2011) *Diet and Nutrition in Palliative Care*, Boca Raton : CRC Press .

Purtillo, R. and Have, H. (2010) *Ethical Foundations of Palliative Care for Alzheimer Disease*, 2nd ed., Maryland : The John Hopkins University Press .
Reed, J., Clarke, C. and Macfarlane, A. (2012) *Nursing Older Adults: Partnership Working*, Berkshire : Open University Press .

Reid, J., McKenna, HP., Fitzsimmons, D. and McCance, TV. (2010) 'An exploration of the experience of cancer cachexia: what patients and their families want from healthcare proffessionals', *European Journal of Cancer Care,* 19(5), pp. 682-689.

Reid, J., Santin O. and Porter, S. (2012) 'The psychological and social consequences of cachexia in patients with advanced cancer: a systematic review', *Journal of Cachexia, Sarcopenia and Muscle,* 3(1), pp. 281-301.

Royal College of Nursing (2015) *Getting it right every time* [online], Available at: *http://rcneolnutritionhydration.org.uk/nutrition-and-hydration/* (Accessed: 5 March 2016).

Royal College of Physicians (2011) *Patients receive high-quality care at the end of life,*[online] Available at: *https://www.rcplondon.ac.uk/news/patients-receive-high-quality-care-end-life* (Accessed: 21st March 2016).
Santarpia, L., Contolado, F. and Pasanisi, F. (2011) 'Nutritional screening and early treatment of malnutrition in cancer patients', *Journal of Cachexia Sarcopenia Muscle,* 2(1), pp. 27-35.

Shaw, C. (2011) *Nutrition and Cancer*, West Sussex: Blackwell Publishing Ltd.

Shaw, C. and Eldridge, L. (2015) 'Nutritional considerations for the palliative care patient ', *International Journal of Nursing ,* 21(1), pp. 7-12.

Skipper, A. (2012) *Dietitian's Handbook of Enteral and Parenteral Nutrition*, 3rd ed., London: Jones & Bartlett Learning, LLC.

Suzuki, H., Asakawa, A., Amintani, H., Nakamura, N. and Inui, A. (2013) 'Cancer cachexia—pathophysiology and management', *Journal of Gastroenterology,* 48(5), pp. 574-594.

Taylor, A. (2008) 'Exploring patient, visitor and staff views on open visiting', *Nursing Times ,* 104(40), pp. 30-33.

Tolson, D., Booth, J. and Schofield, I. (2011) *Evidence Informed Nursing with Older People*, Oxford: Wiley-Blackwell Publishing.

Ullrich, S., McCutcheon, H. and Parker, B. (2011) 'Reclaiming time for nursing practice in nutritional care: outcomes ofimplementing protected mealtimes in a residential aged care setting', *Journal of Clinical Nursing ,* 20(1), pp. 1339–1348.

Watson, M., Coulter, S., McLoughlin, C., Kelt, S., Wilkinson, P., McPerson, A., Wilson R. and Eatock M. (2010) 'Attitudes towards weight and weight assessment in oncology patients: survey of hospice staff and patients with advanced cancer.', *Palliative Medicine ,* 24(6), pp. 623-9.

Watson, M., Lucas, C., Hoy, A. and Wells, J. (2009) *Oxford Handbook of Palliative Care*, 2nd ed., Oxford : Oxford University Press .

Wheeler, H. (2013) *Law, Ethics and Professional Issues for Nursing: A Reflective and Portfolio-Building Approach*, Oxon: Routledge .

Wiegand, D. (2008) 'In Their Own Time: The Family Experience during the Process of Withdrawal of Life-Sustaining Therapy ', *Journal of Palliative Medicine ,* 11(8), pp. 1115–1121.

Review of Negative Pressure Therapy as a Treatment for Diabetic Foot Ulcer

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Abstract

This article focusses on a synopsis review of four articles, which explore negative pressure wound therapy (NPWT) as a treatment option for diabetic foot ulcers. Patients presenting with diabetic foot ulcers are increasing which has a significant financial impact NHS, there is evidence that NPWT is a cost effective treatment. All four articles use a quantitative methodology. This article will critically analyse the methodology, design, sampling, data collection and data analysis that the researchers have chosen to utilise. NPWT has been proven to be an effective treatment option for diabetic foot ulcers however, the evidence is limited in regard to the patient perspective of this treatment.

Keywords

Diabetes, Foot Ulcer, Wound Care, Nurse,

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Introduction

Negative pressure wound therapy (NPWT) has been selected, for this article, as it is a treatment option for diabetic foot ulcers. NPWT occurs when sub-atmospheric pressure is delivered via a dressing of either gauze or foam, which is placed over the wound, sealed and attached to a suction pump, and this provides the negative pressure (Chadwick, 2009). NPWT is an effective treatment, by increasing blood flow and stimulating angiogenesis, granulation of tissue and cell proliferation can occur, while reducing perilesional oedema by the removal of infected fluid and exudate (Meloni et al, 2015). I have decided to research this topic, as I am aware that there are increasing rates of diabetes. Alongside this there are increasing numbers of patients presenting with a diabetic foot ulcer, within a specialist wound unit. I have also chosen this topic, since attending placements as it has increased my knowledge in wound care management, and have used international articles to broaden my knowledge on this topic.

The World Health Organisation (WHO, 2016) estimate in 2014, 422 million adults globally were living with diabetes. WHO (2016) goes on to state the global prevalence of diabetes has doubled since 1980, with as many as 8.5% of the adult population living with diabetes. Diabetes is a condition whereby the body cannot maintain normal blood levels due to either a deficiency of insulin secretion, or a resistance to insulin, and inadequate insulin secretion to make up for the resistance (Masharani, 2015, cited in Papadakis, McPhee and Rabow, 2015).

The most common complication of diabetes is the development of diabetic foot ulcers, specifically, around 10-20% of people with diabetes will have a diabetic foot ulcer at some point in their life (Jan et al., 2016). The financial impact on the NHS in 2012 was estimated to be £650 million due to; increased bed occupancy, prolonged stays in hospital, community care and increased outpatient appointments (National Institute for Health and Care Excellence (NICE, 2016).

There is evidence to suggest NPWT is a more cost effective therapy than others used to treat wounds, for example wet-to-moist therapy (Lavery et al., 2007). They state in their study NPWT cost 42% less than wet-to-moist therapy over a period of 20 weeks.

Whitehead et al., (2011) agrees, explaining NPWT reduced the cost of care, when compared to advance wound care (€24,881 versus €28,855 respectively) per patient per year. They also found NPWT gave patients a higher quality of life, and also healing rates were greatly improved. This demonstrates the cost benefits of NPWT in terms of resources and patient outcomes, and this is the rationale for this subject choice for this article. This article will compare four research studies that investigate NPWT, in particular reviewing the methodologies used, sampling strategies, data collection and data analysis. The findings will then be discussed in relation to current theories regarding the use of NPWT.

Synopsis

'Discover' was used, to search for the most up to date academic articles on the chosen subject for this article. The rationale is that it contains wide range of resources on clinical subjects. The articles were narrowed down from 16,503 to 40, as the search was further restricted to articles published between 2005 and 2016.

Fife et al., (2008), conducted a study that evaluated the safety of NPWT, specifically by using vacuum assisted closure (V.A.C), in an outpatient setting, with patients that had diabetic foot ulcers. This study was undertaken as there was some evidence suggesting this type of wound therapy can have adverse effects, such as bleeding, pain and infection. A comparison was made between the adverse effects of wound care using V.A.C and non V.A.C. machine, and a quantitative methodology was used in this study. According to Polit and Beck (2012) this methodology is concerned with a positivism paradigm assumption that believes reality exist, and the value of enquiry is based on numbers. Using quantitative methodology is common in research that relates to clinical interventions, as it allows for objective numerical data to be gathered and measured (Addo and Eboh, 2014). A quantitative methodology was also adopted in the Seidel et al., (2014) study, which investigated NPWT, compared to standardised wound care in patients with chronic diabetic foot wounds. This study was undertaken because of the limited evidence of the efficacy of NPWT, which is necessary for robust clinical decision making on which type of wound therapy to use.

Stansby et al., (2010), evaluated diabetic foot ulcers in post amputation wounds and

Blume et al., (2008) compared NPWT and moist wound therapy for diabetic foot ulcers. Both studies used a quantitative method, thus the independent variable of NPWT could be measured against the outcome (Ellis, 2010). There was a lack of research/ articles that reviewed the subject of NPWT using a qualitative analysis. A qualitative analysis is a method that collects narrative data through the interpretation of a phenomenon derived from feedback or observation (Lindsay, 2007). The reason there may be a lack of qualitative methodologies used in this type of research, to evaluate medical procedures such as NPWT, may be because it can be subjective, where its focus is on personal experiences (Polit and Beck 2012). Thus, when testing out medical interventions such as NPWT, using objective numerical data appears to be the most efficient methodology.

Blume et al., (2008), used a randomised trial in their study, whereby patients with diabetic foot ulcers were randomly assigned to a NPWT group, or to an advanced moist wound therapy group. Using a randomised controlled trial is a common method in clinical research, as highlighted by Coughlan, Cronin and Ryan (2013). They define randomised controlled trials as an experiment that has the intention to test out a particular intervention, and are usually used to trial a new medication or clinical procedure. Seidel et al., (2014), also used this method to gather the data for their study. They randomly allocated patients to different wound care treatment groups, and they ensured there was a balance of participant characteristics in each group. This is a strength of this study as the inclusion and control group will have the same conditions as the treated group, minus the treatment itself. This ensures the treatment, and its effects, could be accurately studied (Bettany-Saltikov, 2012).

Fife et al., (2008), used data from a medical database which was stratified in various ways, including V.A.C versus non V.A.C and wound type/ size. Moule and Goodman (2014) explains this method is used to test a certain characteristic of a population, to address the research question. A limitation of this method is that it can stratify the data in ways that it may not reflect the population. It is important therefore that researchers apply weighting, so the population is more accurately represented (Lindsay, 2007). Conversely Stansby et al., (2010), used an open non-controlled clinical investigation in their study. Sacca (2010) does not consider this method to be effective, as it is mainly used in studies that look at oncology and haematology interventions. It is not possible to randomly assign these patients to research study groups, which may lead to a potential weakness of this study.

It is vital that the sampling strategy is planned in any research study in advance, as it will allow the project to be manageable within the required time scale. Sampling is a subset of a population, and not the entire population (Moule and Goodman, 2014). All of the studies, Stansby et al., (2010), Blume et al., (2008), Fife et al., (2008), and Seidel et al., (2014), used purposive sampling. It is also called judgemental sampling, as the researchers purposely select participants using certain criteria, to address the research question (Polit and Beck, 2012). This sampling strategy appears to be the most suitable, as patients with different types of wounds are the ones that could provide data about the wound care they received. It is also important that the sample size selected for the research study reflects the population being studied. The reason is, if there are too many participants, there may be too much of a risk exposed to them, and also if there or too few participants significant findings may be missed (Williamson and Whittaker, 2014).

Fife et al., (2008), used 1331 patients that had undergone V.A.C and non V.A.C treatment, Seidel et al., (2014), used 324 patients with a chronic diabetic foot wound and Blume et al., (2008), used 342 patients that had achieved complete ulcer closer. Finally, Stansby et al., (2010), used 14 patients that had post-amputation wounds. It is difficult to judge whether these sample sizes reflect the population been studied, as none of the articles chosen state their sampling strategies number calculation. This is a weakness as (Kadam and Bhalerao 2010) states that sample size strategies should be indicated, in order to produce ethically and scientifically valid results.

Stansby et al., (2010), collected the research data, by measuring the wound surface area and type at the beginning of the study to get a baseline, then at the end. This is so that the result of the intervention of NPWT can be evaluated. According to Williamson and Whittaker (2014) this data collection method is a type of experimental design, which is successful to test out medical interventions, Seidel et al., (2014), also collected the study data of participant's wounds at primary and secondary endpoints. Blume et al., (2008), also used this data collection method as participant's wounds were evaluated at day one, until all participants wounds had achieved closure.

It is essential that any baseline data is collected in advance, before randomisation, so

that the researcher can rule out any possibility that participant's group assignment might affect the outcomes before the tested intervention (Polit and Beck, 2012). Data from 16 outpatient wound centres was collected in the study conducted by Fife et al., (2008). Moule and Goodman (2014) described this type of data collection as evaluation research, whereby existing data is used to test out a particular phenomenon. However, there are limitations with this method, as in order to be consistent all 16 outpatient wound centres would have to complete the database in the same way, and this was not verified.
Stansby et al., (2010), and Seidel et al., (2014), studies both used the intention to treat analysis in their data analysis method. This method works on the principle that all data from the randomised groups is analysed, regardless of whether the participant was exposed to the intervention or not (Gupta, 2011). Williamson and Whittaker (2014) debated that this method is also known as double-blinding, and it is used in research to avoid unintentional and intentional bias regarding the findings. Hence, a valid method to use, as the reliability of the findings will be more robust. Blume et al., (2008), also used intention to treat analysis, along with various tests which included Fishers exact test, ANCOVA and Kaplan-Meier survival analysis. When researchers use standardised tests for data analysis it provides them tried and tested tools, without the need for them to develop their own. Furthermore, the type of test to be used should be decided in advance (Polit and Beck, 2014). Fife et al., (2008), used the software Statistical Package for Social Science (SPSS). This statistical software is considered easy to use, as it has a graphical user interface and many statistical functions (Knott and Steube, 2010). However, some argue the licence is time limited, and expensive so may not be fully accessible (Yalta, 2008).

Fife et al., (2008), has suggested there was no difference between participants becoming more at risk to bleeding and infection, or being in more pain using V.A.C than non V.A.C therapy. Fife et al., (2008), have concluded that V.A.C is a safe method to treat diabetic wounds. However, three of the researchers are shareholders within a wound software database system used, which may raise questions about their creditability and transparency, again a potential weakness to this study. The findings of the studies by Stansby et al., (2010), and Blume et al., (2008), state that NPWT is a positive treatment for wound healing, and in many cases is more effective than advance moist wound therapy. It was not possible to fully understand the Seidel et al., (2014), findings as the trail was still ongoing. However, initial discussions do point to NPWT being also effective for chronic diabetic foot wounds. The findings are consistent with NICE (2016) which recommends NWPT when a wound has a large amount of exudate. This is also in accordance with other grey literature used to research wound care, NPWT and diabetes.

References

Addo, M, and Eboh, W, (2014) Qualitative and quantitative. In: Taylor R (Ed.) (2014) *The Essentials of Nursing and Healthcare Research.* London: Sage

Bettany-Saltikov, J (2012) *How to do a Systematic Literature Review in Nursing, A step-by-step guide* Berkshire: Open University Press

Blume, P, Walters, J, Payne, W, Ayala, J, and Lantis, J (2008), Comparison of negative pressure wound therapy using vacuum-assisted closure with advanced moist wound therapy in the treatment of diabetic foot ulcers: a multicenter randomized controlled trial, *Diabetes Care*, 31,(4), pp. 631-636,

Chadwick, P (2009), The use of negative pressure wound therapy in the diabetic foot, *British Journal of Nursing*, 18, (20), S12-19,

Coughlan M, Cronin P, and Ryan F, (2013) *Doing a Literature Review in Nursing, Health and Social Care* London: Sage

Ellis, P. (2010) *Understanding Research for nursing students* Exeter: Learning Matters Ltd

Fife, C, Walker, D, Thomson, B, and Otto, G. (2008), The safety of negative pressure wound therapy using vacuum-assisted closure in diabetic foot ulcers treated in the outpatient setting, *International Wound Journal*, 5, pp. 17-22,

Gupta SK. (2011) Intention-to-treat concept: A review. *Perspective in Clinical Research* 2(3): pp 109-112

Jan, A, Khan, H, Ahmad, I, and Khan, M. (2016), Diabetic foot ulcer; Risk factors stratification in patient; A study of 150 patients, *Professional Medical Journal*, 23, 6, pp. 693-698,

Kadam P, and Bhalerao S, (2010) Sample size calculation. *International Journal of Ayurveda Research* 1 (1) pp.55-57

Knott C. L. and Steube G. (2010) Using excel in an introductory statistic course: A comparison of instructor and student perspectives *Northeast Decision Science* Institute [online] http://www.nedsi.org/proc/2010/proc/p091112001.pdf [accessed 6th September 2016]

Lavery, L, Boulton, A, Niezgoda, J, and Sheehan, P (2007), A comparison of diabetic foot ulcer outcomes using negative pressure wound therapy versus historical standard of care, *International Wound Journal*, 4, (2), pp. 103-113, Lindsay B (2007) *Understanding Research and evidenced based practice* Devon: Reflect press

Meloni, M, Izzo, V, Vainieri E, Giurato, L, Ruotolo, V. and Uccioli, L, (2015) Management of negative pressure wound therapy in the treatment of diabetic foot ulcers *World Journal Orthopaedics* 6. (4). pp 387-393

Moule, P, and Goodman M, (2014) *Nursing Research, An Introduction* 2nd Ed. London: Sage

National Institute for Health and Care Excellence (2016) Diabetic foot problems: prevention and management NICE guidelines [NG19], [online] https://www.nice.org.uk/guidance/ng19/chapter/Implementation-getting-started , [accessed 30th August 2016]

Papadakis M, A, McPhee S, J, and Rabow M, W, (2015) *Current Medical Diagnosis and Treatment*, 54th ed. USA: Lange Medical Publications

Polit D, F, and Beck C, T, (2012) Nursing research, Generating and assessing evidence for nursing practice, Philadelphia: Lippincott Williams and Wilkins

Sacca L, (2010) The uncontrolled clinical trial: scientific, ethical, and practical reasons for being. *Internal Emergency Medicine* 5 (3) pp.201-204.

Seidel, D, Mathes, T, Lefering, R, Neugebauer, E, Storck, M, and Lawall, H (2014), Negative pressure wound therapy versus standard wound care in chronic diabetic foot wounds: Study protocol for a randomized controlled trial, *Trials*, 15, (1)

Stansby, G, Wealleans, V, Wilson, L, and Morrow, D (2010), Clinical experience of a new NPWT system in diabetic foot ulcers and post-amputation wounds, *Journal of Wound Care*, 19, (11), pp. 496-502

Whitehead, S, Forest-Bendien, V, Richard, J, Halimi, S, Ha Van, G, and Trueman, P (2011), Economic evaluation of Vacuum Assisted Closure® therapy for the treatment of diabetic foot ulcers in France, *International Wound Journal*, 8, 1, pp. 22-32,

World Health Organisation (2016) Global report on diabetes. *World health organisation* Geneva, [online] http://apps.who.int/iris/bitstream/10665/204871/1/9789241565257_eng.pdf, [accessed 30th August 2016]

Williamson G, R. and Whittaker A, (2014) *Succeeding in Literature Review and Research Project Plans for Nursing Students* London: Learning Matters

Yalta, A. T. (2008). The accuracy of statistical distributions in Microsoft Excel 2007.

Computational Statistics & Data Analysis, 52(10), pp79-86.

Health promotion regarding STIs in young people

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Abstract

This article explores health promotion techniques regarding STIs in one of the highest risk age groups, young people under 25 years of age. The article also explores the link between socioeconomic deprivation and poor sexual health. The role and responsibility of the nurse in promoting holistic wellbeing and sexual health is examined.

Keywords

Sexual Health, Socioeconomic, Deprivation, STI, Young People, Health Promotion,

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Introduction

This article will discuss Sexually Transmitted Infections (STIs) with particular focus on one of the highest risk groups; young adults under 25 years old. Rates of STI diagnosis are high in the 15-24 age bracket, with women aged 20-24 most at risk (over 4000 cases per 100,000 population) (PHE, 2015b). Rates of certain STIs such as Syphilis and Gonorrhoea are rising (PHE, 2016). As STIs can be asymptomatic there could be an even greater public health issue than is known. There is also a strong link between socioeconomic deprivation and poor sexual health (PHE, 2016). The Department of Health (2013) has issued a policy but from 2013 services have been commissioned locally by Clinical Commissioning Groups (CCGs) monitored by Public Health England (PHE) potentially risking geographical variation. Health is ‘not merely the absence of disease’ (Naidoo and Wills, 2009, p.4) but also the ability to express one’s sexuality without harm. Sexuality should be considered by all nurses to be essential for holistic wellbeing.

Background

Young people as a whole are classed as a ‘vulnerable group’ in terms of STI likelihood (DoH, 2013), however a young person’s background and geographical location can increase their risk (Coleman, 2007). Young people may lack the skills and confidence to negotiate the sexual world (MacRae & Ladlow, 2011). This could be due to a myriad of challenging factors, such as lack of experience and education, peer pressure, online exploitation, media portrayals of sex, confusion regarding sexual preference/identity, learning disabilities and cultural or religious factors.

The Marmot Review, requested by the Secretary of State for Health to advise upon health inequalities, found that there was a 'social gradient' in health and 'the lower a person's social position, the worse his or her health' (Marmot, 2010, p.16). The review argues that reducing health inequalities will benefit society both economically and socially. One key recommendation of the review was to enable young people 'to maximise their capabilities' and 'have control over their lives' (Marmot, 2010, p.16), this includes control over sexual health. The Review highlights the importance of investing in early childhood education for an enduring impact upon health. Young people can gain in self belief via engagement both at school and in the community, for example skill acquisition via education both in formal and non-formal settings (Marmot, 2010).

Health inequalities have been linked to income inequalities, with the UK having the joint 6th most unequal incomes in the developed world (The Equality Trust, 2016). Furthermore, UNICEF (2013) found that out of 29 rich countries, the UK ranked 16th for child well-being and 15th for risk-taking behaviours (including smoking, alcohol use and teenage pregnancy). The DoH (2013, p.41) states the importance of addressing these wider determinants of health as they form a 'strong link' to sexual health. STI rates vary geographically; for example in Liverpool the rate of new STI diagnosis was higher than average for England (PHE, 2015a).

Education is a major determinant of health and school experience integral to the '...development of self-esteem, self-perception and health behaviour' (Barnekow et al, 2012, p.45). Brook (2016), the UK's leading sexual health charity for young people, believes in the need to provide 'good quality sex and relationships education' as part of a broader health and wellbeing message. Currently Sex and Relationships Education (SRE) is not legally required in schools, however following pressure from advocacy groups such as Brook Advisory, it will become compulsory in UK schools from 2019. However, concerns remain regarding equipping teachers with the necessary skills to deliver this training (Corteen, 2017).

In England, 32% of girls and 26% of boys aged 15 (below the legal age of consent) state that they have had sexual intercourse (Barnekow et al., 2012). Early intimacy is linked to increased risk of STIs, which can have devastating consequences such as pelvic inflammatory disease, miscarriage, infertility, recurring infection, stigmatization, embarrassment and significant emotional impact (Coleman, 2007). Successful schemes which target young people specifically include 1.5 million Chlamydia tests carried out among the 15-24 age group in 2015, as part of the National Chlamydia Screening Programme (PHE, 2016). The 'C-Card Scheme' for condom distribution that entitles young people to free condoms, is also proving to provide easy access to sexual health resources in information and advice services (Brook & PHE, 2014).

Despite the intrinsic role that sexuality plays in physical and mental wellbeing, Peate (2010) argues that it is often overlooked by nurses. The Nursing and Midwifery Council (NMC) Code (2015) emphasises 'treating people as individuals' and ensuring that 'physical, psychological and social needs' are responded to; addressing sexuality is also required. The World Health Organisation (WHO, 2010) states that sexual rights are akin to human rights. The impact of good practice is not only to reduce the number of STIs, but also to promote fulfilling relationships and reduce health inequalities (Peate, 2010).

Furthermore, MacRae and Ladlow (2011) emphasise the consequences of poor sexual health advice as ranging from physical issues, to low self worth, to social issues such as exploitation or violence.

Sexual health nursing is an evolving speciality in the UK in a wide variety of settings, (Melville, 2015). An outreach service may be provided at schools and hostels or youth offending centres (Prospects 2016). A concise history is fundamental to the nurse's role, Duffin (2005, p.388) emphasises 'time, space and a private place' to conduct the assessment as essential prerequisites. In addition to health promotion, it is also the role of a sexual health nurse to undertake diagnostic tests (STI swabs, pregnancy tests), offer pre- and post-test counselling and onward referrals; they may also be registered to provide contraception.

Barriers to the promotion of sexual health may include nurse's attitudes and personal values (Peate, 2010). The nurse may project preconceived ideas on to the client or feel uncomfortable discussing sexuality particularly if this is not their specialty. Peate (2010) recommends increasing one's knowledge base to instill confidence, and self-discovery; for example reflecting on one's own sexuality. Wakley and Chambers (2002, p. 114) stress the importance of expressing the enjoyment of sex to clients, as over emphasising the negatives can be 'counter- productive.'

Health promotion may also include challenging the client's prior knowledge and perspectives. Young people learn about sexuality from a variety of sources, including parents, friends and the media (Sutherland, 2005). Increasingly in the digital age, young people look to the internet for answers regarding sex and 23.9% of young males listed pornography as a source of information (Clifton et al., 2015). This highlights the necessity for the nurse to provide evidence based information, as many of the aforementioned sources may be inaccurate, unrealistic and biased. British Association for Sexual Health and HIV (Bacon et al., 2013) guidelines advocate the use of language that is clear and easy to interpret for both the practitioner and the client. Additionally, it is important to teach practical skills such as effective condom use to reduce risk and for nurses to be competent in clinical skills such as venipuncture, injection technique and potentially advanced skills such as insertion of Intrauterine Devices (IUD) for example. Nurses should be comfortable discussing psychosexual matters such as sexual preference, gender identities, saying ‘no’ to sex, and how to make sex enjoyable (Clifton et al., 2015, p.5). Educating young people on these topics will empower and promote the confidence to resist ‘peer pressure’ or to become involved in behaviour they may not be ready for.

When designing services for young people, it is important to stage consultations to prioritise what matters to them. Commonly cited barriers to accessing primary care include lack of information (e.g. where to go), concerns about low visibility and ensuring confidentiality, for example not been seen by a parent or relative. Therefore, it is crucial to provide specific services designed for young people, and services that values young people’s views (Macfarlane & McPherson, 2007, p.131). Confidentiality is a tenet of the NMC Code (2015) and is crucial to sexual health services.

Conducting an assessment of sexual health may not be easy; patients and young people in particular, may be embarrassed to discuss their sexuality. Peate (2010, p.243) advocates using the assessment as a 'fact-finding activity' whereby the practitioner tries to gain context of the person's life; for example age, relationship status, home living arrangements. This helps the practitioner to build a picture of the person's situation and provide holistic care. Nurses should speak in a manner which avoids technical jargon and should respond to patients in 'a positive, relaxed' tone, perhaps paraphrasing their language to show they have listened and understood what has been said (Peate, 2010, p.243).

It may be helpful to use an assessment model to provide a framework. For example, the PLISSIT model; to ask Permission to discuss the issue, give Limited Information, make Specific Suggestions, and then offer more Intensive Therapy (Peate, 2010, p.245). There is also the BETTER model (Mick et al., 2003, cited in Peate, p.245). This involves Bringing Up the topic, Explaining, Telling (what you have understood, giving information), Timing (is the timing for advice appropriate?), Educating, and Recording (documenting the consultation). However, frameworks should be used as guidance and the nurse must be flexible and bring their own knowledge and skills to the assessment (Peate, 2010, p.245).

Additionally, nurses are well placed to improve patients' health via 'Brief Interventions.' This is an intervention technique 'taking up to two minutes' which follows an '"ask, advise, assist"' structure (Fuller 2015, p.23). This technique is designed to be built into the nurse's everyday work. The nurse should be aware of opportunities to give brief advice in a non-confrontational manner and to signpost the client to further information. This could take the form of discussing smoking or alcohol use with a young person for example, even if the primary reason for their visit to clinic was regarding STIs. NICE guidelines (2007) emphasize that 'interventions to change behaviour have enormous potential' and that appropriate training in these strategies will enable nurses to be more effective in their interactions with patients.

Although all nurses should recognise the importance of sexual health, specialities such as Sexual Health Nurses (SHN), school nurses, midwives, prison nurses and health visitors are most likely to be providing education and interventions regarding STIs. In 1985, Lord Fraser published the 'Fraser Guidelines', to support nurses in providing sexual health advice and treatment to under 16s; assuming that they are satisfied that the young person is competent, aware and consenting (MacRae & Ladlow, 2011, p.225).

As is always the case with any medical intervention, the benefit must outweigh the risk, for example, considering whether the young person will continue to have unprotected sexual intercourse without care. The basic principle of 'beneficence' (doing good) and non-maleficence (avoiding harm) can be applied to health promotion (Naidoo & Wills, 2009). Although confidentiality should always be employed, if a professional identifies a risk in terms of health, safety or welfare, then local child protection protocols should be followed (MacRae & Ladlow, 2011). Ideally the young person should be informed and consulted first, unless the circumstances mean the nurse is unable to do this. Nurses must be aware of Child Sexual Exploitation (CSE), and high profile media cases, such as occurred in the Rotherham grooming scandal (Jay, 2014). Screening for CSE should be carried out routinely, by considering physical injuries, recurring STIs, pregnancy and unexplained relationships with older adults (Rogstad & Johnston, 2014).

Conclusion

The transmission of Sexually Transmitted Infections is a significant public health issue which affects all age groups; however young people are particularly at risk due to a number of factors including increased sexual activity and lack of knowledge and skill surrounding sexual health. As discussed, socioeconomic deprivation is linked to poorer sexual health, which has negative consequences in terms of physical, psychological and social impact for both the individual and society. The role of education, both at the level of Government policy regarding school SRE lessons, and particularly for nurses working with young people, cannot be underestimated. NICE (2017) guidelines for example suggest that condom distribution schemes can function as an introduction to wider health and wellbeing education for young people. The nurse must act to empower and educate young people in a broader psychosocial sense, using a variety of methods, including assessment of needs and brief interventions. Confidentiality and safeguarding are paramount to working in sexual health, particularly when dealing with under 24 year olds. The nurse must be vigilant in safeguarding and spotting signs of abuse, the Department of Health (2015) published guidelines to assist school nurses in tackling sexual exploitation. Nurses must reflect upon their own values and attitudes towards sex in order to practice in a practical, non-judgmental and sensitive manner which is in keeping with the NMC Code to value people as individuals and not discriminate (NMC, 2015). Additionally, both national and local policy makers and commissioning groups should consult with young people regarding what they desire from services, and target services and campaigns at young people as a specific demographic with specialised needs.

References

Bacon, L., Brook, G., Evans, C., McClean, H., Roberts, C., Sullivan, A.K., Tipple, C. Winter, A.J. (2013) British Association for Sexual Health and HIV. *2013 UK national guideline for consultations requiring sexual history taking.* [Online] Available at: https://www.bashh.org/documents/Sexual%20History%20Guidelines%202013%20final.pdf [Accessed 13 April 2017]

Barnekow, V., Currie, C., Currie, D., De Looze, M, Morgan, A., Roberts, C., Samdal, O., Smith, O.R.F., Zanotti, C. (eds.) (2012) *Social determinants of health and well-being among young people. Health Behaviour in School-aged Children (HBSC) study: international report from the 2009-10 survey.* Health Policy for Children and Adolescents, No.6. Copenhagen: WHO Regional Office for Europe.

Brook (2016) *Education* [Online] Available at:
https://www.brook.org.uk/our-work/category/education
[Accessed 13 July 2016]

Brook and Public Health England (2014) *C-card distribution schemes: Why, what and how.* London: Ayedear Productions Ltd.

Brook, PSHE Association and Sex Education Forum (2014) *Sex and Relationships Education (SRE) for the 21st Century: Supplementary advice to the Sex and Relationship Education Guidance DfEE (0116/2000).* London: Department for Education and Employment.

Clifton, S. Datta, J., Field, N., G Jones, K.G., Johnson, A.M., Lewis, R., Macdowall, W., Mercer, C.H., Mitchell, K.R., Sonnenberg, P.,Stevens, A.,Tanton, C., Wellings, K. (2015) Patterns and trends in sources of information about sex among young people in Britain: evidence from three National Surveys of Sexual Attitudes and Lifestyles. *BMJ Open* (2015), 5.
Coleman, L. (2007) Chapter 5: Sexual Health. In: Coleman, J., Hendry, L.B. and Kloep, M. (eds.) *Adolescence and Health*. Chichester: John Wiley & Sons Ltd. pp.83-106.

Corteen, H. (2017) *Schools need brave teachers for sex and relationships education.* [Online] Available at: http://schoolsweek.co.uk/schools-need-brave-teachers-for-sex-and-relationships-education/
[Accessed 12 April 2017]

Department of Health (2013) *A Framework for Sexual Health Improvement in England*. London: Department of Health.

Department of Health (2015) *Helping school nurses to tackle child sexual exploitation.* London: Department of Health.

Duffin, A. (2005) Chapter 14: Sexual Health and Sexually Transmissible Infections,. In:

Andrews, G. (ed.) (2005) *Women's Sexual Health* 3rd edn. London: Elsevier. pp.385-424

Fuller, S., (2015) *Building brief intervention into your everyday work*. [Online] Nursing Times Vol.111, No.5 [Online] Available at: http://www.nursingtimes.net/Journals/2015/01/23/s/k/d/280115-Building-brief-intervention-into-your-everyday-work.pdf
[Accessed 15 July 2016]

Jay, A. (2014) *Independent Inquiry into Child Sexual Exploitation in Rotherham 1997-2013*. Rotherham: Rotherham Metropolitan Borough Council.

Macfarlane, A. and McPherson, A. (2007) Chapter 7: Getting It Right in Health Services for Young People. In: Coleman, J., Hendry, L.B. and Kloep, M. (eds.) (2007) *Adolescence and Health*. Chichester: John Wiley and Sons Ltd. pp.123-142

MacRae, S. and Ladlow, J. (2011) Improving sexual health. In: Linsley, P., Kane, R. and Owen, S. (eds.) (2011) *Nursing for Public Health: Promotion, Principles, and Practice.* Oxford: Oxford University Press. Pp.206-230.

Marmot, M. (2010) *The Marmot review final report: Fair society, healthy lives.* London: University College London.
Available at: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-executive-summary.pdf
[Accessed 13 July 2016]

Melville, C. (2015) *Sexual and Reproductive Health at a Glance.* West Sussex: John Wiley & Sons Ltd.

Naidoo, J. and Wills, J. (2009) *Foundations for Health Promotion* 3rd ed. Oxford: Elsevier Health.

NICE (2007) NICE guidelines [PH6] *Behaviour Change: general approaches.* [Online] Available at: https://www.nice.org.uk/guidance/ph6
[Accessed 15 July 2016]

NICE (2017) NICE guidelines 68 *Sexually transmitted infection: condom distribution schemes.* [Online] Available at:
https://www.nice.org.uk/guidance/ng68/chapter/Recommendations
[Accessed 13 April 2017]

NMC (2015) *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives* [Online] Available at: https://www.nmc.org.uk/standards/code/read-the-code-online/
[Accessed 14 July 2016]

Peate, I. (2010) Chapter 13: The Sexual Being. In: Peate, I. (ed.) (2010) *Nursing Care* *and the Activities of Living* 2nd edn. Chichester: John Wiley & Sons Ltd. pp.236-254

Prospects (2016) *Sexual health nurse: Job description and activities* [Online] Available at: http://130.88.36.167/p/types_of_job/sexual_health_nurse_job_description.jsp
[Accessed 14 July 2016]

Public Health England (PHE) (2015a) *Public Health Profiles: Sexual and Reproductive Health Profiles* [Online] Available at:
http://fingertips.phe.org.uk/profile/sexualhealth/data#page/0
[Accessed 12 July 2016]

Public Health England (PHE) (2015b) *Sexually Transmitted Infections in England, 2015.* London: Public Health England.
Available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/535085/England_STI_Slide_Set_2015.pdf
[Accessed 14 July 2016]

Public Health England (PHE) (2016) *Health Protection Report: Weekly Report, Infection Report*, Volume 10 Number 22. London: Public Health England. Available online at:
https://www.gov.uk/government/publications/health-protection-report-volume-10-2016/hpr-volume-10-issue-22-news-8-july
[Accessed 15 July 2016]

Rogstad, K. and Johnston, G. (2014) *Spotting the Signs: A national proforma for identifying risk of child sexual exploitation in sexual health services.* London: BASSH/Brook.

Royal College of Nursing (RCN) (2014) *Safeguarding children and young people – every nurse's responsibility: RCN guidance for nursing staff*. London: Royal College of Nursing.

Sutherland, C. (2005) Young People and Sex. In: Andrews, G. (ed.) *Women's Sexual Health* 3rd edn. London: Elsevier.

The Equality Trust (2016) *Scale and Trends: The Scale of Economic Inequality in the UK* [Online] Available at: https://www.equalitytrust.org.uk/scale-economic-inequality-uk
[Accessed 12 July 2016]

UNICEF (2013) Child Well-being in Rich Countries: A comparative overview, *Innocenti Report Card 11*. Florence: UNICEF Office of Research.
Available at: https://www.unicef-irc.org/publications/pdf/rc11_eng.pdf
[Accessed 15 July 2016]

Wakley, G. and Chambers, R. (2002) *Sexual Health Matters in Primary Care*. Oxon: Radcliffe Medical Press Ltd.

World Health Organisation (WHO) (2010) *Sexual and Reproductive Health: Defining Sexual Health* [Online] Available at: http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/ [Accessed 14 July 2016]

Inequalities in Access to Healthcare for Transgender Patients

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Abstract

The last decade has seen a rise in the widespread recognition of trans* individuals and a developing understanding of what it means to be trans*. Although education about this is increasing across schools, communities and the National Health Service in the United Kingdom, inequalities in access to health care remains a contemporary issue. Prejudice, stigma and discrimination are the deterring fears when seeking health provision and interventions. This paper will explore the campaigns, charities and Government publications on changing attitudes towards trans individuals; analysis of health care provision, and highlight the reasons for transphobia in the UK.

Keywords

Transgender, NHS, Inequality, Stigma, Nurse, Primary Care, UK,

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Introduction

Trans* is an umbrella term used to describe individuals that may be transgender, transsexual or non- binary, (GIRES, 2016). This article will focus primarily on transgender individuals. However, it is important to consider that trans* health care should not be generalised, and separate guidelines should be considered for disparate groups within the trans* community (DH, 2008). The Office for National Statistics outlined that the 1990s saw the rights of trans* people recognised for the first time. Although campaigning has encouraged commendable historical achievements, inequalities remain prevalent in the National Health Service (House of Commons, 2015).

Historical Advances

Social views on sexuality, changes in terminology and societal awareness, make it difficult to gather sound historical evidence of trans* communities. ‘Action for Trans Health’ campaigners emphasise that the chronicles of modern Britain contain accounts of “people who did not fully identify with or present as the gender they were assigned at birth” (Action for Trans Health, 2016). During the 19th Century, individuals indicating transsexual ‘deviations’ were treated in asylums and suspected to be a result of defective genes (Garber, 2012). In the 1940’s Dr Micheal Dillan, one of the first British males to undergo phalloplasty, described how “the body should fit… to the mind” (Dillon, 1946). When discovered that Dillan had undergone gender affirmation surgery, Dillon fled to Bengal living as a monk until his early death in 1962, aged 47 (Boisvert and Johnson, 2012). The 1950’s saw Roberta Cowell become the first known British woman to undergo affirmation surgery; both Dillon and Cowell’s novel procedures were performed by the same surgeon

(Boisvert and Johnson, 2012). Increased media coverage of late has become a catalyst for further movement in the ever long journey to equality. Knowledge and awareness of the trans* community is increasing in the public eye, with the intention of reducing discrimination and encouraging social inclusion (PHE, 2016).

It is however, crucial to note at this point that although there have been significant improvements in rights for lesbian, gay and bisexual communities, as well as trans* communities; the significance of trans* people can often be overshadowed by LGB communities (Formby, 2012). With the fluidity of Lesbian, Gay, Bisexual and Transexual (LGBT) remits in years past, Trans* communities have repeatedly been marginalized. Hunt and Manji, (2015, p 3) suggest, “Homophobia, transphobia and sexism are intrinsically linked, and not acknowledging this has perpetuated society’s apathy and misunderstanding of trans* people”. Nonetheless, Government legislation now ensures trans* rights are aligning to those of the general population. Development of the Sexual Discrimination Act (1975), Gender Recognition Act (2004), Equality Act (2010) and Marriage (Same Sex Couples) Act (2013) provide legal policy for the trans* communities; although Whittle, Turner and Al-Alami, (2007) suggest that this could progress further. In 1980, Harry Benjamin founded the International Gender Dysphoria Association, later to be known as the World Professional Association for Transgender Health, an organisation devoted to transgender health provision (WPATH, 2016).

The 90’s saw preliminary legal recognition for trans* rights in the UK. The first parliamentary forum on transsexualism took place in 1996, evidence was collated surround the ‘biologically based, multifactorial etiology for transsexualism’ (GIRES, 2009). The Gender Identity Research and Education Society was established in 1997, providing fundamental literature surrounding trans* individuals to educate the nation and establish foundations for further research. The North West Lancashire Health Authority came under scrutiny in 1998 after refusing three women gender reassignment treatment; the High Court ruled this as unlawful and stated that no Health Authority was to "impose any policy amounting to a blanket ban on funding medical treatment for the purposes of gender reassignment" (Whittle, Turner and Al-Alami, 2008). Amendments to the UK Sex Discrimination Act were made in 1999 to ensure protection surrounding gender reassignment in accordance with the Sex Discrimination (Gender Reassignment) Regulations. Thus ensuring further safety remits for trans* individuals within different communities with regards to accessing goods, services and employment (SDA, 1999).

The early 2000's saw the UK Government recognise that "transsexualism is not a mental illness" (DCA, 2009) and trans* individuals in the UK became legally able the change their gender to align with the gender in which they identified (Gender Recognition Act, 2004). The Gender Recognition Act was enforced in 2004, enabling trans* communities' full legal recognition of their affirmed gender. This was a monumental event in trans* history with the responsibility of the prolific event a result of Press for Change Organisation ensuring success (GIRES, 2015). The first trans* health summit took place in 2006 in London; ensuring that health provision is tailored to requirements and found that the trans* community are constantly viewed to be mentally ill within health services and individual's needs are overlooked (Whittle, Turner and Al-Alami, 2008). Subsequent to this, the first National Health Service (NHS) initiative with the Department of Health was held in 2006, chaired by Christine Burns, trans* political campaigner and internationally recognised health advisor (Burns, 2005). Burns (2005) along with Press for Change Organisation drove the movement of raising the profile of trans* health in the UK. As a direct result of this, the Department of Health commissioned Burns to write “Trans: a practical guide for the NHS” a publication on best practice and guidance for NHS staff (DH, 2008).

Since then, resources for NHS staff have developed and become widely recognised as imperative for high standards of care provision. The RCN published guidance for nurses caring for trans* patients in 2016, following the Women and Equalities Committee’s transgender equality inquiry pledged to the Government in 2015 (RCN, 2016). Public Health England responded to the inquiry outlining the necessity to improve training for NHS staff, improving research and data, monitoring public attitudes towards trans* communities, and working to eliminate trans discrimination, inequality and prejudice in the UK (GIRES, 2016). In short, campaigners across Britain have taken exemplary action to ensure that trans* rights become recognised further by mainstream political agenda and enable inequalities to be further eliminated.

Access to Health Care

The National Health Service (NHS) provide seven Gender Identity Clinics (GIC’s) for adults in England and just one service for those under the age of 17 (NHS England, 2015). However, an estimated 65,000 individuals currently residing in the UK, are likely to be, to some extent, gender incongruent (Mitchell and Howarth, 2009). At this point, it is essential to highlight the lack of robust data collected on trans communities within the UK; indicating of an often alluded “hidden community” (Health Policy Project, 2015). Understandably resulting in a difficulty to suggest whether the number of services provided are sufficient to accommodate the needs of the trans population (ONS, 2009).

Similarly, NHS England found that they were unable to recommend service provision in accordance with the need for services due to a lack of feedback received (ONS, 2009). The BBC reported that currently, there are 4,500 referrals to GIC's in the UK per annum; with an average waiting time of 18 months (BBC, 2016). Research from the Equality and Human Rights Commission (EHRC) debates this could be a ramification of the low priority of trans* services, in comparison to other areas of healthcare (Combs, 2010). Nonetheless, the Chair of the NHS National Clinical Reference Group (CRG) for Gender Identity Services, Dr John Dean, regards not treating people, as doing more harm (DH, 2015). Some of the consequences of ineffective health provision will be explored in this article.

Nursing Transgender Patients

The lack of clinical guidance outlines the limited knowledge that nursing staff, as well as other health professionals, have surrounding transgender health care. There are currently no NICE guidelines for nursing transgender patients within the NHS. The NMC does not identify transgender in its standards for pre-registration nursing education, indicating a deficit in nurse education (NMC, 2010). Following Stonewall's trans* inclusive movement in 2014, Hunt and Manji (2015) found that 20% of individuals interviewed had witnessed disparaging and negative remarks towards trans people. By disregarding professional standards; health professionals encourage a stigma (NHS England, 2015).

Nursing values and behaviours must promote the importance of patient satisfaction, daily (NMC, 2015). Alongside this there is a need to create an environment appropriate to promote recovery, patient experience and increased long term health and recognise individuals needs (NMC,2015). Aforementioned recommendations urge nurses to ensure that they act with discretion, care and sensitivity; by enabling trans* patients to feel relaxed and preventing prejudicial views being conveyed to the patient regardless of the reason for attending. There is a need for professionals to ensure due regard in accordance with section 149 of the Equality Act (2010). Trans* individuals can encounter additional health risks from hormone therapy treatments when transitioning (RCN, 2016). Guidance provided by the Royal College of Nursing for all staff emphasises close medical supervision, when undergoing treatment. Polycythaemia, venous thromboembolism, hyperprolactinaemia, increased cardiovascular disease, liver abnormalities and increased cholesterol are known ramifications of hormone therapy (BNF, 2016).

Evidence suggests that trans* individuals unable to obtain hormone therapy through standard NHS routes, may obtain them via unsafe alternatives, such as the internet (GIRES, 2015). Additionally, it is recognised that the trans* community have a higher prevalence of risk behaviours such as smoking, drug and alcohol consumption (PHE, 2016). Nurses should also acknowledge their role when caring for and managing ill people who are vulnerable and delivering healthy lifestyle advice (RCN, 2016).

Acting with discretion and sensitivity, allows a trans* patient to speak openly regarding their visit and ensure that they are cared for in a suitable environment such as a side room, or gendered bay (RCN, 2016). Health care professionals can ensure that they use non presumptive language when caring for patients across all mainstream and specialised health services within the NHS; and ensure published guidance is implemented where appropriate.

Public Health England note that there is a lack of specialised knowledge in mainstream national health services (PHE, 2016). By increasing education and knowledge surrounding trans* health, it could be suggested that health promotion in trans* communities will be more effective; reducing wider determinants of ill health and increasing wellbeing (PHE,2016).

Mental Health within the Trans* Community

The Department of Health acknowledge continued prejudice, resulting in limitations for access to healthcare and failure to provide equitable healthcare (Tweddell, 2008; DH, 2015). In a study reviewed by the Press for Change Organisation, 17% of respondents stated that they were refused treatment by NHS professionals who did not agree with gender reassignment, when seeking general health provision (Whittle, Turner and Al-Alami, 2007). The focus of inappropriate or abusive treatment by healthcare professionals was highlighted within the study, opposing the foundation “to bring good healthcare to all” (Tweddell, 2008; Whittle, Turner and Al-Alami, 2008). The fear of receiving prejudicial treatment by healthcare professionals could be suggested as a reason for trans* individuals delaying treatment, or seeking medical supervision (Whittle, Turner and Al-Alami, 2008).

Although the self-study by Dillon asserted that medical transition should be offered to trans* individuals opposed to treatment for mental illness (Henkin, 2008). The view adopted by many health care professionals is that of trans* being a “mental health issue” requiring mental health professionals input, however Henkin (2008) confirms the need for medical transition should be considered for each patient. The NMC Code of Conduct state that nurses treat individual patients as such with dignity to recognise diversity and patient choice (NMC, 2015).

Mental health intervention is often associated with negative connotations by those with little understanding, implying something outside of the realms of ordinary psychological experiences for trans* individuals. Can a trans* individual not choose to adapt their body as they wish, regardless of cognitive distress? However, as the health budget is ever-strained, it could be argued understandable that anatomical modification is akin to the psychological distress of an individual., as with body dysphoria of women requesting breast augmentation; Similarly, trans* patients are required to undergo psychological intervention prior to referral for gender transition surgery. It is suggested that in both circumstances, indirect discrimination occurs, although this may be objectively justified by local policy. Consequently, trans* individuals are at a greater disadvantage (EHRC, 2016).

The stigma associated with gender nonconformity can have a profound effect. It is therefore deemed necessary to ensure that a person's ability to adjust to life after transitioning is taken in to account prior to surgical intervention (WPATH, 2016). The National Suicide Prevention Strategy recognised that the trans* community experience higher rates of mental health issues and self-harm (DH, 2012). However, over 96% of trans* individuals have positively proven to be satisfied with gender affirmation surgery and subsequently lead happier lives thereafter (Whittle, Turner and Al-Alami, 2007).

The psychosocial implications of trans* discrimination create social isolation experienced by the trans* community (Whittle, Turner and Al-Alami, 2007). Trans* individuals are less likely to leave the house to exercise, or seek employment due feeling vulnerable to discrimination and stigmatisation. Thus increasing health risks both mentally and physically and furthering levels of social isolation (PHE, 2016).

The Future for Trans* Healthcare

The United Kingdom is recognised for being more advanced in attitude and provision of health care for trans* individuals, than countries such as the United States of America according to statistics formulated by the House of Commons (2016). There are still areas that can be developed further, such as diminishing discrimination and increasing awareness through education. In the United States, as seen in the documentary “Southern Comfort” featuring female to male trans* individual Robert Eads, discrimination appeared to contribute to his untimely death from metastasised ovarian cancer, a direct result of over 20 doctors refusing to treat him due to the impression it may impose on their practice and other patient’s view on trans* (Ali, 2011). Increasing awareness of circumstances such as Ead’s could lead to improvement in attitude and health provision to trans* patients in the UK.

Further research and education is needed in the UK to reduce unnecessary mortality and to ensure that the trans* community are equally represented and provided for, in accordance with the Equality Act, which remains to be fully adhered to (PHE, 2016). Increased data collection and peer reviewed studies, should be encouraged, alongside effective monitoring of engagement to current services. National data is currently under represented but essential in enabling the NHS to identify areas for further improvement (ONS, 2009).

To enable further progression education must also be provided. There is a need to educate student nurses at university level and eliminate prejudice from the offset. Incorporating the importance of trans* needs within a national curriculum, advances in health provision should follow. To conclude, campaigners within the trans* community have, since the 19th century, been made huge leaps in awareness and equity of care. However, it is evident that there is much further to go. It is clear that further research is necessary alongside widespread recognition of the current inequalities faced by trans* communities. The ability for nursing staff to effectively communicate with trans* patients in a manner that creates comfort and trust, will ensure individuals are utilising services and promote innovating future service provision. Progression is awareness, provision and society's attitude to eradicate this contemporary issue.

References

Action for Trans Health (AFTH), (2016) *Trans History for LGBT History Month* [online] Available at: http://actionfortranshealth.org [Accessed: 28 Sept 2016]

Ali. S, (2011) LGB&T History challenges & success. NHS: Lancashire. [online] Available at: www.lancashirecare.nhs.uk [Accessed: 6th May 2017]

BBC, (2016) *Transgender Patients in England face 'long waits' for appointments*. [online] Available at: www.bbc.co.uk [Accessed: 30 Jun 2016]

BNF (2016) *British National Formulary: Book 72*. London: BMJ Group and Pharmaceutical Press

Boisvert, D.L and Johnson, J.E. (2012) *Queer Religion: homosexuality in modern religious history*. Oxford: Praeger

Burns, C. (2005) *A Basis for Evaluating Care Approaches and Services for Trans People in the UK.* London: Press for Change

Combs, R. (2010) *Where gender and medicine meet: Transition experiences and the NHS, Unpublished Thesis* (Phd), University of Manchester

Department of Health (DH) (2008) *Trans: A practical Guide for the NHS*. London: Equality and Human Rights Group

Department of Health, (2011) *Advancing Transgender Equality: A Plan for Action*. London: Government Equalities Office

Department of Health (DH) (2012) *Preventing suicide in England: A cross-government outcomes strategy*. London: HM Government

Department of Health (DH) (2015) *Treatment and support of transgender and non-binary people across the health and care sector*: Symposium report. London: NHS England

Dillon, M. (1946) *Self: A Study in Ethics and Endocrinology. Oxford: Butterworth–Heinemann Equality and Human Rights Committee, Trans Inequalities*.[online] Available at: http://equalityhumanrightscommitee.org [Accessed: Sept 2016]

Equality and Human Rights Committee (EHRC), (2016) Trans Inequalities. Available at: http://equalityhumanrightscommitee.org [Accessed: 1 Sept 2016]

Formby, E. (2012) *Solidarity but not similarity? LGBT communities in the twenty-first century*. SHURA: Sheffield

Garber, M. (2012) *Vested Interest: cross-dressing and cultural anxiety*. Rutledge: New York

GIRES, (2016) *Terminology*. Surrey: GIRES

GIRES (2015) *Gender Recognition Panel*. Ministry of Justice, Tribunals and Gender Recognition Certificate Statistics Quarterly, April to June 2015. Surrey: GIRES

GIRES (2009) Definition and Synopsis of the Etiology of Gender Variance. Surrey: GIRES

Gender Recognition Act (2004) c. 17. [online] Available at: http://www.legislation.gov.uk/ukpga/2004/7/pdfs/ukpga_20040007_en.pdf [Accessed 1 Sept. 2016]

Health Policy Project (HPP), (2015) *Blueprint for the Provision of Comprehensive Care for Trans People and Trans Communities.* Washington, DC: Futures Group, Health Policy Project

Henkin, W.A, (2008) *Coming Out Trans: Questions of Identity for Therapists Working with Transgendered Individuals*. [online] http://www.ejhs.org/volume11/Coming_out_trans.htm accessed 6 May 2017

House of Commons, (2016) *Women and Equalities Committee: Transgender Equality*. London: The Stationary Office

Hunt. R, and Manji. A, (2015) *Trans People and Stonewall*. London: Stonewall

Mitchell. M and Howarth. C, (2009) *Trans Research Review*. Manchester: Equality and Human Rights Commission

NHS England, (2015) *Treatment and support of transgender and non-binary people across the health and care sector: Symposium report*. London: NHS

NMC, (2010) *Standards for pre-registration nursing education* London: NMC [online] https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-pre-registration-nursing-education.pdf accessed 6 May 2017

NMC, (2015) *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives*. London: NMC

Office for National Statistics (ONS), (2009) *Trans Data Position Paper. Surrey: Office for Public Sector Information* [online] Available at: www.opsi.gov.uk/click-use/index.htm [Accessed: 28 Sept 2016]

Public Health England (PHE) (2016) *The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document*. [online] Available at:

http://lgbtfoundation.org [Accessed: 27 Sept 2016]

Royal College of Nursing (2016) *Fair care for trans people* [online] Available at: www2.rcn.org.uk [Accessed 30 Jun. 2016]

Sex Discrimination Act, (1999) [online] Available at: www.legislation.gov.uk/ukpga/1975/65 [Accessed: 27 Sept 2016]

Tweddel, L (2008) *The Birth of the NHS* – July 5th 1948. [online] Available at: www.nursingtimes.net [Accessed: 30 Sept 2016]
y

Whittle. S, Turner. L, and Al-Alami. M, (2007) *Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination*. London: Press for Change

Whittle. S, Turner. L, and Al-Alami. M, (2008) *Transgender EuroStudy: Legal Survey and Focus on the Transgender Experience of Health Care*. London: Press for Change

World Professional Association for Transgender Health (WPATH), (2016) *Standards of Care*. [online] Available at: http://wpath.org [Accessed: 15 Sept 2016]

Lessons learned through reflecting on a classroom observation

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Abstract

The aim of this study was to gain experience collecting data using non-participant observation, with a view to considering using this method for carrying out research for a Masters dissertation. Using non-participant structured observation of classroom teaching as a method of collecting data was experienced, the researcher noted who was speaking at 5-minute intervals. Preparation of a chart for 7 expected students became unwieldly when some 20 students attended, which was not anticipated. It soon became obvious that 5-minute intervals were too long, as many students spoke up but not at the points where speaking was recorded, so the final chart was unrepresentative of the classroom behaviour being observed. Some challenges in doing observation emerged during the study such as trying to avoid contributing to the session.

Keywords

Classroom observation, Non-participant, Context, Lessons learned,

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Introduction

During my Masters in Advanced Education Practice, the tutor running the research module asked us all to experience, document and reflect on using a variety of data collection methods; this would then enable us to select data collection methods when carrying out the research for our dissertations. One of the data collection methods was non-participant structured observation of classroom teaching.

What is classroom observation?

Angrosino (2012, p.166) discusses that observation is “well-established and most frequently used for classroom research”, and Punch and Oancea (2014) also comment that observation has been widely used in educational research. Menter et al (2011) explain that observation can be useful when looking for how often a behaviour or event happens. Walliman (2011, p.195) describes observation as “a method of recording conditions, events and activities through the non-inquisitorial involvement of the researcher”. Kumar (2011, p.140) explains that observation is “a purposeful, systematic and selective way of watching and listening to an interaction or phenomenon as it takes place”. Johnson and Christensen (2011) refer to structured observation as quantitative, as there is standardisation of who and what is being observed, and when and where the observations will take place. Cohen, Manion and Morrison (2011, p.456) point out that “observation’s unique strength” is it’s potential to produce “valid and authentic data” because it focuses on the collection of data collected directly by looking at real situations. They explain that highly structured observation is when the phenomena being observed for and recorded is planned in advance. In addition, Moule and Goodman (2009) suggest that strengths of observation for data collection include events that take place in real time and are natural real life occurrences; however, weaknesses that have been noted include how time-consuming and intrusive they can be. It is also important to take note of Menter et al's (2011) argument that many of the limitations of observation can be managed by the researcher's skill and experience, in addition to planning well.

What is non-participant structured classroom observation?

My plan was to observe a colleague and her students during a teaching session, with a focus on who was talking at particular points in time. I was intending to use a non-participant approach, which Gold (1958, cited in Walliman, 2016) explains as the researcher assuming detachment with the intention of being ignored by those being observed, also referred to by Cohen, Manion and Morrison (2011, p.459) as when the researcher "adopts a passive, non-intrusive role". Punch (2009, p.154) refers to non-participant observation as being "pure or direct", which is when the researcher observes but does not "manipulate nor stimulate" those being observed. Similarly, Menter et al (2011) describe non-participant observation as observing and recording whilst not contributing or interfering in the event. Indeed, Kumar (2011) states clearly that this form of observation is about not being involved in the group activities, but rather paying attention to what is seen and heard and then making some conclusions. Further, Check and Schuh (2012, p.194) refer to this approach as "overt observation". Green and Thorogood (2014, p.155) also support this view by stating "non-participant methods … include studies in which the researcher is present to collect the data, but does not interact with participants".

My preparation for the classroom observation

For this activity, I asked a colleague if I could observe her for a one-hour teaching session that she was carrying out with a small class of 7 students who I already knew by name, and who I was already working with in relation to 2 other modules of study in their course. Initially my colleague had some reservations about my planned observation until I reassured her that I was simply trying out observation as a method of data collection for research, to see how it worked in practice, and I was not making judgements on her teaching skills. For simplicity, I decided to prepare a sheet of paper with a table printed on it with the tutor's name and the 7 students' names, along with columns marked at 5 minute intervals, to note who was speaking at each point. I showed this to the tutor, and although I did not show it directly to the students as I had prepared it after I had last seen them, I had previously explained to them what my intention was, so as not to worry them about what I was doing. Creating a simple and practically useful method to record information by ticking boxes is noted to be helpful for observation (Walliman, 2016).

Early trouble-shooting just prior to the classroom observation

Unfortunately, my plan went awry immediately when I arrived at the classroom early: out of the 7 students that I expected to see, only 4 were present and the tutor informed me that the other 3 would be attending the session on a different date. Also, 2 students from a previous cohort were attending instead, although in itself that was not a great problem as I also knew these students by name. Therefore, I simply made some quick alterations to the table to account for the changes. The more difficult problem was that I had not been informed that 14 students from a different course were also attending this session, and I had not met them before, so I had concerns about how I was going to know who was speaking. This now gave me 20 students to observe in addition to the tutor. From a practical viewpoint, just as the session was starting, I struggled to hurriedly sketch in 13 more rows and extend all of the columns on the table so as to include these unexpected students – this did not help as my writing and diagrams are often messy, and I had wanted a neat table to work with. As I did not know the additional 14 students, I hastily allocated numbers to the students, according to where they were sitting. Seating arrangements in the classroom was using a U shape but because of where I sat, I also struggled so see some of the students in one part of the classroom, as they were seated very closely together. As Walliman (2016) points out, to much may be going on that it becomes too difficult to observe everything.

Carrying out the classroom observation

I therefore made a note of who was speaking during the one hour session at 5 minute intervals. I realised that I was using standardised observation, and Flick (2015) notes that one way of carrying this out is to record the frequency of a specified behaviour observed in a set period of time. Johnson and Christensen (2011, p.207) explain that this “time-interval sampling” means checking at specifically pre-planned time intervals to see if a particular event is taking place. This is also referred to by Moule and Goodman (2009, p.291) as “time-sampling”, when the researcher selects a specific timeframe for making a record of the phenomenon being observed. Although this was an interactive lecture style of teaching, it covered a good deal of new and often difficult material, so it was not surprising that the tutor was speaking at 7 of the noted times. For the remaining 5 noted times, 5 individual students were speaking, leaving 15 students who appeared on my table as being silent.

Forgetting that I was not a participant

Perhaps I should also mention that I inadvertently spoke myself by offering a suggested answer to one of the questions posed by the tutor, much to her and the students' surprise, indeed my own as well, as it was obviously unplanned and inappropriate, but as it did not fall on one of the observation points, it was not recorded. Check and Schuh (2012) point out that the researcher's presence in itself may well alter the situation and dynamics, as it is unusual for someone to observe and record what is happening in a classroom setting, therefore those being observed might behave differently. However, I had potentially affected behaviours of those being observed by interfering with my unexpected contribution. I believe that my interjection was because I knew that there was a 5-minute gap between recordings and I was bored waiting for the next time interval, and so became interested and involved in the material and interactions of the session. However, as Cohen, Manion and Morrison (2011) suggest, researchers should practice structured observation, for example, where to sit or stand, how to observe with discretion and without inhibiting people's behaviours, and to test out the best time intervals for the observations. They also review a number of areas of potential bias, including "reactivity" (Cohen, Manion and Morrison, 2011, p.473), which is when participants alter their behaviour, perhaps to impress the researcher, a phenomenon also noted by Menter et al (2011), something I had not considered had only the 7 original students been in the classroom alone.

Considering how representative my recorded observations were

As I spent the whole 60-minute period observing the session, I feel that in hindsight, choosing 5-minute intervals to record who was speaking was too long. I observed several students, particularly student numbers 7 and 8, who talked a good deal during the session, animatedly answering questions and thinking out loud, and also giving examples of how they were linking what they heard to help their understanding; however, by chance, neither of them were speaking at the 5 minute intervals. Thus recording at these wide intervals did not accurately represent what I had seen. Indeed, although student numbers 6 and 10 were observed speaking at the intervals recorded, they also both spoke more than this; in addition, student numbers 9, 17 and 18 who were recorded speaking, did not actually participate very often, so were over-represented on the chart. This left 15 students who appear as silent in the session, whereas in my own overall observation of the session, I know that many of these students did respond frequently to the tutor's questions, particularly student number 16. Indeed, Flick (2015) comments that when carrying out time sampling, the specified behaviour can happen at other times outside of the set times.

I chose 5-minute intervals as I had originally thought that this would be the easiest to manage, but in fact I now believe that I could have very easily reduced these time intervals down to one-minute frequencies, which would perhaps have produced a much more accurate representation of who was speaking at any one time in the session. Indeed, Menter et al (2011) comment that, unless there are a good number of observation events, then what is recorded may be atypical, and it is better to carry out a range of observations to give a better overall picture. Further, Cohen, Manion and Morrison (2011) also stress that structured observation does need to be piloted in order to check out issues such as recording of events and the frequency of observations, and also for the researcher themselves to become accustomed to the procedure. A suggestion that I had not considered comes from Menter et al (2011) who propose that one of the ways to select time intervals is to observe for 10 minutes, then stop for 10 minutes, and so on over an hour.

I assumed that all of the classroom conversation would be about the topic being taught, I may equally have had to record talking related to requests to leave the classroom to use the toilet, or perhaps opening a window if anyone was too warm, for example, something that I had not thought about. In addition, in response to the tutor's questions, in many instances a number of students responded at the same time; this did not happen at the set observation times, but I would think that I would have had some difficulties in identifying how many students had responded so that I could record all of them. Indeed, Walliman (2011) points out that observation can prove difficult if a good deal is happening at the same time, so that the researcher cannot observe and record everything.

Consideration of the importance of context

One final point is that I had not expected the additional 14 students from the different course. It is worth noting that these were UK students, whereas the other 6 were international students for whom English was not their first language, and this context is important, since there is a possibility that they may have felt inhibited speaking technical English in front of others who were clearly fluent. Indeed, only one of the recordings was for an international student, although all of them did join in at times when I was not recording. As Cohen, Manion and Morrison (2011) discuss, structured observation ignores the importance of context, which may have played an important role in this observed session.

Conclusions about my learning

Cohen, Manion and Morrison (2011) point out that researchers need to practice structured observation, with specific reference to issues such as thinking about where to sit, time intervals, and also piloting the technique. Although I clearly made numerous errors with these, arguably this classroom observation was intended to be a pilot for me to try out this particular data collection method. Indeed, as Green and Thorogood (2014, p.166) point out; the researcher has to consider “refining observational skills”. In addition, I have learned that it is best to be well prepared, for example, bringing in extra copies of blank charts with plenty of additional columns, thinking about how to record if more than one student talks at once, however also recognising that even the best preparation does not guarantee that nothing untoward will happen.

Obviously, the main learning for me was that I need to avoid the possible temptation to participate. Numerous authors have pointed out what non-participant observation means, stressing in particular that it is about passively observing behaviours and recording them, not contributing, stimulating, being involved, or interacting in any way (Cohen, Manion and Morrison, 2011; Menter et al, 2011; Punch, 2009; Kumar, 2011; Green & Thorogood, 2014). In summary, the main lesson for me is - don’t participate!

References

Angrosino, M.V. (2012) Observation-based research. In: Arthur, J., Waring, M., Coe, R. & Hedges, V. (Eds) *Research Methods and Methodologies in Education*. London: Sage. Pages 165-169

Check, J. and Schuh, R.K. (2012) *Research Methods in Education*. London: Sage

Cohen, L., Manion, L. and Morrison, K. (2011) *Research Methods in Education*. 7th ed. London: Routledge

Flick, U. (2015) *Introducing Research Methodology: a beginner's guide to doing a research project.* 2nd ed. London: Sage

Green, J. and Thorogood, N. (2014) *Qualitative Methods for Health Research*. 3rd ed. London: Sage

Johnson, B. and Christensen, L. (2011) *Educational Research: quantitative, qualitative, and mixed approaches.* 4th ed. London: Sage

Kumar, R. (2011) *Research Methodology: a step-by-step guide for beginners*. 3rd ed. London: Sage

Menter, I., Elliot, D., Hulme, M., Lewin, J. and Lowden, K. (2011) *A Guide to Practitioner Research in Education.* London: Sage

Moule, P., and Goodman, M. (2009) *Nursing Research: an introduction*. London: Sage

Punch, K.F. (2009) *Introduction to Research Methods in Education*. London: Sage

Punch, K.F. and Oancea, A. (2014) *Introduction to Research Methods in Education*. 2nd ed. London: Sage

Walliman, N. (2016) *Social Research Methods*. 2nd ed. London: Sage

Walliman, N. (2011) *Your Research Project: designing and planning your work*. 3rd ed. London: Sage