The Cumbria Partnership Journal of Research, Practice and Learning

Volume 5 • Issue 1 • Summer 2016

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EDITORIAL
Paul K Miller: Guest Editorial, January 2016

In a time of great uncertainly across the entire public sector, effective knowledge transfer – and the strengthening of practice and leadership through shared expertise – can become a linchpin means of maintaining and improving quality in general public service without the benefits of increasing capital support. This gives us cause to seriously reflect on the prevalent relationship between research and practical knowledge in the healthcare sector. Traditionally, 'academic' investigation has largely been framed for academic audiences, or at least seen in this way from outside the academic community. Moreover, modern researcher 'grading' systems such as the UK's Research Excellence Framework (REF) often value papers in terms of their publication in the most exclusive (and therefore expensive) 'high-impact' journals. This has led to the widespread perception/complaint that health research is often impenetrable – or outright inaccessible – for the professional communities in which its techniques and findings could potentially make the most difference. In short, academic structures both old and new can drive an artificial divide between 'researchers' and 'practitioners'. This, in turn, prospectively inhibits widespread dissemination of important knowledge, implicitly devalues research emanating from outside of academia, and stymies potentially valuable cross-agency collaborations at a time when they are ever more valuable. Fortunately, there has been a recent reaction against this prevailing trend through the rise of Open Access journals, which have an important role to play in forging a new dynamic between 'academic' and 'professional' communities. Most of these journals, however, and despite their free-to-access character, continue to promote a one-way flow of knowledge. The vast bulk of authors remain employees of universities, and the reporting conventions remain true to the standards of their forebears.

The *Cumbria Partnership Journal of Research, Practice and Learning* has been, from its foundation, manifestly tasked with fostering innovation, communication and collaboration within the regional healthcare sphere, and this issue represents a further step forward in this regard. In the following pages, thus, one will find a variety of papers that address these imperatives in a number of distinct and, ideally, more *reciprocal* ways than may be evident in traditional research journals. Herein, and often in direct collaboration with a diversity of authors from the Cumbria Partnership itself, one will find contributions from academics at a number of universities in the North West and beyond: Birmingham Newman, Lancaster, Liverpool John Moores, Manchester, and my own institution, the University of Cumbria. In some cases, this contribution is a relatively direct exercise in academic knowledge-transfer. The five papers in the first section of the journal each outline, in a brief and practitioner-friendly manner, the dynamics of a major social scientific qualitative research method (respectively: ethnography, interpretative phenomenological analysis, grounded theory, conversation analysis and narrative analysis) and its applications in healthcare. It is hoped that these short accounts will help introduce the approaches to unfamiliar readers, certainly, and thereby assist in 'demystifying' empirical studies based upon those approaches. It is also hoped, however, that they might help promote active investigation in the future, and active discussion about how we might best understand the health-related issues around us.

In the second section, the highly prominent issue of leadership within the UK's public healthcare system comes to the fore. The work of the NHS leadership academy, and the structuring of the NHS leadership framework, stand as direct testament to the contemporary relevance of this matter. The three papers included all address CPFT's own management/leadership training programmes. Two report the outcomes of evaluations conducted by *Health and Social Care Evaluations* (HASCE) at the University of Cumbria, the other is an insightful reflective piece by CPFT's Pippa Orr on the experience of conducting a 'change project' within one of said programmes. The former are tasked with informing future practical interventions, the latter points the way towards future research.

The remaining papers are largely collaborative research enterprises with strong academic and practical implications. The work by Adam Joiner and Sam Dearman, on the development of 'medical professionalism' among psychiatry trainees, is an excellent example of this. The matter of reciprocity between communities is perhaps, however, most clearly evident here in the papers from Neil M. Thomas and Leighan Meddick. These report different aspects of a partnership between the Westmorland General Hospital Renal Unit and the University of Cumbria that gave rise to a physical activity intervention for patients undergoing dialysis. The reflections upon process, obstacles and outcomes are highly illuminating in terms of the intervention itself,

but also the practical business of doing this kind of partnership work.

In conclusion, welcome to the new issue of the CPJ! We hope it will provide an interesting read for anyone attached to the health services, either professionally, academically, or both. Do not hesitate to contact any of the authors to discuss any of the issues arising. One never knows from where a productive collaboration may spring.

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METHODOLOGY
Brief encounters with qualitative methods in health research: Ethnography

Adam Benkwitz

Abstract
Ethnography is a research approach that is gradually being utilised more extensively within diverse healthcare settings. It most commonly includes a combination of participant observation and interviews, which enables data collection through both formal and informal means within a natural setting. This paper briefly interrogates the philosophy and benefits of ethnography, paying particular attention to the flexibility that is afforded to the researcher. A review of relevant ethnographies within healthcare is provided, before acknowledging some of the challenges of this approach.

Introduction
As healthcare systems are becoming increasingly complex and challenging in the 21st century, innovative and flexible approaches to research are required (Plsek & Greenhalgh, 2001). Ethnography is one such approach that is gradually being utilised more extensively within a wide range of pertinent settings. Ethnography essentially refers to the writing (*graphe*) of others (*ethne*) (Van Loon, 2007); it is a multi-method approach, which most commonly includes a combination of participant observation and interviews (Bloor, 2007). Participant observation is the distinguishing feature of this approach, as it enables data collection through both formal and informal means (this can be crucial with sensitive topics). It also allows comparisons to be drawn between reported and actual behaviour, and can provide a socio-cultural context for the phenomenon/ culture under investigation (Huby, Hart, McKevitt & Sobo, 2007). Ethnography more broadly can provide insights into, and human portraits of, statistical data; generating information useful for developing or informing hypotheses, theories, and intervention models (Quimby, 2006). Furthermore, the approach also allows researchers to systematically explore complex relationships, for instance, between a healthcare practitioner and a specific demographic group, and by scrutinising how these relations generate varied (and often unexpected) results in different settings (Huby et al., 2007).

Ethnography is just one of a number of different approaches to conducting qualitative research now finding traction in the healthcare area (for instance, see also: phenomenology (Biggerstaff & Thompson, 2008; Cronin & Lowes, this issue) or Grounded Theory (Stoddart, 2012; Earnshaw, this issue). It is arguably misleading and an over-simplification, however, to regard ethnography as synonymous with the qualitative paradigm, or to even use these two terms as interchangeable within healthcare research (for instance, see Quimby 2006). This 'brief encounter' will, therefore, outline a number of key features of this approach, while paying particular attention to the benefits of ethnography's flexibility, before providing an overview of ethnographic studies undertaken in a variety of healthcare settings.

Philosophy & Tenets of the Approach
A researcher's methodological approach reflects, and is underpinned by, specific ontological and epistemological assumptions, whether the researcher likes/realises it or not (Williams & May, 1996). The chosen methodology logically *follows* a researcher's philosophical assumptions, not the reverse (Grix, 2002). Ethnography is best placed within a 'constructivist' paradigm (i.e. it is focused upon individual and collective *meanings*, see: Guba, 1990), although it can also be adopted by researchers with a more realist approach (i.e. those more concerned with objective *facts*).

Constructivist ethnography holds that social phenomena are dependent upon constructions and the interpretations of the social actors involved

(Grix, 2002). The researcher is required to grasp the subjective meaning of this social action (Bryman, 2008), which can be achieved through the combination of emic (view of the social actors) and etic (view of the researcher) accounts (Cresswell, 2007). The centrality of the researcher within this approach highlights the subjectivity of ethnography. The researcher's involvement can vary, however, depending on philosophical assumptions or the nature of the research setting. As Gans (1994) suggested, the researcher can be a *total participant*, where the researcher is completely involved in a certain situation, and must revert back to researcher and make notes once the situation has unfolded; a *researcher-participant*, when a researcher is only semi-involved in a situation, and can fully function as a researcher; or, a *total researcher*, which involves observation but not participation. Therefore, a researcher that accepts and values subjectivity might adopt the total participant role (Lincoln, 1990), whereas a researcher seeking a more objective approach may adopt the total researcher position, seeking to limit their involvement and possible impact upon the situation/participants (see, for instance, Quimby, 2006). This highlights a further benefit of ethnography, in that it is flexible enough to suit researchers with different philosophical commitments. For instance, it can also suit researchers from a realist paradigm that require more objectivity and seek to limit the researcher's involvement (for example, see: Porter & Ryan, 1996). In order to provide further justification for employing an ethnographic approach, the subsequent sections aim to elucidate some of the central characteristics of ethnography.

Understanding lived experiences

Ethnographic methodologies are directly concerned with understanding human experience as it is lived and felt by the participants in that experience (Schwandt, 1990). In this respect, it has strong commonalities with phenomenology (Cronin & Lowes, this issue), and ethnomethodology and conversation analysis (Miller, this issue), though its method diverges from all of them. Ethnographic research seeks to explore and appreciate the complex nature of social life, and focus on both what people say and what people might do, which is often overlooked within positivistic paradigms that use artificial settings (Emerson, Fretz, & Shaw, 2007). In order to focus research on participants' cultural practices and experiences embedded within them, Hammersley and Atkinson (2007) outlined that the researcher participates:

Overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, and/or asking questions through informal and formal interviews, collecting documents and artefacts; in fact gathering whatever data are available to throw light on the issues that are the emerging focus of inquiry. (p. 3)

These features of ethnography lend themselves well to an in-depth, qualitative study of individuals and groups within a specific (sub)culture or healthcare setting (further examples to be discussed in section 3). Not only will this enable "*thick description*"[1], but the long-term flexible nature will facilitate numerous opportunities for the researcher to gain clarification on significant or contentious issues that may arise.

Providing Contexts

In order to capture the qualities of an experience, ethnographic methodologies encompass various procedures for bounding an inquiry within a particular context, as it is only within a context that an experience has meaning (Schwandt, 1990). As Gluckman (2007) maintained, there are so many factors, contexts and considerations for any research project, that in order to realistically provide even a basic understanding of a social world or phenomenon the researcher must provide some boundaries or limits to the study. These boundaries are not only set by broad (and subjective) research questions and methodical procedures, but also subjectively by the researcher through their theoretical approach and their values, or as Guba (1990) stated, reality is seen through both a theory window and a value window.

Naturalistic Inquiry

The third significant feature is that the contexts within which the research takes place must be naturally occurring, as opposed to being contrived or fabricated, in order to explore the actual lived experiences of the participants (Schwandt 1990). Hammersley and Atkinson (2007) specified that the naturalistic approach proposed by ethnographers requires that, as far as possible, the social world should be studied in its "*natural state*", undisturbed by the researcher. This requires the researcher to remain reflexive and also to ascertain their approach as a researcher (total participant, researcher-participant, or total researcher) in advance of entering the research field, as, depending on the specific setting, their mere presence could potentially impact the 'natural state' or the participants' lived experiences. This is often a judgement call, and could

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1 Bryman (2008) described thick description as a concept used by Clifford Geertz (1973) which refers to detailed accounts of social settings that can form the basis for the creation of general statements regarding a culture and its significance in people's lives. Further, Kvale and Brinkmann (2009) viewed it as the ability to see and describe events in their value-laden contexts, and judge appropriately.

be more problematic for those researchers seeking objectivity (rather than subjectivist researchers), especially as the 'natural' research setting can be unbalanced and unpredictable. In order to allow for this unpredictability, the ethnographic approach is particularly flexible.

Flexibility

The researcher produces not a technical report in search of laws, but a type of narrative, text or case report that aims to explicate meaning (Schwandt, 1990). A set of problems may be identified before research begins, and a general framework may be followed, but it is important for the researcher and the project to remain flexible within an unpredictable 'natural' setting (Silk, 2005). A fundamental benefit of ethnography is the constant, flexible interplay between observation, interviews and theory throughout the project, as the researcher can: reflect on emerging themes and their relation to theory; conduct further interviews to explore factors identified during observations; or extend the research period to return to the field to gain further insight (Emerson, Fretz, & Shaw, 2007). Additionally, contemporary ethnography is increasingly utilising this flexibility by adding another dimension to the data collection, as the "*virtual environments*" that participants experience and engage with are being explored (Boellstorff, Nardi, Pearce, & Taylor, 2012). For instance, Copelton and Valle (2009) used a combination of fieldwork, interviews and a virtual ethnography of an online discussion board, and were able to successfully explore the processes of diagnosis for celiac disease patients. The flexibility of ethnography is evident in a range of healthcare settings, which forms the basis for the following review of studies.

Brief Review of Health Research Studies

Ethnography is a research methodology that is now employed in a broad spectrum of work, ranging from anthropology (Geertz 1973; Bourgois 2002; Venkatesh 2008), sociology and cultural studies (Hobbs 1990; Armstrong 1993; Giulianotti 1995), through to organisational studies and management theory (Neyland 2008), and, as shall be briefly discussed here, healthcare. Broadly speaking, ethnography can help to answer questions within healthcare research such as: What are the patient's perceptions and experiences of treatment, recovery, and case management? What factors affect these insights and experiences? How do organisational processes influence lived experiences? What behaviours are engaged in or avoided by patients? What are their sources of support? (Quimby 2006). More specifically, ethnographic studies have been undertaken using a range of theoretical frameworks

and in a variety of settings – a selection of which are highlighted here.

Some of the earlier ethnographic studies within health settings were underpinned by symbolic interactionism, and focused on the experience of patients. Examples include: patients being in *Asylums* (Goffman, 1961); the complex interactions involving paediatric outpatients (Strong, 1979); and the training of healthcare professionals who interact with patients (Dingwall, 1977). From the mid-1970s onwards, and due to the influence of Michel Foucault (1973), an increasing focus on the body and illness using ethnography also developed. For example, in the work by Lawler (1991), which utilised various methods in order to explore the body-work of nurses. A strength identified by Lawler was how the ethnographic study was flexible enough (in terms of taking more time and gathering data from different methods) to adapt to the challenges of sensitive issues; such as the nurses' responses to the sexuality of male patients. The flexibility of ethnography has since seen an expansive range of theoretical frameworks combined with this approach to research (an overview of which is provided in Atkinson, Coffey, Delamont, Lofland and Lofland's (2007) edited collection).

Further contemporary studies have utilised an ethnographic approach in nursing, as well as other healthcare settings. Ethnographic studies have examined: the systems of emergency nursing practices (Fry, 2012); the interaction between nurses, parents and children (Clancy, 2012); and also the complexities of trust and power relations involving nurses in residential homes (Baumbusch, 2011). The centrality of participant observation is also evident in research in settings including psychotherapy (Siddique, 2011), social workers in mental health contexts (Bransford, 2006), rehabilitation (Hackman, 2011), and also physiotherapy (Thomson, 2010).

Moreover, ethnographic projects are also being undertaken in diverse and challenging healthcare settings around the world, highlighting how flexible the ethnographic approach can be. For instance, at a micro level, Plummer et al., (2008) used ethnographic methods to gain further understanding of the beliefs and the practices involved in abortion in rural Tanzania. Similar methods have also been used to explore healthcare issues on a relatively micro level, examples being: examining the impact of HIV/AIDS on the practice of primary care nurses in Jordan (Nawafleh, Francis, and Chapman, 2012); and also in understanding the perceived health needs of women in two small, rural Ecuadorian communities (Schoenfeld & Juarbe, 2005). In contrast, Chuengsatiansup (2008) highlighted the strength of ethnographic practice at a more macro level; specifically, when accounting for the reality of the global-local boundaries when considering the epidemiological transition of avian flu in Thailand.

Conclusion

This article has briefly highlighted the benefits of ethnography, however, this approach does have a number of limitations and challenges that should be acknowledged. It has been suggested that ethnographers must do more to clarify to funding bodies and peers what their approach constitutes, that it is rigorous and what it offers (Huby et al., 2007). Furthermore, researchers adopting this approach must endeavour to work within the short timescales of some health services research (Quimby, 2006), which can be a challenge as ethnography is often very time-consuming (Smith & Caddick, 2012). Still, it is stated that "*with care, the pace can be accelerated without compromising quality*" (Huby et al., 2007, p. 194). There may also be restrictions or complications regarding the researcher's access to participants/locations, though this is dependent upon the specific healthcare setting under investigation, and would arguably be true of any research approach.

As has been outlined here, ethnography has a range of benefits for a researcher within a healthcare setting. Its flexibility is viewed as being particularly useful, as it can be suitable for researchers from differing philosophical paradigms, or who have diverse theoretical backgrounds, and/or who are located in various environments around the world. However, it is the flexibility of the actual process that is considered most valuable, as within unpredictable, natural settings the researcher can adapt to changes or challenges, while continuing the fluid interplay between participant observation, interviews and theory.

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Brief Encounters with Qualitative Methods in Health Research: Phenomenology and Interpretative Phenomenological Analysis

Colum Cronin and Jonathan Lowes

Abstract

Developed from a strong philosophical tradition, phenomenological research puts human experience at the heart of the research process. Interpretative Phenomenological Analysis, in particular, is a methodological stance that embraces the lived and subjective views of those who experience a given phenomenon. This flexible and descriptive approach provides researchers with an opportunity to depict and situate lived experience in rich contextual detail, while also accounting for the meaning-making of participants. Given the importance of patient/client voice, and a personalised view of health, phenomenological methods such as IPA can contribute extensively to health research by providing rich contextual accounts of experience which shed light on the essences of important phenomena.

Introduction

Phenomenology is a research method that:

> Emphasises inductive logic, seeks the opinions and subjective accounts and interpretations of participants, relies on qualitative data analysis and is not so much concerned with generalisations to larger populations but with contextual description and analysis. (Gray, 2009, p. 28)

Gray's definition of phenomenology is a clear and helpful starting point in this discussion, but the above characterisation of phenomenology could also be applied to other interpretivist qualitative approaches such as ethnography (see Benkwitz, this issue), symbolic interactionism, and to an extent, Grounded Theory (see Earnshaw, this issue). Thus, for those unfamiliar with phenomenological work it may be difficult to identify and articulate what makes phenomenological research distinct, useful or indeed even phenomenological. Accordingly this paper aspires to provide practitioners with:

1. A brief introductory account of the development of phenomenological philosophy;
2. A description of the Interpretative Phenomenological Analysis (henceforth IPA) method that is prevalent in health research;
3. A short consideration of the contribution that IPA can make to the work of health research.

Mindful of the challenging language often associated with phenomenology, this article will further endeavour to introduce and streamline key concepts and practice. The approach taken herein may aid practitioners' initial appreciation of phenomenological methodology, but cannot, within the strictures of the article, fully capture the intricacies, debates, or controversies of this vast area. Consequently, readers are directed to key texts throughout.

Philosophical underpinnings of Phenomenology

Born out of the philosophical work of Edmund Husserl in the late 19th and early 20th centuries, phenomenology was, and continues to be, considered a human-orientated (social) science. Husserl sought to recognise and embrace individual lived experience as a means to reach a better understanding of phenomena (Cerbone, 2006). Specifically, Husserl (1900/1973) argued that understanding a phenomenon is achieved through rich description and deep reflection upon subjective experience. Husserl's emphasis on lived experience, and focus on the human within the scientific process, was in response to perceived limitations with the dominant positivist approach of psychology of the time (Moran, 2000). In particular, Husserl was frustrated by the common scientific practice of attempting to objectively study isolated psychological phenomenon by removing subjective experiences and views from the research process itself. Husserl argued that such a research approach produced cause and effect models that are divorced from lived experience, and do not explain

or describe the essential and universal elements of phenomena (Husserl, 1900/1973; Husserl, 1913/1982).

It is important to recognise that despite the emphasis on subjective experience described above, phenomenology is certainly interested in managing personal bias and presuppositions. Indeed, one of Husserl's foremost contributions was to encourage the 'bracketing' (identification and temporal removing) of preconceived ideas through intense questioning and introspections of one's own prior experience (Cerbone, 2006). Husserl explicitly advocated bracketing as it encourages researchers to have an *intentional* focus on the phenomena. Specifically, Husserl suggested that philosophers and social scientists might be able to direct their attention (consciousness) not at the cause or effect of a phenomenon, but at describing the universal essence (structure) of the phenomenon itself. Moreover, Husserl suggested that, following the bracketing process, researchers should engage in imaginative variation which involves considering the phenomenon with and without structural elements. By this, Husserl emphasised focusing on the innate properties of the issue at hand to identify what is truly essential to the phenomenon. For example, in a study of nursing, what are the essential properties that embody the business of nursing as opposed to other acts by other medical professionals? Using the example of nursing, a simplified imaginative variation of the process might involve considering whether caring is *actually* essential to the act of nursing. And if so, in what way?

Husserl also argued for the consideration and examination of essential properties across subjects and episodes i.e. inter-subjectivity (also a key theme in Conversation Analysis, see Miller, this issue). In the nursing example we are utilising, researchers should consider if 'caring' is common to all episodes of nursing. Such questions, and the processes of imaginative variation and inter-subjectivity that they represent, may lead researchers through descriptive accounts of nursing to the essential universal structures of nursing as a phenomenon i.e. a return to the thing itself. Thus, the emphasis in Husserlian phenomenology is upon universal structures rather than the mechanical cause, consequence or description of a single or specific episode of a phenomenon.

While contemporary phenomenology, thus, builds fundamentally on the work of Husserl, authors such as Heidegger (1927/2005), Sartre (1943/1984), and Merleau-Ponty (1962/2002) have made seminal contributions to the philosophical underpinning of the discipline. In general, these authors have emphasised a more existential and interpretative approach. Exploration of these bodies of work is beyond the scope of this paper, but interested readers are directed to Spiegelberg (1982) for further discussion, or Dowling (2007) for an article specific to health

research. Similarly, Mackey (2005) provides a clear yet critical account of how nursing research has moved on from Husserlian phenomenology and has embraced the work of Heidegger.

In contrast with a pure Husserlian approach, Heidegger's interpretative phenomenological method focuses less on universal structures and more on the nature of 'being'. Drawing on the nursing example above, an interpretative study of this order would seek not to answer what is the essential structure of nursing but may ask what it means to be a nurse. Heidegger (1927/2005) proposed that we need to answer more ontologically-ordered questions such as these. Therefore an interpretative phenomenological study should interpret, clarify, and reflect upon experiences within core context. Heidegger referred to the context in which phenomena are experienced as the 'lifeworld' (also an important concept in Narrative Analysis, see Rowe, this issue). Mackey (2005) also calls on researchers engaged in interpretative phenomenological studies to not only position a subject's experience within their lifeworld, but to ensure the researchers' role as interpreters within the study is also considered. This emphasis on the role of the researcher as a *research instrument* is in stark contrast to Husserlian phenomenology that sought to bracket the researcher's preconceptions, and once again illustrates the ongoing development of phenomenological philosophy.

Phenomenological philosophy has been a work-in-progress for over a century, and has inspired a range of procedures for doing phenomenological research (Giorgi, 1975; Colazzi 1973, 1978; Van Manen, 1990). The focus of the remainder of this paper is upon one of the most applied variants of the tradition, and the one most prevalent in contemporary health research: IPA (Smith & Osborn, 2008), which *"...has proven to be particularly suitable"* for health-focused investigation (Brocki & Wearden, 2006, p. 101). Accordingly, the following sections will describe the key features of IPA which, of course, builds upon the previously discussed work of both Husserl and Heidegger.

Interpretative Phenomenological Analysis
The principal objective of IPA is to explore how participants are making sense of their personal and social world. The approach is phenomenological in that it involves a detailed examination of personal, lived experience of a phenomenon. Rather than attempting to produce an objective statement on the nature of the phenomenon however, IPA prioritises the participant's personal experience and personal perception of an object or event (Flowers, Hart & Marriott, 1999). As suggested above, researchers in the healthcare sciences have used IPA to explore a range of phenomena for some time. For example, in a review of the impact of the method in health

psychology, Brocki and Wearden (2006) identified 52 articles using IPA, exploring a diverse range of areas and conditions including self-injury, dementia, dermatological issues, chlamydia, anorexia, sexual health, spirituality and bereavement and addiction.

For those unfamiliar with IPA, Smith and Osborn (2008) provide a comprehensive description of its underpinning theoretical foundations and produce illustrative examples of each stage of the method. Based upon their experiences, the authors (ibid) urge researchers to engage with the methods flexibly, so that it is adapted to the preferred techniques and topic under investigation. In this respect, IPA purports that research is a dynamic and iterative process within which the researcher performs an active role. Indeed, IPA's commitment to a detailed but flexible exploration of the meaning participants are making of their own social and personal world renders it particularly pertinent for sensitive, complex, or novel research questions. Conversely, while the researcher is trying to access the personal world and experience of the participant, it is arguable if this can ever be directly or completely achieved. In addition, the challenge is further complicated by the researcher's own conceptions that are required to make sense of that other personal world. Thus a dualistic interpretative process, or double-hermeneutic, takes place in IPA. Herein, the participant is trying to make sense of their world, and the researcher is trying to make sense of the participant trying to make sense of their world. Thus, the flexible and active role of the researcher brings both potential benefits and challenges to IPA studies.

Methodological Procedures (Sampling, Bracketing, Interviewing and Writing)

IPA is typically an idiographic mode of inquiry comprising a small sample size. The small sample size encourages meticulous analysis of data to elucidate the perceptions and thoughts of participants' experiences of a specific phenomenon. Thus, IPA typically avoids attempts to make more generalised claims more consistent with a nomothetic approach. Purposive, homogenous sampling is therefore utilised and this differentiates IPA from other qualitative methodologies such as grounded theory, as the sample is selected to illuminate a particular question and develop a comprehensive and insightful interpretation of the data. Grounded theory (in its classical sense) uses theoretical sampling to continue collecting data until saturation is reached (see Earnshaw, this issue). Smith, Jarman, and Osborn, (1999) consider this a problematic concept, as the next interview always carries the potential to provide unique data. IPA researchers are therefore urged to

acknowledge the representational limits of their data. Once these objectives have been reached, analysis can be considered complete but must, of course, be in keeping with IPA procedures.

Reflecting the pure phenomenological roots of the approach, and considering the active role of the researcher, Brocki and Wearden (2006) cite several authors who explicitly describe undertaking a conscious process of 'bracketing' to manage pre-existing assumptions when conducting IPA studies. This divergence between 'removing' and 'embracing' the role of the author reflects the flexibility of IPA in attempting to be both interpretative and phenomenological. This flexibility is, in most accounts, both the strength and weakness of IPA. Indeed, Wagstaff, et al. (2014) argues that the interpretative role of the researcher in IPA is at odds with classical phenomenology, and can taint studies through bias. Similarly, Giorgi (2010, 2011) argues that the flexible and interpretative element of IPA is incongruent with Husserlian pure phenomenology as a rigorous science. Therefore, Giorgi views IPA as more 'phenomenologically-inspired' than phenomenology *per se.* In response, Smith (2010) argues that flexibility in IPA is a key tenet and strength, as it allows researchers to use their own experience-based interpretation to add value and clarity. He urges researchers not to attempt to remove their interpretations from studies, but to embrace their preconceptions through transparent, managed, and rigorous methods, e.g. reflexive accounts (Smith & Osborn, 2011). Such an approach should enable readers to *"make links between the findings of an IPA study, their own personal and professional experience, and claims within extant literature"* (Smith & Osborn, 2011, p. 56). Acknowledging this methodological debate, Brocki and Wearden (2006) argue that if studies are methodologically rigorous, transparent and explicit about philosophical underpinnings, then IPA studies have much value to add to health research. The process of conducting and analysing in depth interviews is however, key to this rigour.

Smith and Osborn (2008) promulgate the use of semi-structured interviews as the exemplary method of collecting data due to its flexibility and potential to produce rich, affective perceptions[1]. They further recommend techniques used in the course of their own research and discuss how themes are established, connected, and clustered as superordinate concepts. These themes can then be used as the framework for analysis of the next participant's data. Convergent and divergent themes can then be identified and analysed across participants. Jarman, Smith, and Walsh (1997) contend that such themes should be represented

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1 Readers are signposted to Smith and Osborn (2008) for an illustrative account of how to conduct analysis of such interviews.

clearly in the transcripts and should be selected for articulacy and immediacy, and not just because of prevalence.

To aid trustworthiness in IPA studies, extracts of participants' views may be selected to explicate the most accurate expression of a theme (Flowers et al 1999; 2000a; 2000b; 2001). Osborn and Smith's (1998) IPA of chronic lower back pain is one example that uses extracts to demonstrates issues which involve an analysis beyond description of any single episodic account, yet are simultaneously grounded in participants' experiences. For instance, Osborn and Smith (ibid) illustrate the theme "*comparing this self with other selves" through the following extract:*

> *Well my personality's gone, I used to be right bubbly and lively and you know, but it's, that's gone, and even my mum says that I've changed, she never really says in what way, she says I've got more snappy and more nasty. You want the old Alice back but you can't.*

The above quote has transparently phenomenological implications. Is it is rooted in an idiographic personal experience as lived by the participant and, in addition, the authors also provide the following extract which illustrates meaning-making of the participant but also (as evident in the *italicised* and **bold** sections which were inscribed by the authors) clearly depicts a double hermeneutic i.e. the authors' interpretation of the participant's experience.

> *You feel like, just not particularly giving up, but* you don't feel the person that you are **[author's emphasis]** *that you're capable of feeling or capable of doing basically. It makes you feel a bit down and a bit miserable (Dottie).*

Thus the theme, "*comparing this self with other selves"* adds insightful phenomenological analysis of lower back pain, while the descriptive illustrative extracts situate the experience in the lifeworld of those who live and experience lower back pain. Such information may support practitioners as they encounter sufferers of this condition.

Conclusion
As illustrated above, a robust IPA holds much potential for health research. In particular, the emphasis on subjective lived experience will resonate with many practitioners who seek to provide patient-centred and patient-focused care. IPA can make an important contribution by describing patient experiences. This is important for practitioners as patient voice is at the heart of key health documents including the NHS constitution (2013), and the Keogh Report (2013). As a flexible and potentially rigorous method, IPA can also draw upon the expertise of researchers, to ensure that participants' experiences are contextually situated and insightful analysis is derived. Such insights have the potential to inform

and add value to the work, understanding, and empathy of health practitioners as they encounter patients who have unique and personal experiences.

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Brief encounters with qualitative methods in health research: Grounded theory

Thomas Earnshaw

Abstract

Given that research evidence is having an increasing influence on health professionals' understanding of human health and policy and practice within an ever-changing interdisciplinary healthcare environment, it would prove useful for practitioners to possess an understanding of the theoretical perspectives and methodological approaches underpinning contemporary health research. One such approach is grounded theory, a means of inductively generating explanatory theories of social processes and phenomena in specific contexts.

Introduction

"A grounded theory is one that is inductively derived from the study of the phenomena it represents" (Strauss & Corbin, 1990, p. 23). This explanation of the research outcome provides a useful starting point, but in order to fully appreciate the approach, an understanding of its methodological principles and procedures are also needed. The methodology, or 'paradigm of enquiry', is influenced by a set of philosophical principles (Backman & Kyngäs, 1999); a worldview to inform research design and decision making during the research process (Birks & Mills, 2011; Gliner, Morgan & Leech, 2009). In grounded theory specifically, it determines the study's focus when exploring and developing theoretical concepts during the analytical process (Birks & Mills, 2011). The methodological approach selected should reflect the researcher's own ontological and epistemological standpoints, that is, their understanding of reality and how best to obtain truth about it (Hallberg, 2006).

Existing within the methodology, grounded theory methods are actions designed to construct theory from examples illustrated in empirical observations (Green & Thorogood, 2014). In this sense, the theory is 'grounded' in the data. In the seminal works of Glaser and Strauss (1965; 1967), the approach sought to discover social and social psychological processes, with the substantive theory generated serving to accurately interpret, explain and predict these processes.

Grounded theory is suited to studying phenomena in a given context (Bradley, Curry & Devers, 2007; Goulding, 1998), for example, a particular hospital ward. It is often used to generate new theory to explain connections between issues and human behaviour e.g., carer-patient relationship dynamics. This can mistakenly pertain exclusively to newly emerging topics about which there is little known. The approach can also be used to provide fresh perspectives on well-established issues, contribute additional concepts to pre-existing grounded theories, and make connections between variables previously considered unrelated (Backman & Kyngäs, 1999; Batson & Chesnay, 2015: Corbin & Strauss, 1990).

Data collection typically involves participant observations, interviews, diaries or other transcribed accounts (Backman & Kyngäs, 1999). Glaser and Strauss (1967) or applied in-depth interviews (Bradley et al., 2007), but grounded theory literature has since advocated using a combination of these strategies so as to compare reported behaviour and that observed (Backman & Kyngäs, 1999).

Grounded theory methods involve using a set of systematic analytical procedures (Strauss & Corbin, 1994). These procedures are part of a cyclical process whereby traditionally separate stages of participant selection, data collection, data analysis and theory development are interdependent, iterative and often overlapping (Charmaz, 2006). The research process is data-driven. Findings from analysis and coding of initial data form abstract concepts and theoretical ideas, informing the next participant sample and lines of enquiry. This process is recurrent so as to further focus the topic of study, develop increasingly sophisticated concepts, and 'test' any emergent hypotheses i.e., statements of concept relationships (Strauss & Corbin, 1994). The research process ends with 'saturation'; whereby no additional data can

further develop the theory's core categories (high-level abstract concepts) in terms of their properties and dimensions, with links established between relevant concepts (Goulding, 1998).

Grounded theory is the most commonly employed qualitative research method (Bryant & Charmaz, 2007), yet can be overlooked within health research in favour of other interpretivist approaches such as phenomenology (see Cronin & Lowes, this issue) and ethnography (see Benkwitz, this issue). While phenomenology and ethnography are somewhat limited to identifying themes and categories relevant to contextual behaviour, grounded theory intends to produce theory. While there is no definitive approach to inquiry, there are data analysis methods more appropriate in healthcare studies (Bradley, Curry & Devers, 2007). This 'brief encounter' seeks to inform health practitioners of grounded theory's applicability in health research. The article introduces some of the key canons and philosophical principles of grounded theory, with a brief account of health studies that have applied the approach and consideration of potential challenges facing researchers.

Philosophy & Tenets of the Approach
Classical grounded theory provides a general methodology for both qualitative and quantitative data (Glaser, 1967). Positivistic objectivity produced codified qualitative analytic methods (Artinian, Giske & Cone, 2009). A lack of methodological explication, due to a concern that it would limit grounded theory's usefulness (Birks & Mills, 2011; Glaser & Strauss, 1968), later afforded diversity in its development and the type of research it may appeal to (Bryant & Charmaz, 2007).

The philosophical principles underpinning grounded theory methodology have since been tied to symbolic interactionism, stemming from pragmatism (Corbin & Strauss, 2008; Heath & Cowley, 2004). Pragmatism identifies inductive and abductive reasoning as means of establishing truth. Unlike the traditional quantitative paradigm of inquiry that advocates deductive inferences to form hypotheses and then seeks data to confirm it, grounded theory appropriates inductive reasoning to generate theory explaining data, with the data being central to that theory. Induction is personified in the formation of new theory that irrefutably 'fits' the data and its context. Abduction is used to make inferences about data based on theory deriving from other data. Here, inductive and deductive reasoning are combined as data serves to generate hypotheses, which then inform subsequent inquiry and are checked against new data sets, and verified or reformulated accordingly.

Symbolic interactionism views people as self-aware sentient beings capable of altering their behaviour depending on their situation in relation to others (Charmaz, 1990; Heath & Cowley, 2004; Mead, 1934). The interactionist approach to inquiry focuses on how concepts gain significance through their prevalence and patterned relationships (Blumer, 1956; Heath & Cowley, 2004). Personifying interactionism, grounded theory repeatedly compares data sets so as to develop significant concepts within them and suggest relationships between them (Hammersley, 1989; Health & Cowley, 2004). Grounded theory seeks to explore the meanings people attach to phenomena and operates under the symbolic interactionist assumption that participants must be aware of these meanings and able to communicate them to the researcher (Backman & Kyngäs, 1999). A grounded theory researcher is required to take into account their influence on the participant and vice versa; significant in many studies using health professionals, given the often intimate practitioner-client relationship.

Charmaz's (1990; 2006) constructivist grounded theory approach would appear most appropriate for research in many healthcare settings. Belonging to the interpretative tradition, it sits between positivism and postmodernism (Hallberg, 2006), adopting epistemological subjectivism and ontological relativism (Bryant & Charmaz, 2007; Gardner, McCutcheon & Fedoruk, 2012). Subjectivism rejects the idea that researchers can be completely objective. The researcher-participant relationship is embraced to co-construct theory, offering more flexible strategies for data analysis and allowing for abstract interpretations of data (Creswell, 2008). Accordingly, research is interactive, cooperative and participative. Social constructions of language, consciousness and shared meaning provide instruments for establishing understanding of phenomena and the meanings people attach to them (Gardner, McCutcheon & Fedoruk, 2012). Relativism purports that there is no one true reality, how people make sense of their world is constructed through interaction and shared understanding, so the participant's perspective of truth is confined to their given context. This methodology proves useful for explaining issues and phenomena within specific healthcare settings, but can limit its applicability outside of a given time, locality, or culture (Gardner, McCutcheon & Fedoruk, 2012), making generalisability problematic (Rennie, Phillips & Quartaro, 1988).

A grounded theory is considered the result of interpretation and therefore should be considered an understanding rather than an explanation or prediction of phenomena (Charmaz, 2006). This understanding can enhance practitioners' discursive practices to better address problems expressed by patients, offering perspectives of patients' attitudes and behaviours not obtainable within the clinic environment (Charmaz, 1990). Constructivist grounded theory provides a practical methodological

framework for the health professional-come-researcher interested in studying their patients as, rather than distance the participant from the researcher and analysis process, their perspective is utilised to generate theory. This allows care provision and research to occur simultaneously (Gardner, McCutcheon & Fedoruk, 2012). However, as data analyses are social constructions involving both the researcher and participant, the research outcome can be seen as narrative identifying relationships between conceptual categories, rather than a hypothesis (Hallberg, 2006). Within health research, these descriptive accounts are often then evolved into theories through subsequent research (Batson & Chesnay, 2015).

Constant Comparison

A key feature of the analytic process is constant comparison; a general method of comparative analysis to develop theoretical elaboration (Glaser & Strauss, 1968). It describes the regular interplay between correspondingly coded data and emergent theory (Green & Thorogood, 2014). Grounded theory uses four iterative phases of constant comparison (Glaser, 1965): relating and grouping incidents to form categories; discovering relationships between categories; establishing parameters for categories and their relationships; and forming theory. Comparative analysis has commonly been misused as a means of disproving a peer's theory by identifying negative cases contradicting the 'fact' upon which it is based (Glaser & Strauss, 1968). However, grounded theory applies this process to create new concepts and categories aiding further development of a peer's theoretical understanding. The constant comparative method had previously been limited in application to large scale social units such as organisations, institutions, nations or global regions (Glaser, 1965), but grounded theory has since allowed for comparison making between individuals (and their roles) and small organisational units (Glaser & Strauss, 1968), such as GPs in local surgeries.

Theoretical Sensitivity

Theoretical sensitivity, a researcher attribute rather than a methodological procedure, describes the intuitive capacity to apply meaning to data and distinguish its relevance to the topic studied (Bitsch, 2005; Strauss & Corbin, 1990). It can be obtained through professional and personal experience, or during the analytic process, whereby the researcher immerses themselves in the raw data to access a participant's meanings of lived experience. It may also be developed by reviewing literature, but in subject areas other than that directly under study or after the researcher has fully developed the emergent theory and left the field. Here, literature reviewing is

not neglected, just delayed; serving to position the emergent theory in relation to existing knowledge (Walker & Myrick, 2006). Exercising theoretical sensitivity streamlines the research process by focusing on the most pertinent emerging concepts and themes to be subjected to further exploration and testing.

Theoretical Sampling

Theoretical sampling is an iterative data collection procedure intended to aid the development of theory (Backman & Kyngäs, 1999; Green & Thorogood, 2014). Once initial data is analysed, the researcher gains general ideas to formulate primitive theories which they wish to explore in greater depth. It is flexible in selecting the next line of participants that will best 'shine light' on emerging themes and issues (Backman & Kyngäs, 1999). Exploration of previously unknown but pertinent issues is encouraged, even demanded (Walker & Myrick, 2006). It focuses questioning and discourages the gathering of extensive general information; ensuring rich data is obtained and time is not wasted analysing irrelevant data. Theoretical sampling enables deeper dimensional construction of a concept as it can be examined across a range of settings (Breckenridge & Jones, 2009).

While classical grounded theory deemed theoretical sampling appropriate (Glaser, 1978), many studies since have adopted purposive sampling. A purposive participant sample is selected from the outset based on a common denominator relevant to the studied phenomenon, typically some shared experience or knowledge that may help answer predetermined questions (Sandelowski, 1995). Whereas theoretical sampling cannot know the selection criteria until initial data is analysed and what is relevant emerges (Breckenridge & Jones, 2009; Glaser, 1978). So, theoretical sampling is purposeful, but not all purposive sampling is theoretical (Hood, 2007). Ideally, a grounded theory study uses purposive sampling to identify the initial participant sample, and theoretical sampling from then on (Birks & Mills, 2011).

Trustworthiness

The strength of any grounded theory is based on establishing trustworthiness (Shenton, 2004). Claims of credibility, a qualitative research alternative to internal validity, are made through the 'close' explanation of phenomena it provides (Lincoln & Guba, 1985). As the theory is derived directly from empirical data, evidence of its existence is well illustrated, making it irrefutably tied to experimental data.

Focusing on generating statements about participants using solely their accounts creates ecological validity by providing great context specificity and ensuring the theory works in that setting i.e., it

predicts, explains, or describes what is happening in the field studied (Glaser & Strauss, 1968; Strauss & Corbin, 1990). Novelty, or originality of findings, is created through building theory from the ground up (Birks & Mills, 2011). Direct literature reviewing is discouraged so that preconceived ideas do not influence the formation of concepts within the emergent theory or hypotheses, allowing for genuine discovery (Charmaz, 1990). Such methods reduce the opportunity of simply adopting an existing theory or 'force-fit' their findings to a desirable theory; a criticism of deductive methods. Parsimony is achieved via the systematic, repetitive process of data reduction and formation of abstract concepts to produce a 'lean' explanation of the connected constructs describing the phenomenon under study in the simplest, most elegant manner (Morse & Field, 2002).

Brief Review of Health Research Studies

Grounded theory research has been applied across a range of disciplines, including fields of healthcare, such as intervention, service management, professional practice and training, and patient diagnosis and treatment. It has been employed to explore patients' perceptions and experiences of their condition, diagnosis, treatment and recovery (Batson & Chesnay, 2015; Fenwick, Chaboyer & St. John, 2013; Khair et al., 2013), the sources of these perceptions and patients' desired and avoided behaviours (Fenwick, Chaboyer & St. John, 2013; Perrett & Biley, 2013), and their interaction and relationships with health care providers, family, and friends (Stoddart, 2012). The following is a brief note of some such studies.

In the original grounded theory study (Glaser & Strauss, 1965), a theory was generated to explain the social psychological processes involved in the relationship dynamics between patients aware that they were dying, and their relatives and carers. Similarly, due to insufficient existing data, the approach produced a description of the participative role elderly tumour patients' companions played during interactions with healthcare providers (Ellingson, 2002). Charmaz (1987) applied her constructivist grounded theory approach to address themes of self-esteem, continuity and change of 'self' concept. Data collection and analysis led to further exploration of emotions and the self, and information-control regarding self and illness. Cooney (2012) developed a grounded theory to identify how elderly people establish a sense of 'home' while in long-term care settings. The methodology has formed theory to explain 'the journey of chronic pain' experienced by elderly people with leg ulcerations (Taverner, Closs & Briggs, 2012).

Atkinson and Peden-McAlpine (2013) formed the 'advancing adolescent maternal development' theory in which social psychological issues identify at-risk

mothers to poor post-pregnancy outcomes. Price and Mitchell (2004) investigated teenage women's experiences of the maternity services, allowing participants to form their own ideas of what care they should receive. Hernández-Plaza, Padilla, Ortiz & Rodrigues (2014) examined the influence of severe socio-economic inequalities on migrant women's maternal needs as users of primary healthcare. They were able to focus on numerous context-specific social and psychological processes, with participants' voices being central to the development of emergent concepts and themes. Sandelowski (1995) conducted three studies, one using grounded theory, synthesising different theoretical approaches to ascertain the transitional processes involved in infertile couples becoming parents.

Grounded theory methodology is common within mental health research given the focused concern of psychosocial processes (Batson & Chesnay, 2015). McCann and Clarke (2003) explored the role of nurses in motivating young adult patients with schizophrenia to seek early access community services to avoid increased severity of illness. It also allowed Puolakka, Haapasola-Pesu, Kiikkala, Astedt-Kurki & Paavilainen (2013) to identify pertinent mental health issues of schoolchildren and devise appropriate interventions. Andersson, Eriksson & Nordgren (2013) compared care provision in different settings for patients recovering from heart failure. They identified themes of patients' needs while moving between primary care and specialised clinic settings. In Stone's (2013) study of general practitioners' accounts of patients with unexplained symptoms, constructivist grounded theory methodology produced concepts and frameworks for strategies for assessment. Studies have used grounded theory for management evaluations of healthcare provision. For example, Leach and Mayo (2013) assessed the operations of a hospital's emergency response team, leading to restructuring of communication systems.

It is commonly assumed claims made by grounded theories are limited to their particular sample and setting. However, Cranley, Doran, Tourangeau, Kushniruk & Nagle (2012) examined staff nurses' everyday experiences of work-related uncertainties, addressing global nursing issues. The resulting substantive theory of 'recognising and responding to uncertainty' had wider clinical, educational, administrative and research relevance (Batson & Chesnay, 2015).

Conclusion

Like all research methodologies, grounded theory is not without weaknesses and limitations. However, due to the appeal of its core principles, much research methods literature devoted to solving issues inherent with the general approach is available, providing the

novice with guidance and affording them confidence to conduct systematic, independent research. Grounded theory's value is evident in the diverse adaptation it has undergone to ensure its applicability in a wide range of research fields. It has experienced greater popularity and development within the qualitative domain, particularly in health topics such as clinician and nursing practice, intervention, and patient perspective. Constructivist methodology would appear most suited to these research areas. As well as affording the participant a sense of empowerment in addressing the issues they experience, the research gains close access to the participant's perception of lived experience through intimate interaction.

As health issues are becoming increasingly social, grounded theory offers a viable means of understanding human behaviour and meanings of lived experience so as to address problems of human health and healthcare services.

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Brief encounters with qualitative methods in health research: Conversation analysis

Paul K. Miller

Abstract
This paper provides a brief introductory outline of the conversation analytic method, and some of its applications in health research. Drawing on extant literature and an illustrative original case study of suicide risk-assessment in primary care, the core tenets and techniques of the approach are described.

Introduction

Conversation analysis (henceforth CA) is, in the grand scheme of things, a relatively recent development in the systematic investigation of the social world, pioneered as a coherent set of analytic principles chiefly by Harvey Sacks in a pathbreaking series of lectures in the 1960s and early 1970s[1]. These lectures outlined an original field of study that was, certainly initially, concerned almost exclusively with the organised properties of 'ordinary' everyday conversation which, crucially, Sacks considered to be the form of talk from which all other forms either derive or deviate (Sacks, Schegloff & Jefferson, 1974). It is the first kind of talk that everyone learns to 'do', and it is done largely *ad-hoc*. Sacks' project was, then, grounded in an empirical study of huge bodies of such naturally occurring talk, with a view to elucidating the systematic properties of what was 'going on' between speakers. In his own words (Sacks, 1984):

> The idea is to take singular sequences of conversation and tear them apart in such a way as to find rules, techniques, procedures and maxims… that can be used to generate the orderly features we find in the conversations we examine…

He continues:

> So what we are dealing with is the technology of conversation. We are trying to find this technology out of actual fragments of conversation, so that we can impose as a constraint that the technology actually deals with singular events and singular sequences of events – a reasonably strong constraint on some sets of rules (p.414-415).

This paper provides a very brief introductory outline of the conversation analytic method, and some of its applications in health research. Drawing on extant literature and an illustrative original case-study of suicide risk-assessment in primary care, the core tenets and techniques of the approach are described.

Key tenets of the method

The core focus of all studies in CA is upon the way that interaction unfolds turn-by-turn. It focuses upon how speakers use what others have said previously during an interaction as a *resource* when forming their own utterances, and how these utterances themselves inform the range of possible future turns. Simply put, within an interaction, what we say is influenced by how we have interpreted what others have said, and what others subsequently say is then grounded in how they have interpreted us. Levinson (1983) explains this 'proof procedure' principle thusly:

> Conversation, as opposed to monologue, offers the analyst an invaluable analytical resource: as each turn is responded to by a second, we find displayed in that second an analysis of the first by its recipient. Such an analysis is thus provided by participants not only for each other but for analysts too (p.321).

From this point of view (and this is the principle that gives CA its analytic distinctiveness), it is not the task of the researcher to impute layers of significance to the words of the people we study, or to fit them into *a priori* analytic categories. Rather, the job here is to track, describe and elucidate how people make sense to each other in the to-and-fro of interaction. In doing so, we can explain, for example, how apparently

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1 His collaborators Gail Jefferson and Emmanuel Schegloff were instrumental in popularising these lectures. They also made their own contributions to the field both before and after Sacks' premature death in 1975.

highly sensitive topics can be successfully raised and discussed without offence being caused; how major breakdowns of understanding can occur when they theoretically should not (or vice-versa); how one individual can 'guide' another into giving particular kinds of answers; or how phenomena such as 'authority' or 'respectfulness' are produced in face-to-face scenarios. More importantly, perhaps, and as Grimwood and Miller (2014) illustrate, its focus upon how interaction actually (rather than ideally) unfolds allows us to observe how even such apparent 'nothings' as silences operate in interaction. Compare, for example, two different ways (below) of *representing* a GP delivering a diagnosis of depression in primary care[2]. Firstly, we might consider what was ultimately *said*, as is typically done in qualitative health research:

Extract 1
Doctor: Yes, well [Patient's name], it strikes me that you have depression. Not severe, but it's just as well you came in. I know there are some misperceptions about depression, it's not an uncommon illness though and we can sort out treatment now. And in a minor case like this, there should be no problem. It's not a big deal at all.

Herein, we treat the GP's talk as, ostensibly, a monologue. If, however, we consider, the way the interaction unfolded, turn-by-turn[3], with the inherent silences mapped in seconds (and parts thereof)[4]:

Extract 2
1. D: ye:s (.5) well [Patient's Name] it strikes me that you (.) have depression (.) not severe but it's just as well you came in
2. P: (1.0)
3. D: I know there are some (.) misperceptions about depression
4. P: (.5)
5. D: it's not an uncommon illness though (.) and we can sort out treatment now
6. P: (1.5)
7. D: and in a minor case like this (.) there should be no problem
8. P: (1.0)
9. D: it's not a big deal at all

Note how in the first transcript, the talk comes off as totally unproblematic. In the second, however, we get a

sense of a rather more difficult interaction. The silence of a single second after the diagnosis (in Turn 2) is demonstrably interpreted by the GP (a) as the *patient's* silence and (b) as a noticeable absence of agreement, because he begins to work on 'downgrading' the hearable import of that diagnosis. In short, his post-hoc activity indicates that *he has taken that silence as indicative of a negative reaction* (either as a result of his general experience with diagnosing depression, or anticipation of this particular patient's likely reaction). Had he not, he would likely have moved the consultation on to a discussion of treatment options as is typically done at this stage (Frankel, 1984). With each silence thereafter, however, he moves to explain ever more explicitly how depression is not a 'problem' diagnosis and, thus, to placate or reassure the patient, even though no active objection has been made. In short, the GP uses the *absence* of replies as a resource through which to infer ongoing negativity from the patient regarding the diagnosis he has made. This enables us to interpret the GP's practical reasoning regarding what is actually 'causing' this silence. If he had inferred that the silence was a result of the patient having not heard, or not understood, the diagnosis, then his verbal activity here would likely have been very different. The fact that he works to underscore just how 'everyday' and 'real' the condition is indicates that he has taken the silence to be indicative of *resistance*.

CA and medical interaction
Arguably the most practical and user-friendly guide to the actual doing of CA remains *Conversation Analysis* by Ian Hutchby and Robin Wooffitt, (2008), now in its second edition[5]. To date, the method also has produced a rich body of work in the study of interaction in the medical and broader healthcare fields. Instructive, book-length accounts therein include David Silverman's (1997) remarkable investigation of the interpersonal dynamics of HIV counselling, and Christian Heath's (1986) classic study of body movement and talk in medical interaction. Antaki and colleagues (2007; 2007; 2008), meanwhile, have produced a rich body of work exploring talk in the psychotherapeutic domain, while activity in Primary Care has been a major concern for other conversation analysts (Heritage & Robinson, 2006; Maynard, 1992; Maynard, 1997; Peräkylä, 1998)[6].

For those familiar with social scientific studies of medical interaction, it is important to emphasise that work in CA often provides a very different picture of

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2 Full ethical clearance for the research was received from the pertinent NHS committee.
3 Note that, herein, D=Doctor and P=Patient.
4 (.) indicates a micropause of less than half a second.
5 There are several other excellent introductory texts on the method available, for example Ten Have (2007), while David Silverman (1998) provides an insightful overview of Harvey Sacks' broader programme ofinvestigation.
6 An excellent starter volume for those interested in CA's general approach to medical interaction is Heritage and Maynard's (2006) edited collection of papers on the topic.

medical discourse to that evident in more 'critical' accounts (see, for example, Wodak, 1996). The latter often seek to expose power relations in talk between healthcare professionals and their clients, often (necessarily) beginning from the proposition that GPs, psychiatrists and so forth effectively 'subjugate' their patients with complex jargon and institutional totems. In CA, however, specific interactions are monitored *as they unfold* without such presumption. This facilitates intricate tracking of how conflicts occur when they occur, for sure, but also how apparently tricky topics can be discussed without hiccup, or how resolutions and compromises are found by speakers working together (in this respect, see also Rowe, this issue). As an example, section 4 briefly outlines some findings first reported in Miller's (2013) study of suicide risk assessment in primary care, with a view to illustrating the dynamics of the conversation analytic method in terms of its applicability to a practical interactional issue in that domain.

Case study: Suicide-risk assessment in primary care

Depression and suicidal ideation are, in the vast majority of medical texts, taken to be universally stigmatised phenomena, and therefore inherently difficult things to discuss. As such, clinical dictats, such as those in Tylee, Priest & Roberts' (1996) often-cited guidebook, provide a normatively oriented set of recommendations for conduct in the primary care consultation when addressing these difficult matters. On the surface, the general recommendations are highly logical: Using 'open' questions; asking about feelings; not hurrying the consultation; employing a friendly and empathic style; asking for clarification of verbal cues; asking direct questions about depression and never interrupting a patient. Tylee, Priest & Roberts (1996) do acknowledge that 'unquantifiable' factors such as culture, use of language, social skills and so forth play roles in the consultation. These matters are not really addressed in the guidelines, however, which are instead based upon common-sense 'universals' for what is understood to be good clinical practice (Silverman, 1997).

Exploring specific primary care consultations in which the topic of suicidal ideation is raised, however, Miller (2013) highlights how GPs often use tacit *social* skills – which can superficially look very much like 'poor practice' in the light of the guidelines outlined above – to highly constructive, context-sensitive ends. Consider, for example, extract 3[7].

Extract 3

1.   D: Are you finding the symptoms disruptive (.) um (.) in your routine?

2.   (.5)
3.   P: Yes (.) very much (.) I keep crying at work and that's really (.) well (.5) stup. ahm (.) embarrassing (.) but I just can't help it
4.   (1.0)
5.   D: I see [intake of breath] (.5) so (.5) you (.) um (.) don't know how to cope with all this?
6.   (.5)
7.   P: Well..
8.   D: ...do you (.) sorry (.) ever think that it's just all too (.5) much or that (.) you can't carry on? Um..
9.   P: No: (.) I've (.) I've never felt that bad (.5) no (.) just very (.) you know (.) down (.)
10. D: Good ((continues))

From the point of view of a normative framework in which the characters of, for example, 'open style' and 'interruption' had been pre-assumed, it could be argued that even during this very short period of interaction the GP is guilty of:

- Asking leading questions, rather than open ones (turn 5), and/or:
- 'Telling the patient what she meant' (turn 5), and therefore not employing a sufficiently open style, or even lacking contextual empathy, and:
- Actively interrupting the patient (turn 8) and also, thereby, not fully listening to what the patient was attempting to tell him, or hurrying through the consultation.

A more careful analysis of the way that the talk is used here, however, reveals something rather more productive at work. UK National Health Service (henceforth NHS) primary care guidelines clearly stipulate that a general practitioner (henceforth GP) should explore the danger that any patient with suspected depression represents to themselves at the first available opportunity: "*Always ask people... directly about suicidal ideation and intent.*" (National Institute for Clinical Excellence, 2009, p. 120). One of the key problems that faces a GP when asking a question about suicidal ideation at a point like this (where depression is clearly suspected) is that it may 'surprise' the patient, seeming out-of place in the consultation, and induce a strong negative reaction. So this presents a very real practical problem for a GP. How does one directly broach the matter of suicidal ideation when the patient may not be expecting it?

One key way in which this is done is by *pre-establishing* a sense of relevance (Miller, 2013) for the issue itself. So, in Turn 5, D summarises P's previous

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7 This uses a simplified version of the original transcription notation.

words in a way that can be hearably connected to an actively depressed state by the patient. It might well seem a lot more logical to ask someone who 'doesn't know how to cope' about suicidal ideation than someone who is just 'embarrassed about crying at work.' In Turn 7, P begins with a 'Well' which, as noted by a number of analysts, often indicates forthcoming disagreement (Schegloff & Lerner, 2009). By cutting off the patient at this point, D thereby *sustains* the relevance of the question that he has to ask when the patient may have diminished that by contesting his summary. Consequently, when it is finally asked in Turn 8, P answers in the negative, but unproblematically so. There is no 'recoil' from it because it is hearably a logical upshot of what was already being said.

The study from which these findings are taken further illustrates a range of ways in which GPs and patients work together to negotiate potentially difficult situations in consultations to positive ends, not all of which, normatively speaking, would appear to be 'good practice'. For example, the GPs often used rather "*vague*" questioning about suicidal ideation which, although lacking institutionally recommended "*directness*" (National Institute for Clinical Excellence, 2009), demonstrably served to "*soften the blow*" of the question itself (Miller, 2013) where a full sense of its relevance could not be generated. In sum, GPs consistently used a range of apparently "*dysfunctional*" but highly skilled, interpersonal activities to make potentially difficult questions easier for patients to hear, and to sustain "*local social solidarity*" (Silverman, 1997) within the consultation itself.

Conclusion
The short discussion of CA above barely scratches the surface of the method itself, but is manifestly intended to illustrate a few small ways in which the broad approach has had, and can have, great facility in health research. Perhaps its most potent quality in this sense is in its capacity to illuminate the tacit skills of healthcare professionals and their clients without recourse to pre-judgements about power or over-simplified notions of 'good practice'. In this respect alone, qualitative health researchers may find the extant corpus well worth investigating.

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Brief Encounters with Qualitative Methods in Health Research: Narrative Analysis.

Louise Rowe

Abstract

Narrative research is a recently developed approach to qualitative investigation in health settings which is growing in popularity. The methods and analytic procedures used, however, are diverse, have developed in very different disciplines and are often not well prescribed in the literature. This can make it difficult for those new to this approach to assess what narrative research actually *is*. The aim of this article, therefore, is to introduce the process of narrative research and open a discussion on what constitutes a 'narrative', and the defining features of narrative analysis. Some examples of narrative research in health will then be presented.

Keywords:

health; narrative analysis; participant-centred analysis; qualitative research

Introduction

Narrative research "*...refers to any study that uses or analyses narrative materials*" (Lieblich, Tuval-Mashiach & Zilber, 1998, p.2). Put simply it is the study of a story. The approach evolved from the study of literary works and folklore, but has since been adopted by a wide range of disciplines. It is a more recent qualitative method to emerge, with a rapid increase in popularity in the last few decades (Murray, 2000).

Although many other qualitative methods use some form of narrative as their object of study, narrative research is characterised by the use of methods and analytic procedures that examine the way that the story is told, and preserve the voice of the participant. These elements are often lost in other qualitative research procedures. For example, Overcash (2003) notes that ethnographic accounts of experience (see Benkwitz, this issue), despite putting the participant at the centre of the research, are often over-reliant on the voice of the researcher to describe the phenomena under investigation. Narrative researchers also criticise standard thematic analysis, and grounded theory (see Earnshaw, this issue), for mechanistically dissecting text into disjointed segments which are then rebuilt into themes. This can break the narrator's intended connection between sequence and consequence, and also disrupt or obscure meaningful narratives. This cause-effect in personal meaning-making is an essential feature of narrative data.

Personal narratives can take many forms, such as research interviews, observations of conversations, journals, written accounts or even reports or discussion documents. Online stories in the form of blogs, or YouTube videos, have also been used (Wen-Ying, Hunt, Folkers & Augustson 2011). A unifying

feature is the requirement of the research objects under scrutiny to recount some event from history which can then be analysed systematically using narrative theory.

This 'brief encounter' will seek to explain the philosophy behind narrative research and explain how this should influence the methods employed. A brief review of narrative research in healthcare settings follows, which serves to illustrate its applications.

Philosophy & Tenets of the Approach

Narrative analysis is a qualitative-interpretative method that has gained significant popularity in recent years. The story, or narrative is the most common vehicle with which humans represent their experiences (Frank, 2012), but the retelling of events is proposed to provide more than a simple factual account (Mishler, 1995). Instead, those events are given meaning by us when they are woven into a spoken narrative which has a beginning, middle and an end. Narratives provide a "*continuity of self*" (Adler, 2012), linking past experiences to present and future events and in doing so actively construct or preserve our self-identity. Riessman (1993) proposes that stories are the organising principle for human action, and therefore, the story metaphor can be adopted to deconstruct peoples' experiences.

In addition to personal meaning-making, Frank (2012) observes that personal narratives are rarely exclusively our own. Multiple voices can be heard in any story, including the voices of the other actors in the story and embedded "*cultural narratives*". Murray (2000) identifies four levels at which narratives operate: (a) the personal level representing lived experience; b) the interpersonal level which is co-created with other; (c) the positional level between the researcher and participant and (d) the societal level which draws on wider cultural narratives. Identity, therefore, is viewed as socially constructed and the stories that people tell can be used to study wider social phenomena such as gender and power relations (Emerson & Frosh, 2009). As such, narrative research emerges as a flexible methodology which can provide a multi-layered approach to reveal the complex layers of human experience (Sparkes & Smith, 2013).

In order to draw out this complexity, narrative research analyses data on two levels: the textual level, which focuses on the content of what is said, and the 'narratology' which relates to the manner in which the information is told. However, the degree of emphasis placed on content versus narrative, and the proposed relationship between them, often differs from one study to another depending on the philosophical orientation of the researcher.

Some narrative analysts argue that the reality of 'the self' cannot be disentangled from the narrative

or rhetoric that is used to describe it (Emerson & Frosh, 2009) and that, therefore, the relationship between the content and the representational nature of the language is not hugely important. In this case the participant's story *is* their experience and the research logically focuses more on the content of the narrative in an attempt to understand the lifeworld (a core phenomenological concept, see Cronin & Lowes, this issue) of the participant (a debate articulated by Robert & Shenhav, 2014).

In contrast, some researchers adopt the more classically positivistic ontological view that an objective reality exists independent of the narrative, and that the participant's story offers an insight (either directly or indirectly) into the truth of a broader existence. In such cases, the representational nature of language becomes more important because linguistic devices, such as the form of expression, metaphors chosen, and roles the narrator assigns to themselves and other actors within the story tell the researcher something about the reality of the self or social world. As it is for practitioners of Conversation Analysis (see Miller, this issue), the function of language for these narrative analysts is primarily to modify the way in which we present ourselves to others, and its use becomes a performative act designed with others in mind.

Researchers that take this latter position will place more emphasis on the representative nature of the story and the interpretation of its true meaning. If the content of the narrative is not taken at face value it becomes more important for researchers to articulate the relationship between content and representation and to show the reliability of their research claims. For this reason, researchers undertaking narrative enquiry are advised to declare their ontological position and clarify the relationship between narrative and 'truth' before embarking on their project (Robert & Shenhav, 2014).

What constitutes a narrative?

In narrative research, collected data must be either autobiographical in nature or reflective of the unfolding of a story over time. All narrative research, therefore, places events in some sort of unfolding order. The timeframe examined could be very long, as in a life story, or much shorter, as in the recounting of a critical incident or encounter (Murray 2000). In addition, the analytic methods used should preserve the holistic nature of this account by identifying narrative themes that recurrently permeate the story.

Despite these common features, there are differences in the way that narratives are defined, collected and analysed in the literature and this often proves confusing to those new to this approach. Robert and Shenhav (2014) provide a helpful 'typology' of narrative types and make the distinction

between classical and post-classical schools. Classical narratology takes an objectivist stance, viewing the narrative as something which exists as an entity. Thus a narrative is defined by a set of temporal characteristics, clause structures or other relational linguistic properties. The researcher identifies them by applying a set of analytic procedures to the text (for example, the structuralist framework proposed by Labov, 1997) in an objective manner. Some analysis procedures define the whole story as one narrative, identifying plot-lines and story 'types' while others identify the many smaller narratives which are embedded into larger ones (Stenhouse, 2012). Regardless of the analytic framework applied though, classical approaches identify narratives using the temporal and structural properties of the text.

Post-classical approaches take a more subjectivist view of narrative, and maintain that it is never possible to objectively represent the experiences that are voiced in research interviews. Since the process of telling a story is the result of an ongoing negotiation between the teller and the listener, the researcher plays an active role in shaping the collected narrative. This school of thought thus treats narratives as more fluid and context-dependent because they are produced in response to the interlocutor. If this view is taken, then a more conversational interview is seen as an acceptable way to generate the research narratives. It also requires the researcher to recognise the vagaries of the researcher-participant relationship in the analysis.

The post-classical position is also grounded in the contention that narratives are not always characterised by organised stories with recognisable temporal coherence, but are often disjointed, contradictory and lack closure (Emerson & Frosh, 2009). This is particularly true in health research, which often focuses on people confronting difficult challenges like disability, trauma or illness. The challenge for the researcher is to recognise these inconsistencies and show how they reveal the tension between individuals and the social worlds they inhabit (Robert & Shenshav, 2014). This requires a more discursive form of analysis, such as Gee's (1986) poetic line-breaks, or the use of metaphors which emphasise meaning over and above the structure of clauses. If these analytical methods are taken then the transcription of the interviews also needs to record the participant's emotions, pitch, tone and emphases and the interpretation of these is also more subjective.

In reality many studies combine these two approaches. Often classical methods will be used to identify narratives or plots followed by a more subjective interpretation of meaning. It is this variety and combination of analytical approaches in narrative research which perhaps most confuses those new to the field.

Brief Review of Health Research Studies

Stories help to make sense of our experiences, particularly those which surround challenging or significant life events like illness, disability, childbirth, death and dying. For this reason narrative methods are becoming increasingly popular in healthcare settings, and can provide a useful insight into the lifeworlds of patients and service users (Albright, Epstein & Duggan, 2008). Munhall (2012) explains that the field of 'Narrative Medicine' allows people to *give voice* to their experiences, producing an account with which others can identify. The 'others' in this statement refers both to medical professionals, who can use narrative research to individualise patient care, and also to patients themselves, who can use the narratives of peers to better understand the challenges they face and develop effective coping strategies (Overcash, 2003).

Examples of narratives which focus on the personal level of the lived experience are plentiful in contemporary health research. Stenhouse (2012), for example, interviewed psychiatric patients about their recent experiences on an acute psychiatric ward, and uncovered their key concerns about safety. 'Psychological safety' was identified as a key concern for patients and distinguished from physical safety. By explicitly recognising the concerns of patients and identifying institutional factors which affected them, recommendations to improve patient care were made. Another recent study in the domain, meanwhile, focused on personal experience related to women's use of Complementary and Alternative Medicine (CAMs) during pregnancy (Mitchell, 2014). Through narratives, the author identified key concerns for pregnant women relating to control over their physical, emotional and spiritual wellbeing in pregnancy and reflected that the traditional medical model of maternity care typically neglected these things.

In addition to providing useful insight into participant perspectives, narrative research has been used to explore the experience of healthcare professionals. Greenhalgh (2012), for example, writes extensively on the process of clinical decision-making, and details how the study of narratives has revealed the subjectivity of clinical diagnosis and the role of experience in effective practice. Kucera, Higgins & McMillan (2010) conducted interviews with Australian advanced nurse practitioners, asking them to recount the everyday experience of their professional practice. From these, narratives were identified which detailed the key tacit skills required for the job. These were then developed into a model detailing a set of competencies for use in training future professionals.

The personal narrative has always played a central role in mental health, with Adler (2012, p.595) arguing that "*...stories **are** the currency of psychotherapy*" [emphasis added]. Coherent personal narratives which show a high degree of

personal agency are often taken to be indicative of psychological wellbeing. Disrupted life-narratives can result from mental illness and psychological trauma, and research has demonstrated that increases in personal agency and coherence in patients' stories throughout their treatment can be strong predictors of their recovery (Adler, 2012).

Therapists' narratives have also been examined alongside those of their patients to elucidate common concerns or perspectives which are associated with good treatment outcomes. The co-constitutional nature of narratives was particularly explored in a recent study focused on meaningful encounters between patients, their next-of-kin and healthcare professionals (Gustafsson, Snellma & Gustafsson 2013). Participants were asked to give written descriptions of a critical encounter. This approach combined both classical and post-classical perspectives by performing a structural analysis to identify story plots, followed by a deeper analysis through metaphors and finally an interpretive or dialectic account of the encounter. The results have relevance to medical staff from all fields that would like to improve the caring nature of their interactions with patients. An example of research which focused more on the socially constructed aspect of narratives in health, meanwhile, was conducted by Busanich, McGannon & Schinke (2014) who analysed narrative interviews provided by a male and a female distance runner, both with eating disorders. As well as illuminating personal narratives relating to the participants' experiences, the authors revealed that these were affected by social constructions of gender which had an impact on health behaviour.

Conclusion

In conclusion, this review of narrative research in healthcare has ideally shown that the approach has many useful applications in the field, and has already been used extensively to gain insight into the lifeworlds of patients and practitioners. Narrative analysis is distinguished from other forms of qualitative research through its use of multi-staged analytic procedures which focus on the expression of the narrative itself. Some qualitative researchers have criticised the narrative approach for placing too much emphasis on its verbal expression, highlighting that not all experience can be expressed verbally. Perhaps, because of this, narrative research been accused of being ethnocentric because it ignores other expressive acts which might be prevalent in certain cultures (Roberts & Shenshav, 2014).

Narrative analysis uses a diverse range of practical methods and its analytic procedures are not well prescribed in the literature (Cresswell, 2006). Although this may cause confusion in those new to the approach, this freedom offers great flexibility to the researcher. In navigating the field it is useful for researchers to identify their ontological position on the relationship of the narrative with the world as it actually exists. Further, they should clarify whether the narratives are viewed as something that can be objectively recounted and defined, or whether their existence is more subjectively defined. For those attempting a narrative study for the first time, the reader is referred to Whiffen, Bailry, Ellis-Hill & Jarrett (2014) who published in detail the analytical processes they went through in their narrative research.

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LEADERSHIP
Evaluating the upskilling impacts of a management and leadership training programme in the healthcare domain: Quantitative findings from a Cumbrian NHS initiative

Paul K. Miller, Nicola S. Relph, Tom Grimwood & Elaine Crooks

Abstract
This paper reports key quantitative survey results from a broader evaluation of the Foundation in Management and Leadership (FIM) programme run by Cumbria Partnership NHS Foundation Trust during 2012 and 2013. Using a large-scale quantitative survey, administered before and after the intervention, changes in a range of leadership skills and knowledge are measured. Results indicate a strong level of improvement across many key indicators among participants, and thus a high level of success for the intervention itself.

Keywords
education; evaluation; healthcare; leadership; learning; quantitative methods; training

Introduction
The Foundation in Management (henceforth FIM) programme was developed from a strong evidence-base within Cumbria PFT "*…to build the foundations of effective management by setting the context of the organisation, providing essential practical skills, knowledge and behaviours…*" (Cumbria PFT, 2012,

p.3) requisite for the performance of day-to-day operational roles within an enlarged organisation[1] facing a challenging NHS climate, the demands of increasing quality with reduced financial income, and recurrent negative findings from staff satisfaction surveys (Cumbria PFT, 2014).

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1 Mental Health and Learning Disabilities Services had merged with Community Provider Services some 10 months prior to the beginning of the FIM programme, and "…the scale of [the] Trust has increased by 300% from [its] FT inception in 2007." (Cumbria PFT, 2014, p.6).

The Programme

Combining theoretical perspectives, practical organisational knowledge and structured reflective learning, the overall stated aims of the programme were to provide participants with an enhanced understanding of the scope of the PFT itself, of self and responsibility in relation to individual roles and the vision and values of the PFT (and how these apply to particular service areas and roles). It was also designed to help participants develop their knowledge of, and practical essential skills in, the undertaking of operational roles, and encourage a broad perspective upon the leadership approaches necessary to encourage self- and team- development.

Specifically designed, thus, to provide insight into participants' leadership styles, and to provide opportunity for participants to develop confidence in management and team-working, the programme comprised an introductory day followed by four sequentially ordered modules:

1. Understanding the Organisational Context;
2. Self-Awareness and Leading for Professional and Personal Growth;
3. Service Quality and Performance and
4. Practical Management of Teams.

Consequently, the intended outcomes for participants were stated as (Cumbria PFT, 2012, p.4):

- "Knowledge and practical skills to undertake your operational management role with greater confidence;
- Insight into your leadership style and the impact of behaviours on your team and colleagues;
- Development of self-awareness;
- A deeper understanding of quality and performance measures and why they are needed to build a successful health care organisation and
- Clarity of your role and influence within the service and wider organisation."

Evaluation

The evaluation[2] was commissioned by the Cumbria PFT and executed by Health and Social Care Evaluations (HASCE) at the University of Cumbria. In its totality, it explored all aspects of the FIM programme via a range of different collectors, including session feedback (qualitative and quantitative), participant interviews regarding their experience of the programme, interviews with managers of participants to assess third-party views on workplace impacts and a two-tranche survey designed to assess longitudinal change in participants'

knowledge and aptitudes as managers and leaders. This paper reports only key findings from the latter. The specific aim of this aspect of the evaluation was to compare the opinions of participants both pre and post FIM programme. The content of these opinions were two-fold covering both evaluation of management and delivery of the programme and development of the participants' leadership skills. It was hypothesised the participants perceptions of their leadership and management skills *in the workplace* would improve, post-FIM programme, relative to their more general, stable self-image.

Method

An online survey, using the Bristol Online Surveys (henceforth BOS) system, was designed to provide an initial and post-hoc analysis of the demographic characteristics and self-evaluations of the participating cohort, and thereby to monitor change and impact over the duration of the FIM itself. The first tranche of data was collected in September 2012, the second in July 2013.

Participants

Of the total number of participants in the programme (N=100), all were invited to complete the online survey via email. The response rate was 88% in tranche 1, and 62%[3] in tranche 2, with a demographic breakdown as shown in Table 1.

The distribution of roles within this population, in terms of part and full time work, years of service and clinical and non-clinical professions, meanwhile, is shown in Table 2.

Variable	Survey 1		Survey 2	
Gender	Female = 78	(88.6%)	Female = 56	(90.3%)
	Male = 10	(11.4%)	Male = 6	(9.7%)
Age	Range = 24 years to 61 years		Range = 25 years to 62 years	
	Mean age = 42.3 years		Mean age = 44.4 years	
NHS Band	Band 4 = 2	(2.6%)	Band 4 = 2	(3.3%)
	Band 5 = 6	(6.8%)	Band 5 = 3	(4.8%)
	Band 6 = 37	(42%)	Band 6 = 26	(41.9%)
	Band 7 = 41	(46.6%)	Band 7 = 28	(45.2%)
	Band 8 = 2	(2.3%)	Band 8 = 3	(4.8%)

Table 1: Core population description

Variable	Survey 1		Survey 2	
Role Status	Part-time = 24	(27.3%)	Part-time = 16	(25.8%)
	Full-time = 64	(72.7%)	Full-time = 46	(74.2%)
Role type	Clinical = 62	(70.5%)	Clinical = 39	(62.9%)
	Non-Clinical = 26	(29.5%)	Non-Clinical = 23	(37.1%)
Years worked in NHS	Range 1 to 40 years		Range 0 to 24 years	
	Mean Years in Service = 15.84		Mean Years in Service = 15.50	
Years worked in NHS Management	Range 0 to 26 years		Range 0 to 24 years	
	Mean Years in Service = 4.49		Mean Years in Service = 5.34	
Number of people managed by participant	Range 0 to 61 years		Range 0 to 40 years	
	Mean number managed = 11.36		Mean number managed = 10.63	

Table 2: Professional role breakdown

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2 A full copy can be obtained from the authors.

Procedure

The survey was designed to account for three key issues: The specific information required by Cumbria PFT itself, the need to produce comparable, longitudinal data across two survey tranches (pre-FIM and post-FIM), and the core methodological imperatives outlined in prior survey work on management and leadership, most notably those arising from the established Multifactorial Leadership Questionnaire (see Bass & Riggio, 2006). As such, an inventory of 57 questions, in a five-section format, was employed to explore the following major themes:

- Participants' demographic details and role outlines;
- Participants' self-evaluation of pertinent managerial skills and knowledge in general life settings;
- Participants' knowledge of Cumbria PFT's organisational structures and vision;
- Participants' self-evaluations of their specific skills in managing, and being managed, in their NHS role and
- Participants' overall appraisals of themselves as managers within the NHS, and of the programme itself.

The 48 self-evaluative questions were measured using 10-point Likert scales to assess levels of agreement with given statements, and 10-point rating scales on which participants could provide assessments of their own levels of skill or knowledge in given fields. Ten-point scales were preferred to more familiar five-point models in order to provide greater sensitivity of measurement in subsequent analysis of longitudinal change (De Vaus, 2002).

Analysis

A full suite of descriptive statistics was initially run on each individual question and, following consideration of the data, post-coding was executed on three variables to facilitate statistical analysis. Number of years working for the NHS was grouped into 1-10 years, 11-20 years, 21-30 years and more than 30 years. Number of years working in a managerial position was grouped in to greater or less than 10 years. Number of people currently managed was grouped in to 1-10 people, 11-20 people, 21-30 people and greater than 30 people. Three different aspects of participants' self-assessments were then explored:

Analytic Category	Description
Assertiveness	Capacity to be assertive with others
Confidence	Faith in own ability to execute tasks effectively
Openness	Capacity to respect and listen to others
Communication	Outcomes from effective communication with others
Resource Management	Capacity to utilise time, money, and information effectively
Satisfaction	General comfort with status quo
Conflict Management	Capacity to negate or deal with conflict
Self-Positivity	Contentment with performance
Other-Positivity	Positive view of how self is seen by others

Table 3: Analytic categories used in survey

Participant aptitude analysis
Eleven basic analytic categories, sensitive to the stated aims and objectives of the intervention (listed above) were derived from direct and combined ratings of 'general' skills, attitudes and knowledge: assertiveness, confidence, communication, listening, numeracy, time management, conflict-management, comfort with change, team-playing, independent decision-making and respect of authority. Nine analytic categories (shown in Table 3, below) were derived from compounds of variables describing a range of pertinent practices at work[4].

'General' categories were then recombined for comparison with those nine specifically manifesting within workplace environments to assess whether participants viewed themselves as, for example, more or less assertive in their broader lives than in their professional roles, and how these issues vary according to gender, experience, role factors and so forth. These findings were then compared between tranches 1 and 2 to assess statistically significant differences (i.e. changes) over the duration of the FIM programme.

Furthermore, participants were asked to assess their ability to balance their working roles (i.e. the managerial and the operational aspects of their job) via the simple Yes/No question "Do you feel that you are able to effectively balance the operational and managerial aspects of your role?" Findings from tranches one and two were compared.

Participant knowledge analysis
Participant self-ratings (/10) relating to three aspects of organisational knowledge were descriptively analysed:

1. Understanding of services within Cumbria PFT;
2. Understanding of Quality performance measures used within Cumbria PFT, and
3. Understanding of Cumbria PFT's Organisational vision, strategy and business plans.

Descriptive findings were also compared between tranches 1 and 2 to assess statistically significant differences (i.e. changes) over the duration of the FIM programme.

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3 Although still a perfectly feasible sample from which to draw inference, the lower response rate in the second tranche is likely an output of the mid-summer (i.e. holiday season) timing.
4 E.g. 'Role Openness' being formed out of combined results from four questions on capacity to listen, and given/received respect.

Results

Aptitudes and change

Self-characteristic variables (n=11) and role-characteristic variables (n=9) were checked for normality. As not all variables followed a normal distribution, non-parametric two-related variable tests (Wilcoxon matched-pair signed-rank test) were used to compared differences between self-scores and role-scores. The accepted alpha level was adjusted using a Bonferonni correction, (0.05 / number of comparisons) which reduced the accepted significance level to $p<0.005$ (0.05/10). None of the 'general' self-ratings were significantly different between the two surveys; in short, the participants rated their qualities *outside* of the workplace in much the same way before and after the intervention. As such, these measurements provide a consistent baseline against which professional change can be observed. Findings are summarised in Table 4.

These findings are particularly striking, indicating that during the course of the FIM five of the key measures moved rightwards across the table, while the two already on the right remained unchanged. In the cases of self-positivity and satisfaction, the measures moved all the way across the table; participants in tranche 1 were more satisfied and positive about themselves in general, while in tranche 2, they were now *more* so at work. Only confidence (no significant difference), resource management and conflict management (stronger in general) remained unchanged when changes were possible. It should be further noted that these measures did not trend with any key demographic variables.

In terms of aptitude for role-balancing, it is clearly evident from an inspection of Figure 1 that a significant shift in this capacity also took place during the course of the FIM, with a substantially greater proportion of the participant sample (79.19%) viewing themselves capable of achieving this balance post-FIM than did so beforehand (57.95%).
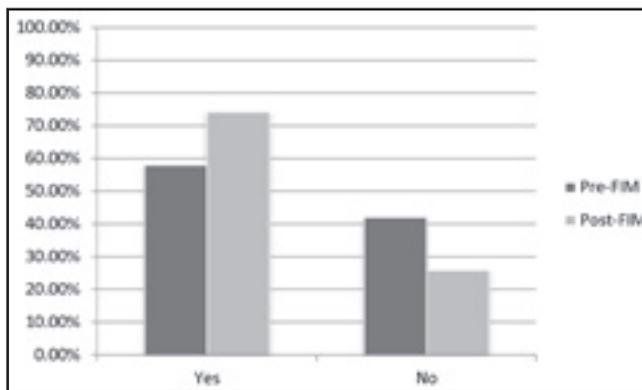

Figure 1: Role balance – comparison

Knowledge

A tranche-to-tranche comparison of role-balance assessments (i.e. participants' capacity to balance managerial and operational aspects of their roles), meanwhile, can be seen in Figure 2. Comparing knowledge-related findings between the tranche 1 and tranche 2 results revealed statistically significant improvements in all three of the specified domains. As further evidenced in Figure 2, these improvements are relatively substantial. In terms of knowledge of services within Cumbria PFT, for example, the mean self-rating rises from 6.01 to 7.19; a relative increase of very nearly 20%. Knowledge of measures and organisational vision, meanwhile, show relative improvements of an even greater order (22.4% and 28.3% respectively).

In tranche 1, there was a significant difference between clinical staff and non-clinical staff, with the latter rating their knowledge in all three domains more highly. In tranche 2, however, these knowledge measures did not trend with any key demographic variables, indicating a relatively greater improvement in organisational knowledge for clinical staff.

Aptitude	Stronger in General	No Statistically Significant Difference	Stronger in Professional Role
Assertiveness		A	Ω
Confidence		A Ω	
Openness			A Ω
Communication	A	Ω	
Resource Management	A Ω		
Satisfaction	A		Ω
Conflict Management	A Ω		
Self-Positivity	A		Ω
Other-Positivity	A	Ω	
A = Tranche 1; Ω = Tranche 2			

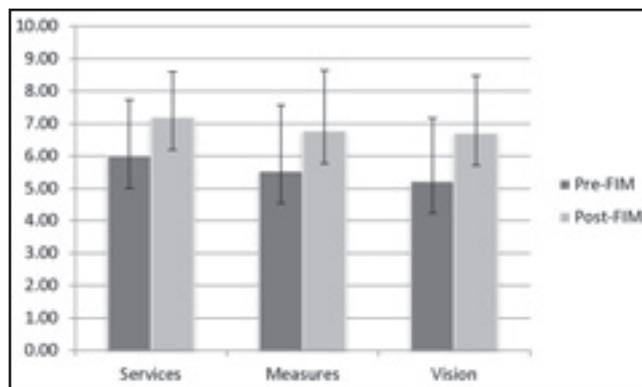**Table 4: Aptitudes and change – comparison**

Figure 2: Organisational knowledge – comparison; data presented as means, error bars denote standard deviations

Discussion

There has been a strong relationship reported between leadership capability and performance in healthcare professions (NHS Leadership Academy, 2014). Indeed there has been a shift away from traditional notions of 'management' policy in England's NHS in recent years, and greater focus on the importance of personal leadership qualities (Hewison and Griffiths, 2004). Indeed, a recent study by McDonald (2014) highlighted the need for greater understanding and evaluation of leadership programmes to ensure future investment on successful training.

The aim of this particular investigation was to evaluate the impacts of Cumbria PFT's FIM programme on participants' leadership and management skilling. Respondents were asked to self-rate in terms of confidence, assertiveness, communication skills, openness, conflict management skills, resource management skills, personal satisfaction, personal conflict management, positivity in self-image and positivity in perception of others' views. Prior to the inception of the FIM, the participants overwhelmingly rated their skills and aptitudes as stronger in general life than in their professional roles. Only openness and conflict management skills were deemed stronger in the workplace. Assertiveness and confidence were rated as roughly equivalent in both domains.

Following participation in the FIM, only resource management and conflict management were rated more strongly outside of the workplace, with confidence, communication skills and positivity showing no overall difference between domains. All other aptitudes were then rated more highly in the workplace. These aptitude changes did not trend with any key demographic variables. Moreover, a significant shift in perceived capacity to balance the managerial and operational aspects of professional roles took place during the course of the FIM. A substantially greater proportion of the participant sample (79.19%) achieved this balance post-FIM than did so beforehand (57.95%). Pertinently, a comparable evaluation by Cunningham and Kitson (2000a, b) of an 18-month nursing leadership programme, concluded there was a need for more development activity, but also that well-designed training induced significant improvement in these exact forms of leadership capability among ward sisters and senior nurses and, hence, improvements in patient care. In a comparative vein, Carr, Lhussier, Reynolds, Hunter & Hannaway, (2009) reported the success of a leadership programme in the sphere of health improvement work, in which participants reported an increased capacity for self-reflection, an energising effect, an increased political astuteness and, again, confidence as leaders, enhanced strategic thinking abilities, greater awareness of health improvement tools

and an enhanced evidence base for practice.

Participants were also asked to rate their knowledge and understanding of Cumbria PFT's organisational structure pre- and post-FIM. Pre-FIM, participants rated their knowledge of Cumbria PFT's services (mean=6.01) most highly, with measures and vision both rated between 5 and 6. There were no variations in knowledge ratings according to gender, age, experience, full-time or part-time status, or number of people managed. There was, however, a significant difference between clinical staff and non-clinical staff, with the latter rating their knowledge in all three domains more highly in tranche 1. This is likely an output of the non-clinical staff having worked more extensively *across* the trust's pre-merger legacy bodies, while clinical staff would have been more discreetly located within the old PCT. Post-FIM ratings increased significantly in all three domains (knowledge of services, measure and organisational vision). In terms of knowledge of services within Cumbria PFT, the mean self-rating rose to 7.19; a relative increase of very nearly 20%. Knowledge of measure and organisational vision, meanwhile, show relative improvements of an even greater order (22.4% and 28.3% respectively).

Edmonstone and Jeavons (2000) reported a comparable order of success in an NHS leadership programme conducted in the North of England. As reflected above, the primary findings of their evaluation were that participants found greater confidence to delegate roles, and to assertively plan for the future as a result of better fundamental institutional grasp. Similarly, Werrett, Griffiths & Cliffors, (2002) completed a large scale evaluation of a healthcare leadership programme in the West Midlands. Again, the overall results were positive, and the programme was recognised as useful to participants who developed a range of new skills within and, crucially, knowledge *of* their professional environment.

As a footnote to these findings, one should, of course, exercise caution when approaching any survey statistics, being mindful of key issues of internal validity. These findings discussed above show that, while participants remained stable in their general self-assessments, their workplace-based self-assessments improved substantially (and in some cases dramatically) during the course of the FIM. These improvements were widespread across the whole diverse cohort, which indicates that the FIM itself was likely a major factor in this improvement. It does not, however, preclude the possibility that a range of other factors were in play at the same time, with their own impacts on participant aptitudes.

Conclusion

There is strong evidence to suggest that NHS leadership programmes, in general, have been

successful in progressing and improving leadership skills. Participants in the current evaluation reported an improvement in confidence, communication skills, positivity, satisfaction, self-image and positivity following leadership training. They also felt they had improved their knowledge of the organisation. Therefore, it can be surmised that FIM created a platform for team development between staff from different services, building on a sense of shared purpose and understanding of contribution to the wider organisational strategic goals. In these terms, the FIM programme was manifestly successful in achieving a number of its key aims.

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Reflections on Leading Learning and an NHS Library Outreach Service

Pippa Orr

Abstract

Cumbria Partnership NHS Foundation Trust Learning Network, in partnership with the University of Cumbria, delivered a transformational learning programme involving personal development, experiential work and individual role development. In this paper, reflections are presented on the techniques involved, including action learning, one-to-one mentoring, formal teaching and project management, and how Library Outreach Service improvements were identified using customer journey mapping.

Keywords

learning; transformational learning; action learning; personal development; library outreach services; customer journey mapping

Introduction

During 2012-2013, I participated in the Learning Leader Programme (LLP) delivered by Cumbria Partnership NHS Foundation Trust (CPFT) Learning Network in partnership with the University of Cumbria. Using transformational learning theory (Brown & Posner, 2001) the programme involved action learning and project work aimed at developing the Learning Network across the organisation, involving all grades of staff, service users and carers. This paper outlines my own involvement in the LLP and the learning and development I gained from it.

I participated in the LLP as a way to further explore the benefits of learning, both for myself and for others. I feel I act as a lead to learning through my specialist library role of facilitating access to knowledge and information and saw this as an opportunity to develop new skills to take this role further, "*… in the present world, leadership is not learned but rather that it is learning*" (Brown & Posner, 2001, p. 275). Not knowing exactly what would be involved I had no preconceived expectations, the Programme unfolding as we went along.

My specialist role includes carrying out information and evidence searches (Booth, Papaioannou & Sutton, 2012) on behalf of NHS staff users and delivering training to enable them to find and evaluate evidence independently (Poyner, 2005). I deliver library services on an outreach basis, working with users to translate knowledge from evidence into practice (Healthcare Improvement Scotland, 2012).

Prior to the LLP itself, I had a clear project pre-planned. After attending the first study day however, I reflected that it would be useful to implement one that could clearly be achieved within the timeframe of the LLP, which I could carry out independently and that would benefit from the format of the Programme. I thus developed a project "*customer journey map*" (CJM; Oxford Strategic Marketing, 2008) to outreach delivery of the North Cumbria NHS Library and Knowledge Service that delivers library support to all staff and healthcare students at CPFT. I would offer services to all those involved in the LLP, to help with their own change projects or with their usual roles. CJM is a form of consultation designed to improve a service by finding out how people *actually* use it, and how they interact with the service provider. The aim of my redesigned project was, therefore, to raise awareness of, and improve access to – and delivery of – the Library Outreach Service.

Method

Action Learning Sets

Being part of a reflective Action Learning Set (ALS; McGill & Beaty, 2001; Chivers & Pedler, 2010) was a new experience for me and the skills learned are transferable to my outreach role, e.g., listening attentively to the needs of users, understanding user perspective and encouraging them to relate more easily to the services we offer. ALS members, by actively sharing their perspectives and experience (see Table 1 for staff roles, teams and services represented), added value to discussions resulting in robust actions being identified to progress my project.

One-to-one mentoring

Individual mentor meetings with the LLP facilitators provided additional support and guidance throughout the Programme, helping clarify or adjust what I was doing, and introducing project management techniques to specifically benefit my project. I appreciated the different professional viewpoints of the facilitators as it brought a more balanced perspective to my project and learning, coming as they did from organisational development and higher education environments.

Project and Participants: Customer journey mapping the Library Outreach Service

The initial part of the project, delivering services and collecting the feedback, took seven months between September 2012 and March 2013 (Table 1).

Table 1: Characteristics of project participants

N=16 out of the N=18 invitees used the Library Outreach Service (Table 2).

Responses	Participants
Invitees	N=18
Used Service	N=16
Returned CJM	N=10
Did not use Service	N=1
Did not complete LL Programme	N=1
LLP role	
Learning Leaders	N=13
NHS LLP organiser & facilitator	N=2
LLP Co-ordinator	N=1
CPFT roles, teams and services represented	
Acquired Brain Injury Service, Carlisle	
Administration, Eden	
Administration, Learning Network, Eden	
Assistant Practitioner, Copeland	
Children and Young People's Services, Allerdale	
Clinical Audit, Carlisle	
Communications, Learning Network, Eden	
Community Mental Health Team, Carlisle	
Community Nursing, Carlisle	
Leadership and Management, Eden	
Nurses, Eden	
Psychotherapy, Carlisle	
Research and Development, Carlisle	
Short Term Intervention Service, Eden	
Speech and Language Therapy, Allerdale	

Project analysis was carried out using the Straussian Grounded Theory approach (Strauss & Corbin, 2008) of reading through the feedback and grouping recurring ideas together to form tangible themes. These themes were then shared with all participants to give them the opportunity to add further comments, as a "*credibility check*" (Silverman, 2006).

Table 2: Library outreach service used by participants:

Service used	Participants
Training, including one group session with colleagues	N=8
Training and information search	N=5
Information search	N=1
Information search, library induction and library web site	N=1
Borrowed books, remotely via the	N=1
	Total N=16

Results and discussion

The themes provided positive outcomes, taken from the CJMs (Table 3).

Table 3: Themes and outcomes

Feedback from the project suggested that once customers become aware of the Library Service they appreciate the support and skills we offer, reflecting the challenge we face of reaching staff across all trusts in Cumbria from five library sites and two learning spaces. Anxiety around lack of time to use library resources and concern about remembering how to do so perhaps reflects the preference of the Learning Leaders to

1	Realisation Library and Knowledge Services can help: Becoming aware of the service one was "keen to try it" and felt "relief"
2	Feelings of anxiety: Three sub-themes emerged • Time pressures Impacting on the "need to understand" electronic systems • Uncertainty Knowing how to choose the "right words to express my needs" when asking for help • Retaining learning Though "easier than I thought, will I remember it?"
3	The Personal touch – added value: Being "very calm" while explaining resources puts users "at ease"
4	On the positive side ... satisfaction and relief: One was "thrilled with the results" from a search, finding it "very informative"
5	On the negative side ... dissatisfaction and confusion: Using electronic resources can be "too lengthy and time consuming", especially when "running slow"

| 6 | Increased confidence from learning: One was "surprised" at how they could "reduce time spent on research tasks" Sharing learning with colleagues: One "passed on" their learning "which in turn assisted a colleague with searching for information" |
| 7 | Sharing learning with colleagues: One "passed on" their learning "which in turn assisted a colleague with searching for information" |

develop independent skills, e.g. N=13 participants requested a training session with N=7 asking me to do a search on their behalf. Participant perspective was varied so it is valuable to know when services work well as it reinforces our approach, e.g., responding to searches quickly and tailoring service delivery to individuals. Understandably, when systems or resources do not work effectively this can impact negatively on customer experience so we need to be proactive about resolving issues where we may. As a result of using the Library Outreach Service participants felt a sense of increased confidence in their own skills and abilities and several participants shared their learning with colleagues, further embedding their own learning.

Recommended improvements
As a consequence of these project findings, the following service changes were recommended for review and implication:

- The outreach librarian should join wider CPFT service improvement project teams to contribute knowledge and research support;
- Use step-by-step user guides at the point of need;
- Increase advertising of Library Services;
- Introduce follow-up sessions;
- Review Library and Knowledge Service web site;
- Make CJM template more user friendly.

My project generated work for my outreach role and for our Library Services, North and South Cumbria, raising awareness of our Library Outreach Service and increasing our engagement with customers. The recommendations will help us improve access to and delivery of the Service and will feed into our strategic and marketing plans supporting the CPFT. I practised project management approaches and learnt new ones.

The LLP enabled me to engage effectively with participants as we gradually got to know each other over the 12 month period, increasing my understanding of their perspectives and roles. The added value of the Library Outreach Service comes from how I contribute over and above the practicalities of delivering services, drawing on my accumulated knowledge and expertise and on my own approach.

One of the main elements of transformational learning is role development and my taking part in the LLP and my project raise the question of how best to use the role of specialist librarian within the NHS. My effectiveness at supporting customers increased because I was part of the LLP group over an extended and defined period of time, enabling me to get to know them and their areas of speciality more than I usually would and I felt I could contribute in more depth and in a more sustained way. Reviewing the specialist role is further supported by the recommendation to use it more effectively by joining project teams as a 'knowledge advisor' for the duration of a project. I could focus on specific areas of trust development for a given period, gain in-depth knowledge of the area and perspective of staff roles and contribute my specialist skills to the project.

As a direct outcome of the LLP I have been asked to join a newly funded project group as their knowledge advisor. The project is looking at developing an intensive rehabilitation inpatient unit and provides the Library Service with an opportunity to directly contribute to trust service development. A second result of the LLP, meanwhile, is that the CPFT are investigating the development of a staff learning space at Penrith Hospital, an area for study and continuing professional development purposes. I will be involved in the planning and looking at the provision of library support.

Conclusion
I benefitted professionally and personally from the LL Programme. I found the LLP stimulating and motivational, as it matched my own preferences for collaborative working and learning from personal experience and reflection, while at the same time introducing me to new skills to support others with their learning. Practising the action learning techniques of active listening, empathy and insightful questioning proved an effective method of solving real issues and I am increasing my use of these skills when communicating with others. The Programme encouraged me to appreciate and develop my strengths and I look forward to building on this and contributing more to trust activities. The study days provided a refreshing environment for discussion and questioning; enabling the group to learn together and benefit from different perspectives represented, and the reflections above illustrate the explicit gains made from the project work.

Acknowledgements

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Impacts of 'change projects' in Cumbria partnership trust's Learning Leaders programme: Evaluating qualitative participant end-point reflections

Nicola S. Relph, Vicki Goodwin & Judi Egerton

Abstract
This paper reports findings arising from a broader evaluation of the first tranche of Cumbria Partnership Foundation Trust's Learning Leaders Programme (LLP). At the final 'Celebration Day' of the LLP, all participants (N=15) were invited to fill a form in which they could self-assess the impacts of their projects, and results were analysed using Straussian Grounded Theory. Responses indicated that key concerns related to extant impacts, impact mechanisms (i.e. the manner through which impacts were effected) and obstacles to impact. The overwhelming consensus generated was that the projects had produced strong positive impacts at time of reporting, and had the potential to effect further affirmative change.

Introduction
This paper reports findings arising from a broader evaluation of the first tranche of Cumbria Partnership Foundation Trust's Learning Leaders Programme (LLP) running from 2012-2013, conducted by analysts at the University of Cumbria's unit for Health and Social Care Evaluations (HASCE).

The LLP was developed against a backdrop of extensive organisational change to serve a number of purposes in the Cumbria Partnership Foundation Trust (CPFT). The programme was primarily designed to support the development of a Learning Organisation. A diverse group of Trust employees, service users and carers, who otherwise might not meet in the course of their everyday work, would come together to share ideas and experience, and consequently take up more formalised roles in developing learning across the organisation.

The LLP was further designed (a) to promote and develop a Learning Network across the organisation, (b) to be a resource for organisational development, (c) to develop expertise in the Trust's chosen change methodology, (d) to facilitate the embedding of a learning culture within the organisation, and (e) to encourage participants to take a lead in further embedding a reflective approach to the delivery of care across the organisation. The content of the LLP's 'taught' component was developed using an experiential learning model (Kolb, 1985) and included learning models, action learning sets (ALS), difference and diversity, communities of practice leading change and influencing decision making. A large part of the programme involved participants in 'live' change projects of their own choosing, using simple change methodology (a fuller account of the LLP objectives and content can be located in CPFT, 2012)

Change projects
Although numerous forms of data were collected for the evaluation exploring all dimensions of the programme, the focus here falls upon one dimension. This is the reflections made by programme participants regarding the impacts of their change projects. These were an integral part of the LLP, designed to be:

> [A] project in [the participant's] area of work which would form part of the selection process and clearly makes the link between 'learning' and 'doing'. The project would be something [the participant] is already working on or wanting to develop but requires help, support and skills development. Projects will have a focus on supporting integration and improving the experience of patients and carers. Projects should be chosen with full support of locality management. (CPFT, 2012)

The participant projects addressed a wide range of concerns related to leadership and learning.

Evaluation Methodology
At the final 'Celebration Day' of the LLP, all participants were invited to complete a form in which they could self-assess the impacts of their projects. Participants were provided with free-text space to facilitate personalised responses, presented here with the greatest degree of anonymity possible with qualitative data of this form. A total of *n=13* participants, from a total cohort of *N=15*, returned these forms. All participants are indexed by a number (i.e. P1, P2 etc.).

Design
The form focused upon three specific areas, via the following questions:
1. Please tell us why you applied to take part in the Learning Leaders programme.
2. Please tell us five things you have learned/ discovered/found beneficial while on the programme, or since becoming a Learning Leader.
3. Please tell us here about the milestones/ successes/obstacles you faced while carrying out your project. What worked? What didn't? What would you change? How do YOU think your project has made an impact?

This paper, given strictures of brevity, and also a core interest in the unanticipated insights that can emerge from largely unstructured qualitative data (Silverman, 2010) focuses only upon the free-form responses emerging from question three.

Data analysis
Data were explored for patterns and themes using many of the general principles of Straussian Grounded Theory (Strauss & Corbin, 1998) and within Scientific Software's ATLAS.Ti qualitative analysis package. Evaluative strategy herein involves two central analytic steps geared towards ongoing category-refinement, as displayed in Table 1 (below):

Table 1: Analytic Steps in Straussian Grounded Theory

Step	Activity
1. 'Open' Coding	The initial classification and labelling of concepts in qualitative data analysis. Themes are discovered through careful examination and questioning of the data.
2. 'Axial' Coding	The reanalysis of the findings of step 1, aimed at identifying the important, general concepts.

Results
Project impacts discussed by participants fell into two broad categories; extant impacts and prospective impacts (i.e. those that they were confident *would* occur).

Extant impacts
The dimensions of the first of these categories are illustrated in Figure 1 (below), and were taken to have manifested in three core domains.

A number of participants indicated that participation in the project had, among other key impacts, directly affected their own workplace style and skills.

There was the direct effect of bolstering project management skills, but participants further noted
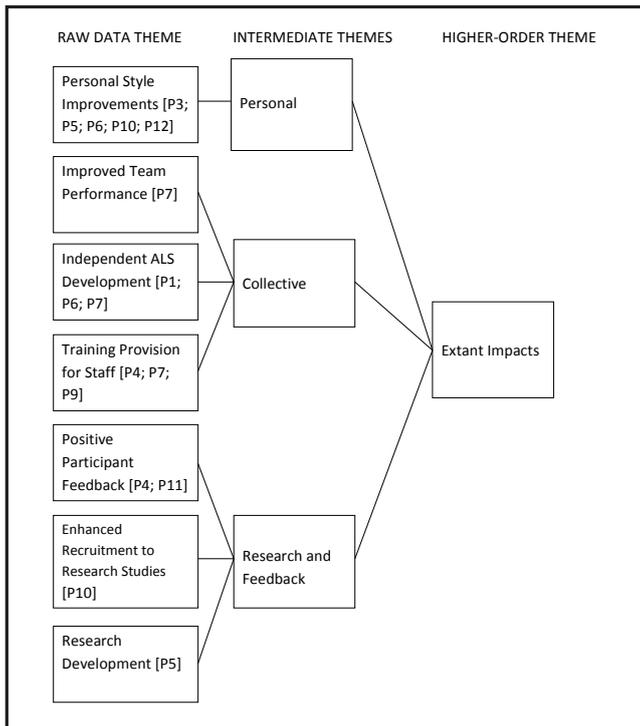
Figure 1: Extant project impacts

boosts in confidence and motivation. As P12 notes, "*My learning and leading styles have changed completely since taking part.*"

In a more tangible domain, there is a range of structural-collective raw data themes that are noted by participants to be clear impacts of their projects in operation. Firstly, P7 argues that the impacts of the project upon their workplace team had visible and measurable indicators:

P7: "*The impact on the cohesion of the team has been enormous, leading to us re-asserting our evidence-based and essential approach to our client group. In addition over the year, sick leave has fallen and though our number of referrals has doubled so has the number of face to face contacts.*"

Secondly, three participants (P1, P6 and P7) maintained that the introduction of independent Action Learning Sets within their own workplaces as parts of their project had improved general communication and cohesion. Finally, two further participants (P7 and P9) draw attention to the fact that direct training for Trust staff has already been provided as part of their projects. For example:

P7: "*A team training day was arranged, all tasks were delegated to members of the ALS. We influenced senior managers to support the day, and gained funding.*"

The final intermediate theme relating to extant impacts addresses research and feedback. In terms of feedback, P4 and P11 both note that the collection of feedback from participants in their projects (and

related enterprises) had yielded highly positive results, indicating strong levels of user-satisfaction. Moreover, P11 directly indicated that this feedback would inform future stages of the project itself.

P4: "*[F]ollowing the training I asked delegates to complete an evaluation form regarding the training and the information discussed. All of these anonymous forms were positive.*"

P11: "*Useful feedback and recommendations were received from participants, which will contribute to the development of the Library Outreach Service developments.*"

In a related vein, P5 drew attention to the development of formal research tools as part of their project, with the potential to be rolled out at a wider level, while P10 indicated a quantitative increase in recruitment to research studies as a direct output of Learning Leaders project work:

P10: "*I can definitely say from our recruitment figures for this year that our research awareness programme that was launched for the first time last year in August was a great success. It has clearly attracted quite a few professionals to take part in different research studies approved by our trust so far.*"

Prospective impacts

Alongside the firm impacts documented above, participants also outlined *prospective* (which is to say 'expected but as yet unrealised') impacts of the LLP project work. These prospective impacts fell into three central categories.

As evidenced in Figure 2, human impacts addressed such issues as benefits for patient care, for the provision of as yet undelivered training and for the enhancement of social inclusion and employment. Regarding the first of these, P3 was in little doubt that while "*… [the] project is in the very early stages, [it] will definitely make an impact in patient care.*" As regards the latter, P6 asserted that:

P6: "*I have been working with the local training provider…to look at setting up an unpaid employment placement for six months, with the intended progression to paid employment for the remaining six months as an apprentice.*"

In short, wheels were turning in order to make such placements a reality. In terms of resources, quantifiable financial gains were expected as a project impact by P10, who asserted that "*I am sure that the result will clearly be seen in revenue figures in our trust.*" P13, meanwhile, forecast that "*…the project will cut down on the time spent by both clinicians and clinical audit staff…*" in a range of activities. Finally, further research development was expected as an outcome of P9's project, while P13 was confident that improved information access across the Trust would be a measurable impact.
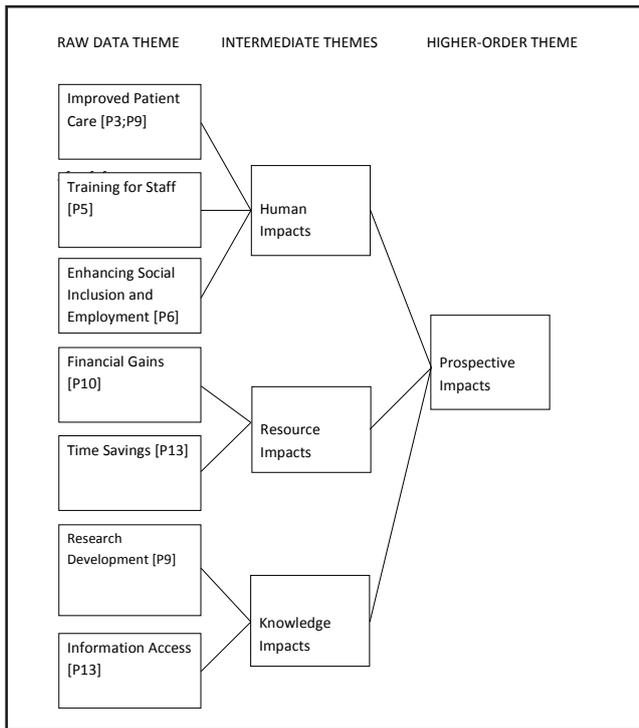
Figure 2: Prospective project impacts

Figure 3: Obstacles to impact

Obstacles to impact

In terms of obstacles to the achievement of anticipated project impacts, participants identified a variety of issues in three core domains, as evidenced in Figure 3.

The change-effected obstacles noted by participants related to shifts in the roles of individuals as results of restructuring within the Trust itself. These had the impact of slowing, or altering (and thereby slowing) the progress of the project. In one case, this related to a role-shift for the participant themselves, and in another the project was derailed by the relocation of a supportive manager:

> **P1:** *"My project plan had to be put on hold as finally changes were afoot in my department. It was frustrating to feel that the time wasn't right to proceed with the project but six months down the line my role has changed and now the time is right to get back on track with that particular project."*
> **P4:** *"My manager at the time encouraged me to develop a programme regarding dignity, nominated me to attend the dignity workshops throughout Cumbria and hold dignity training in my work place...Unfortunately due to organisational change my initial manager was relocated."*

Four participants identified time constraints as being natural obstacles to the success of their projects, citing both a general lack of time within their own schedules, poor estimation of how long things might actually take from the outset and also a lack of spare time to absorb the impact of delays. For example:
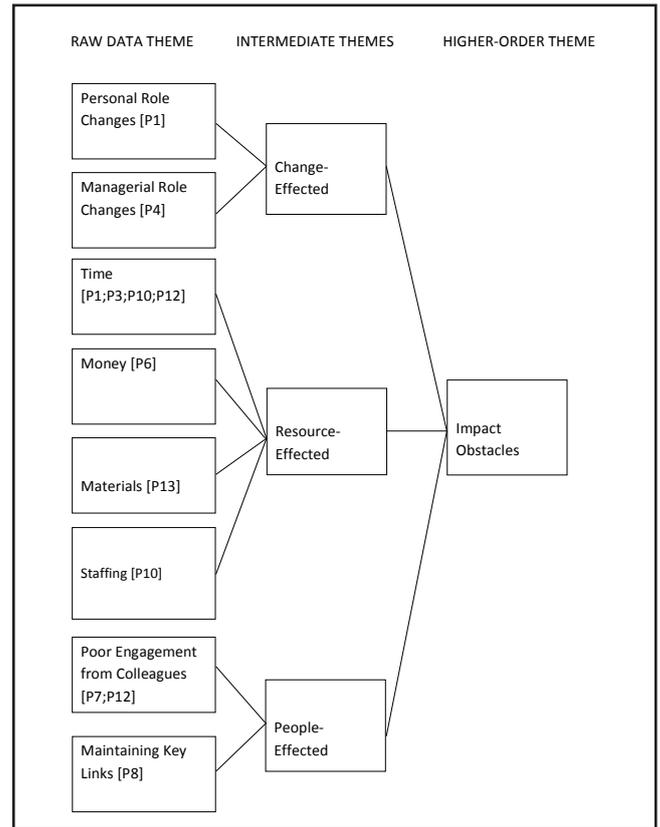
> **P3:** *"[I] need to be more realistic whilst maintaining my belief in the project proposal...I would change my underestimation about how long things take!!"*
> **P12**: *"There are many obstacles around the limited number of hours I work. However, the final project is now well underway, deliverable and of benefit to both service users and our Trust."*

Other cited obstacles in the realm of resources included difficulties securing funding when it was needed (P13), difficulty in accessing materials such as computer software (P13) and human resources – i.e. being short-staffed.

Finally, some participants found human agents to be the key obstacles. P8 highlighted the difficulties of sustaining the intensity of key relationships on a day-to-day basis such that project momentum could be sustained, while P7 and P12 noted a general lack of engagement and/or enthusiasm from some colleagues, which inevitably limited the scope of the project's reach, especially at the beginning.

> **P7:** *"I found that it was difficult to maintain the team's interest/commitment over that [early] time frame and was disappointed by their passivity."*

Key impact mechanisms

The final higher-order theme to emerge from the impact reflections related to the mechanisms through which the participants believed that impacts had been,
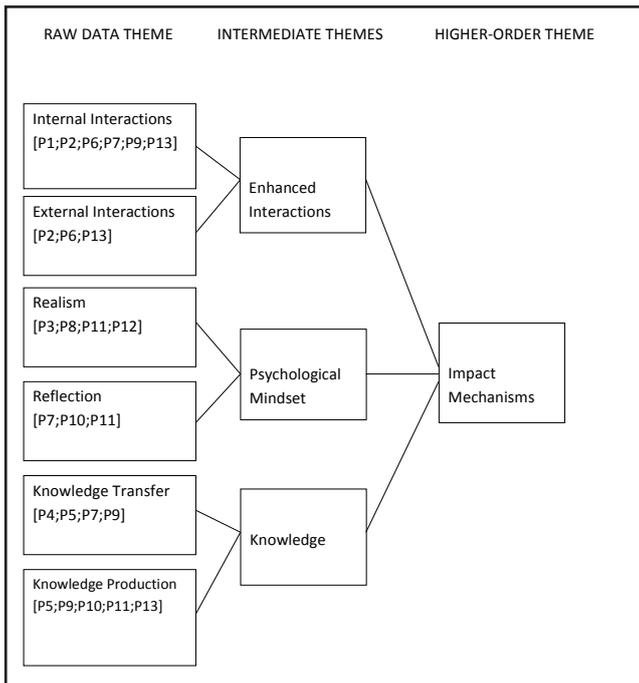
Figure 4: Impact mechanisms

or would be, achieved. Intermediate themes within this category were also three-fold. As shown in Figure 4, these themes each comprised two main issues.

In terms of interactions, participants cited an enhanced willingness to cooperate with others, both within their own teams, within the wider Trust and without, as core to the success of the projects:

> **P2:** *"I had a vision of how things could be improved but after having my first learning set meeting, I changed or incorporated quite a few ideas, [and] questions, because I was lucky enough to get a Bank Staff member who works quite regularly to join us and she has some really useful views."*
>
> **P6:** *"I have [also] been working with my colleagues within children services admin team throughout this project and they all share my passion and enthusiasm to ensure this pilot [is] successful."*
>
> **P13:** *"I discussed the idea with several clinicians – who were enthusiastic – and with my manager – who agreed that we would implement the idea."*
>
> **P13:** *"University involvement was very helpful for my project, especially when my tutor suggested I investigate screen capture software."*

Secondly, participants highlighted increased use of a realistic and reflective mindset (assimilated through the Learning Leaders programme) when addressing the demands of the projects. This was, in some cases, deemed essential to the projects' practical progress. For example:

> **P8:** *"The first milestone was realising and accepting that you can't change the world! However you can influence people, systems and the way we work."*

> **P11:** *"After Day 1 I reflected and then submitted a different and more realistic project plan."*
>
> **P12:** *"[Among] my personal milestones [was the moment] when I realised I could not 'Change the World' with a very large project."*

Finally, participants drew attention to the importance of (i) knowledge *transfer* and (ii) knowledge *generation* as key vehicles for their projects' success. Four participants explicitly cited the classic knowledge transfer cycle of learning (via training) and then training others as linchpin mechanisms within their projects. Five participants, meanwhile, stressed the importance of first-hand research (i.e. knowledge generation through novel data) as key. For example:

> **P9:** *"I will collect my surveys forms soon then collate and analyse them and present the result and recommendations to the Learning Network. The result of this should inform the organisation of training needs to raise awareness and knowledge for the benefit of patients and their carers."*
>
> **P11:** *"Useful feedback and recommendations were received from participants, which will contribute to the development of the Library Outreach Service developments."*
>
> **P13:** *"I investigated and evaluated a range of alternatives to the training and information that our team had so far been providing to support trust staff to carry out clinical audit projects."*

Discussion

The impacts of the projects (and participation in them) were explored in terms of the extant and the prospective. Extant impacts detailed by the participants included personal growth; collective impacts such as training delivery, team performance improvements and the development of independent Action learning Sets; and impacts in the domain of research and feedback such as increased recruitment to research studies, positive feedback from service users and the development of new research tools. Prospective impacts included human impacts such as further training provision, improvements in service-user experience and greater social inclusion; resource impacts such as time savings and financial gains; and knowledge impacts such as greater information accessibility and further research development. This provides evidence for project success and continuation of this training programme.

Other programmes have also supported leadership training for managers using comparative techniques. Graham and Partlow (2004) used a similar learning set approach to develop nurse leaders and the results of the evaluation were very positive. Participants stated the training facilitated their growth as a leader, and helped them explore new ideas through sharing personal and professional experiences. As a consequence, they became more confident and

knowledgeable in their leadership roles. Evaluating a management training programme in Lanarkshire, Scotland, Munro and Russell (2007) found similar impacts, concluding that "*…the impact that the education provision has made on the ability of the participants to do their job better throughout their working lives [is] a result of the learning that has taken place.*" (p.441).

Obstacles to extant or prospective impacts being made, as cited by participants in the current study, were organisational changes – such as mid-project changes of role for participants or their managers; resource restrictions, such as limited time, funds, materials and personnel; and unengaged colleagues, and difficulties in sustaining intensity in important links. These barriers to change have been reported in previous literature. Werrett, Griffiths & Clifford (2002) evaluated a leadership training programme in the West Midlands and participants reported both organisational barriers and resource issues as barriers to improvements. Furthermore, Janes (2008) stated financial constraints and cultural issues (such as tradition and custom) as inhibitors to change. These could be acknowledged in future LLPs.

The mechanisms through which participants felt change had been actualised – or would be – were enhanced and productive interactions with individuals and agencies within the Trust and without; a more realistic and reflective mindset; and effective production and transfer of knowledge. These explanations for change are supported in previous literature. For example Edmonstone and Jeavons (2000) reported managers felt more knowledgeable about the institution and hence more capable of installing change following leadership training. Similarly, Werrett *et al.*, (2002) noted improved assertiveness and creativity of managers following training. Janes (2008) further indicated training enhanced workplace change due to changed attitudes and increased knowledge of both participants and their colleagues.

Conclusion

In conclusion the evaluation of the Cumbria Partnership Foundation Trust's Learning Leaders Programme was very positive. Participants were able to report that the training had brought about both instantaneous and prospective impacts on their practice. Potential barriers to change were also highlighted to inform future programmes. Finally, training induced three beneficial improvements in the interactions, psychological mind-sets and knowledge of both participants and their staff.

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RESEARCH REPORTS
Results and recommendations following an in-depth case file review of 28 patient suicides in Cumbria

Rachel E. Brown & Dr Philip Taylor

Abstract

This paper presents the characteristics of 28 patient suicides registered in Cumbria in relation to common risk and escalating factors and outlines some common themes in relation to Serious Untoward Incident (SUI) recommendations and areas for improvement. The results support previous suicide audit work in that cases are complex and multifactorial. The common risk factors were related to criminal history, physical health conditions and alcohol and substance misuse. The common risk escalators were relationship breakdown and economic loss. We found that potential areas for improvement relate to documentation, communication and assessment of risk. A total of five recommendations have been made based upon the results.

Introduction

Suicide is an important public health issue that is recognised as a preventable cause of mortality (World Health Organisation, 2014). Research highlights that many people who die by suicide suffer from mental disorders (Bertolote, Fleischmann, De Leo & Wasserman, 2004), and in the UK around 25% of those who die by suicide have contact with mental health services in the 12 months prior to death (Appleby et al., 2013).

National statistics reveal that the 2012 suicide rate in Cumbria has increased since 2008 (Health and Social Care Information Centre, 2014), and local data suggests that the rate is likely to remain similar for 2013, thus highlighting the importance of local understanding on recent suicides in Cumbria. In-depth research carried out on Cumbria suicides registered in 2008 aimed to improve understanding of contextual and individual factors and confirmed that causal pathways are complex and multifactorial (Siddle, Mathieson & Brown, 2011). The results of this case-file review builds upon the findings of the 2008 research, however with a specific focus on individuals who were in contact with mental health services in the 12 months prior to death (patient suicide). As suicide is recognised to be a preventable cause of mortality and that mental health disorders are associated with increased risk of suicide, contact with specialist mental health services can provide an important opportunity for prevention of suicide in Cumbria.

The aims of this study were three-fold. Firstly, to describe the characteristics of patient suicides in Cumbria in relation to common risk factors and risk escalators. Secondly, to determine common themes in relation to improving the secondary mental health care provided, and thirdly to provide recommendations to help guide future local action and clinical practice.

Method

This study was a retrospective case-file review of patient suicides in Cumbria using primarily quantitative analysis. Guidance and permission were sought from the Head of Information Governance in Cumbria's Partnership NHS Foundation Trust and the Caldecott Guardian from the Cumbria Clinical Commissioning Group. Consent from the coroners in the North and West and South and East of Cumbria, and Cumbria Police Constabulary were also sought.

Case file selection

Cases of resident deaths by suicide (ICD-10 codes X60-X84) and undetermined injury (ICD-10 codes Y10-Y34 excluding Y33.9) registered in Cumbria were obtained from the Office of National Statistics public health mortality file between 1 January 2012 and 31 December 2012 and weekly death registrations between 1 April 2013 and 18 August 2013 . The term 'suicide' in this study corresponds with the national recognised definition of deaths from suicide and undetermined injury combined and in compliance

with the national definition; any deaths under the age of 15 coded between Y10-Y34 were excluded from analysis (Office for National Statistics, 2013). A total of 78 resident suicides were cross referenced against the Cumbria Partnership NHS Foundation Trust Independent Electronic Records (IER) patient database in order to identify the total number of patient suicides. Of the 28 patient suicides, 18 SUI reports were obtained and reviewed.

Patient suicide

The term 'patient suicide' in this study corresponds to the definition outlined within the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). The NCISH defines a patient suicide as an individual in current or recent contact (within the previous twelve months) with secondary mental health (Appleby et al., 2013).

Data sources

Data were collated from both routine (public health mortality file and weekly death registrations) and non-routine sources (coroner records, primary care, specialist mental health care files, SUI reports, and Cumbria police custody records). Collating data from a number of sources enabled the researchers to identify risk and escalating factors across the life course.

Data Analysis

Data were collated using a locally adapted audit pro-forma that was based on the 2006 Care Services Improvement Partnership suicide audit instrument. The pro-forma enabled the researchers to capture any narrative (qualitative) information deemed significant in order to develop individual formulations and to map information chronologically into a timeline. Key themes, risk factors and risk escalators were then established and individual formulations were produced. Close examination of the transcripts enabled common themes to be established, the identification of key lessons learnt, and the production of recommendations. Recommendations made in the SUI reports were quantified using a thematic analysis method.

Results

Patient Characteristics

Of the 28 patient suicides 64% were male and 36% were female, resulting in a ratio of men to women of 1.8:1. Most patients (54%) were aged between 45 and 64 years old; the mean age was 54 years (46 for males and 58 for females). Depressive disorders and alcohol dependence/abuse were the most common mental health diagnoses and just under half of individuals had been an inpatient in a psychiatric hospital in their

Table 1: Demographic and Clinical Characteristics of 28 Patient Suicides in Cumbria

Characteristic	*n*	%
Gender		
Male	18	64
Female	10	36
Age		
Under 25	3	11
25	6	21
45	15	54
65+	4	14
Suicide Method		
Hanging	17	61
Self-poisoning	7	25
Other	4	14
Mental Health Diagnosis		
Depressive disorder	15	54
Schizophrenia and other delusional disorders	1	4
Bipolar	2	7
Alcohol dependence	9	32
Drug dependence	4	14
Anxiety disorder	5	18
Personality disorder	4	14
Other	4	14
Lifetime psychiatric inpatient hospital admission		
Yes	13	46
No	13	46
Unknown	2	7
Lifetime Self-harm History		
0 episodes	8	29
1 episode	7	25
2 episodes	5	18
3 or more episodes	8	29
Self-harm episodes (one or more)	20	71
Lifetime Criminal Conviction		
Yes	13	46
No	15	54
Custodial contact in last year		
Yes	6	21
Physical Health Condition		
Yes	17	61
No	11	39

lifetime. The demographic and clinical characteristics of the patient suicides are described in Table 1.

Patient treatment characteristics are described in Table 2. In the past 12 months, prescription of anti-depressants was the most prevalent, following by benzodiazepines and anti-psychotics. Over half of individuals' last face to face contact with mental health services was while on caseload and a quarter were assessed but not taken on case load and under a fifth was discharged from caseload.

Further documentation revealed that 18 individuals (or 64%) had been in contact with secondary mental

Table 2: Treatment Characteristics of 28 Patient Suicides in Cumbria

Treatment Characteristic	n	%
Prescribed Medication (in last 12 months)		
Antidepressants	21	75
Benzodiazepines	12	43
Anti-psychotics	8	29
Mood Stabili	0	0
No medication prescribed	3	11
Unknown	2	7
Nature of Last Contact		
Contact while on caseload	15	54
Assessment, not taken on caseload	7	25
Discharge from caseload	5	18
Discharge from inpatient care	1	4
Lifetime psychiatric inpatient hospital admissions		
Yes	13	46
No	13	46
Unknown	2	7
Contact following discharge from last psychiatric inpatient care		
Within 48 hours	6	46
Follow up arranged, no contact documented	3	23
Patient died on release or within 48 hours	3	23
Not known	1	8

health services in the three months before death. Ten of those individuals had last seen a member of the specialist mental health team within seven days prior to death, equating to 36% of all patient suicides included in the study.

Risk Factors

Criminal History

We noted that in 46% of patient suicides the individual had been arrested and taken to a custody suite in the county at least once in their lifetime (table 1). Of those, just under half had been in a custodial suite in the 12 months preceding death (46%, *n*.6), and five of those individuals had been arrested on at least one other occasion. An arrest was most common among males (50%, *n*.9) and the arrests were commonly related to alcohol and/or assault (either domestic, affray or sexual). A criminal arrest in all cases was combined with a number of other social stressors including alcohol and/or substance use, a relationship breakdown and economic loss.

Physical Health Conditions

A physical health condition was present at the time of death for 17 (61%) individuals. Conditions such as erectile dysfunction, alcoholic liver damage, and hypertension and ischaemic heart disease were identified. However, the most common physical health conditions were pain related; we identified seven

(25%) individuals with at least one diagnosis of a pain related condition, these included back pain, gout, sciatica, lumbar spondylosis and arthritic conditions.

Alcohol and Substance Use

Alcohol and/or substance use was identified among 14 (50%) patients. Alcohol dependence was most prevalent, with eight patients known to be alcohol dependent (57% of alcohol and/or substance users), a further four (29%) had a recent history of alcohol misuse. Of the 12 with alcohol dependence/misuse, four (29%) were noted to have co-existing substance misuse problems. In this sub-group of patients alcohol and substance use was identified as being both a risk factor and risk escalating factor in contributing to their suicide.

Risk Escalators

Relationship Breakdown

We identified that a relationship breakdown was the most common risk escalator. There were 12 cases (43%) in which a breakdown of a significant relationship was evident in the weeks leading up to the death. In most cases, the relationship breakdown led to deterioration in mental state and an increase in emotional distress. For instance, there were two cases in which an arrest was made for assault against an ex-partner the day before death. Of the 11 whereby a relationship breakdown was identified as a risk escalator, eight (73%) were also known to be alcohol and/or substance misusers.

Economic Loss

We identified 11 (39%) individuals with evidence of recent economic loss. This included loss or impending loss of appropriate accommodation, financial concerns, recent unemployment and recent change to benefits. Almost half (45%) of those with evidence of recent economic loss were also known to be alcohol and/or substance users and had a previous criminal arrest or conviction.

Documentation, Communication and Assessment of Risk

We highlighted 20 (71%) cases where documentation, communication and/or assessment of risk could have been improved and often this related to a combination of the three areas in question.

Assessment of Risk

Of the 20 cases there were 15 (75%) instances identified whereby there was insufficient evidence documented to support the assessed level of risk. In six of the 20 (30%) cases the Galatean Risk Screening Tool (GRiST) was either not up to date or not fully completed. There were also cases where the assessed level of risk was questioned based upon the 'low, medium or high' categories, for example one

individual was assessed as being at medium risk for suicide following a serious suicide attempt and had identified their mood as 0/10.

Documentation

In eight of the 20 cases (40%) there was evidence to suggest documentation was not completed in a timely manner, including documentation of referrals between different healthcare professionals. The results also identified instances whereby the inclusion of dates on certain documentation was missing. As recent contact with the Criminal Justice System (CJS) was found to be a risk factor, we noted that documentation on a patient's forensic history was often incomplete. We found cases where a discharge pathway had not been fully signed and dated, referrals being made and no documentation to support whether the patient had been seen and a follow-up appointment from inpatient care discharge not being documented.

Communication

In ten of the 20 (50%) cases there was evidence of poor sharing of information within Secondary Mental Healthcare teams and between different healthcare professionals. In one of the cases we highlighted the importance of clinicians escalating concerns for a patient's wellbeing following presentation to services with suicidal ideation followed by disengagement with services. There were cases where communications either within or between teams were absent or that this was simply not documented.

Serious Untoward Incident Reports

In total, 86 recommendations were made in 18 SUI reports, an average of approximately five recommendations per SUI.

There were 11 (61%) SUI reports where at least one recommendation regarding communication was made. The common themes of these recommendations were related to developing and promoting close working relationships with other agencies and providers in relation to requesting and sharing patient information to support assessment and decision making. There was also a recommendation relating to communication with patients to ensure an understanding of procedure if no contact is made, and also that all communication should be in a language which is understandable.

There were 11 (61%) SUI reports where there was at least one recommendation associated with documentation which often related to the quality of documentation. For example ensuring that care plans are signed and dated, that the record of care is in chronological order, promptly documenting changes to care plans and where patient compliance is an issue this information, along with any interventions, is to be documented. There was also a recommendation that specified training in regard to documentation of narrative and also that any significant events relating

to a child's mental health should be summarised at the beginning of notes.

There were nine (50%) SUI reports where at least one recommendation in relation to assessment of risk. These tended to centre on regular reviewing and updating of individual risk assessments and promoting a cohesive multidisciplinary assessment and formulation approach to ensure that all sources of information are explored. There were also two recommendations relating to staff training and risk assessment and evaluation.

There were five (28%) SUI reports in which one of the recommendations referred to family or carer views being considered and incorporated into patient care plans and/or follow-up with regards to patient safety. Training of staff was cited as a recommendation in four (22%) reports including reflection and exploration of key findings from SUIs, guidance on good 1:1 time, safeguarding children and increasing awareness of risks such as alcohol withdrawal. Other recommendations were related to implementation of care plans in a timely manner, sickness/absence cover, improving discharge plans, referrals and effective leadership.

Discussion

This study examined 28 patient suicides in Cumbria using coroner files, primary care and secondary mental health care files, custodial records, and SUI reports. The results show that all patient suicides are multifactorial and that mental illness is to be considered alongside a myriad of other risk factors.

The themes identified from this in-depth review many some similarities with previous local audit work (Siddle, Mathieson & Brown, 2011), which therefore highlights the importance of practitioners who come into contact with service having an awareness and understanding of the significant risk factors and escalators for suicide and that these are considered and documented consistently within risk assessments. For example, relationship breakdown and economic loss continue to be significant risk and escalating factors for suicide, in particular among individuals with recent and historic use of alcohol. Alcohol and/or substance use was shown to often contribute to a further deterioration in a patient's mental health and once again physical health conditions (in particular pain related conditions) were found to be prevalent.

This case-file review was the first one locally to utilise and include information from Cumbria Constabulary's custodial database and as such an additional risk and escalating factor was confirmed. Suicide literature recognises that having a criminal history is a risk factor for suicide (Webb et al., 2011) and forensic history is included within the format of the Galatean Risk and Safety Tool (GRiST). Almost half of the patient suicides were found to have been

arrested in Cumbria at least once in their lifetime and most importantly just over one fifth were seen in a custodial suite in their year prior to their death. Documentation of forensic history was often found to be poor and our findings signify that such information should be sought to aid individual assessment of risk.

Communication, assessment of risk and documentation consistently feature as areas for improvement within SUI report recommendations which also supported the findings to emerge from the case-file review. An internal review published in October 2012 also highlighted similar themes that the Trust should be focusing on. Although there are challenges in determining whether such improvements will prevent suicide in Cumbria, it is however good practice that all staff members are up to date in terms of training and knowledge and assessment of risk and that clear documentation and effective communication is recognised and implemented. It is worth noting that research conducted as part the NCISH found that services which implement key mental health service recommendations are associated with lower rates of suicide and services that do not implement recommendation have little reduction in suicide (While et al., 2012).

Limitations

There are several limitations to consider. First, the results rely on the accuracy of information provided within patient case files. Secondly, the nature of this study is retrospective and improvements or changes to clinical practice may have been implemented since. Thirdly, the weekly death registrations from 1 January 2013 to 31 December 2013 were not available at the time of data collection due to public health transition implications. Finally, despite identifying areas for improvement in relation to documentation, communication and assessment of risk it is important to note that we are unable to determine whether those issues could have made a significant contribution in preventing the death, nor are we able to say from this study how typical or otherwise the standard of record keeping is.

Recommendations

Based on the results of this case file review, we propose the following recommendations:

- Given the link between custodial contact and its potential as both a risk and escalating factor, the assessing team should request and share information regarding forensic history from the police. This information may be vital in initiating a multi-agency risk evaluation.
- There are common and consistent risk factors which emerge from our local suicide audits and

these should be reinforced during staff risk formulation training.
- Long-term health conditioners were identified as a prevalent characteristic of patient suicide. Proactive sharing of information with pain management and primary care teams and a two-way communication process is crucial.
- Given that the case-file review and SUI analysis both highlighted communication, documentation and assessment of risk as areas for improvement. It is imperative that all staff members regularly attend training with regards to assessment and documentation of risk and that the importance of communication within teams and with other organisations is reinforced.
- We also recommend that the Trust consider a move towards an electronic recording system and phase out hand-written case notes which can be difficult to decipher and can become unordered.

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EVALUATION/QUALITY
A Case Controlled Study Investigating the Short-term Effectiveness of a Supervised Exercise and Education Programme for Non-Specific Low Back Pain (NSLBP)

Iain Hedley Quinn & David M. Webster

Abstract

Non-Specific Low Back Pain (NSLBP) is a highly prevalent musculoskeletal disorder. Evidence based management guidelines have been published by the National Institute of Clinical Excellence (NICE 2009) for NSLBP. A case controlled study was completed to establish the effectiveness of a supervised group exercise and education programme in patients with NSLBP based on these guidelines. The results demonstrated a significant short-term impact of the six session intervention. Further research is required to determine the long-term effectiveness of this intervention for NSLBP.

Keywords

non-specific low back pain; back to fitness; back pain; exercise; education; Roland-Morris disability questionnaire

Introduction

Low back pain is a common disorder, affecting around one third of the United Kingdom adult population each year (National Institute of Clinical Excellence [NICE], 2009). As a result, around 20% of people with low back pain will consult their General Practitioner (GP) (Macfarlane et al., 2006). NSLBP is a highly prevalent clinical presentation identified through the assessment process in our Musculoskeletal Physiotherapy Outpatient Department in the Furness locality of Cumbria (Barrow-in-Furness, Dalton-in-Furness, Askam-in-Furness and Kirkby-in-Furness). NSLBP describes symptoms in the area between the 12th rib and buttock crease caused by no specific pathology (NICE, 2009). It is classified as lasting for more than six weeks but less than 12 months (NICE, 2009). Appropriate management has the potential to reduce the number of people with NSLBP and thus reduce its personal, social and economic impact (Maniadakis & Gray, 2000). It was decided to review the treatment options of care provided for NSLBP in accordance with the NICE (2009) guidelines.

NICE set the standards of high quality healthcare. The current NSLBP guidelines released by NICE (2009) advocate exercise and education as primary options for treatment. Therefore, the purpose of this study was to establish the effectiveness of a supervised group exercise and education programme in the management of NSLBP.

Methods

A case controlled study was completed from 1 October 2012 to 30 April 2013.

Patients

Specialist musculoskeletal physiotherapists assessed patients seeking treatment for low back pain referred by GPs. Patients with NSLBP should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals (NICE, 2009). Accordingly, informed consent was obtained from each patient.

To be eligible for inclusion, patients had to be 16 years old or over, present with a diagnosis or acute episode of NSLBP and be able to attend up to six exercise group sessions. A diagnosis of NSLBP was defined as pain in the area between the 12th rib and buttock crease without leg pain. Patients were excluded if they had any of the following: nerve root compromise; 'red flags' for serious spinal pathology (for example, infection, fracture); spinal surgery in the past six months; pregnancy; severe cardiovascular or metabolic disease; or the inability to read and understand English. In addition, patients with significant psychosocial factors were also excluded due to the potential necessity of other intervention techniques. Significant psychosocial factors were assessed using The Distress and Risk Method (DRAM) (Main et al., 1992) with specific reference to threshold scores for somatic pain and depression. Excluded patients were subsequently seen individually in the musculoskeletal physiotherapy outpatients department.

Intervention

During the intervention patients were asked not to seek treatment for their NSLBP other than that provided in the case controlled series. However, patients on a course of analgesia or Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) were advised to continue with the use of this medication.

Treatment was provided by two practitioners, one specialist musculoskeletal physiotherapist and one exercise therapist in a gym environment. The supervised group exercise programme consisted of up to 10 patients attending on a weekly basis. A 10-minute warm-up was undertaken prior to an exercise circuit consisting of aerobic exercise, range of movement exercises and stretching exercises. Each patient completed the exercise circuit under the instruction of the physiotherapists. A total of 10 stations with exercises of three levels of difficulty were available. Each exercise in the circuit was of two minutes in duration. Patients were able to progress in each exercise every week as they felt able. A 10-minute cool-down followed the exercise circuit; this consisted of aerobic exercise, range of movement exercises and stretching exercises. In addition to the scheduled treatment sessions, patients were encouraged to perform prescribed exercises at home and to follow postural education and pain management advice.

An education session was integrated after the supervised group exercise programme. This consisted of weekly physiotherapist led discussion sessions regarding lumbar spine anatomy, pain management techniques, manual handling and ergonomics, and exercise guidance.

Measures

Roland-Morris Disability Questionnaire (RMDQ) is a health status measure designed to be completed by patients to assess physical disability due to low back pain (Roland & Morris, 1983). Patients completing the RMDQ are asked to tick a statement if it applies to them that day. This approach was chosen to make it suitable for following short-term changes in low back pain.

The RMDQ has good psychometric properties as evidenced by internal consistency (Crohnbach's alpha coefficient: 0.93 [Hsieh, Phillips, Adams & Pope 1992], 0.90 [Kopec & Esdaile, 1995] and 0.84 [Jarvikoski, Mellin & Estlander 1995]) and responsiveness (Jordan, Dunn, Lewis & Croft 2006). An important element of a questionnaire's responsiveness is the smallest effect that is clinically significant. Jordon et al. (2006) suggest that the smallest change likely to be clinically significant is 30% with the RMDQ.

The RMDQ was completed individually with each patient pre and post intervention. The physiotherapists were not blinded to the RMDQ during the assessment procedure.

Results

From 1 October 2012 to 30 April 2013, 26 patients were included in the study. Twenty-three completed the study.

Table 1 demonstrates the RMDQ scores. Twenty-three patients completed the class; the mean average number of sessions was five (range 3-6). The mean average RMDQ pre- intervention score was eight (range 3-18), mean average RMDQ post-intervention score was three (range 0-10), and the mean average RMDQ difference pre-post intervention was clinically significant (a RMDQ score of 5).

A clinically significant difference incorporates the measurement error of the RMDQ, and allows patients with different grades of severity to improve: 30% = clinically significant improvement (Jordan et al., 2006). Twenty-two patients showed clinically significant improvements in pain and disability with a mean average of 63% (range 0-100%).

Discussion

NICE Guidelines (NICE, 2009) highlight the necessity to self-manage persistent NSLBP. The purpose of this case controlled study was to establish the effectiveness of a supervised group exercise and

education programme in the management of NSLBP. The RMDQ was used to evaluate changes in pain and disability. The results demonstrate that a supervised group exercise and education programme is an effective intervention in management of NSLBP. Furthermore, significant improvements in pain and disability were achieved in up to six supervised sessions. The exercise programme has demonstrated clinical effectiveness. This can provide clinical assistance in regards to future exercise prescription for NSLBP. The management of NSLBP can be further complemented with an educational component. This may consist of lumbar spine anatomy, pain management techniques, manual handling and ergonomics, and exercise guidance.

Anomalies were identified in the results of the case controlled study. Three patients failed to complete the supervised group exercise. Initial RMDQ scores (3, 8 and 19) between the three patients indicated no correlation with pain and disability. No reason for non-attendance was established. One patient had no improvement in their RMDQ but reported a self-perceived improvement of 70% using a secondary outcome (Burgio, Goode, Richter, Locher & Roth 2006). This was attributed to psychosocial factors identified using the DRAM (Main et al., 1992) but they have been included in the results to demonstrate clinical reality in the case controlled study.

The case controlled study is predisposed to selection bias which limits the confidence in the results. Patients within our geographical locality had to travel and be available at a specific location and time to access the supervised group exercise programme. The therapist knowledge of treatment implemented can also influence the patient selection and management of patients. Blinding of the patients and physiotherapists did not occur in the assessment procedure which could potentially yield larger treatment effects. As a result, the methodology and thus the internal validity of the study, is not without potential bias. This should be acknowledged in the interpretation of the results and application to other patient groups.

Improved understanding of low back pain and its management are identified as key components of care by both patients and healthcare professionals. The case controlled study supports the current NICE Guidelines which advocate the frontline management of NSLBP with exercise and education. Detailed exercises and patient education have been integrated into a supervised group exercise and education programme which is effective in the management of NSLBP.

Patient	RMDQ Score Pre- Intervention	RMDQ Score Post- Intervention	RMDQ Difference	RMDQ Change (%)
1	6	3	3	50
2	9	4	5	56
3	8	2	6	75
4	6	4	2	33
5	12	12	0	0
6	5	1	4	80
7	9	3	6	67
8	14	4	10	71
9	3	0	3	100
10	6	4	2	33
11	6	0	6	100
12	3	2	1	33
13	6	1	5	83
14	7	3	4	57
15	3	2	1	33
16	10	0	10	100
17	11	2	9	82
18	10	2	8	80
19	18	9	9	50
20	6	0	6	100
21	16	10	6	38
22	11	3	8	73
23	4	2	2	50

Table 1: RMDQ scores pre- and post-intervention with RMDQ difference and percentage change

However, further research is required to determine the long-term effectiveness of a supervised exercise and education programme for NSLBP. Moreover, the written component to patient education was not investigated in the case controlled study and future studies would clarify the potential effectiveness of this adjunct.

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From research to practice: Adapting low intensity (LI) interventions for individuals with common mental health problems and a co-morbid physical health long-term condition (LTC)

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Abstract
People with a long term physical health condition (LTC) are two to three times more likely to experience a common mental health problem such as anxiety or depression. This pilot study investigated a collaborative care approach to delivering a low intensity psychological intervention to this population. Six Psychological Wellbeing Practitioners (PWP) received referrals for 161 people, of whom 81 people engaged in between two to seven sessions of guided self-help and achieved a recovery rate of 59%. A case study is presented to illustrate how the collaborative approach worked in practice. The study demonstrated that low intensity psychological intervention with additional practitioner training can be effective with this population.

Introduction

Long Term Conditions (LTCs) such as diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease (CHD) are the leading cause of death and disability throughout the world (WHO, 2005). Currently in England, over one third of the population are living with at least one LTC and with the ageing population these statistics are expected to increase (Department of Health, 2008a). Individuals in this significant proportion of England's population are often frequent and intensive users of health services, accounting for 52% of all GP appointments, 65% of all outpatient appointments and 72% of inpatient bed days; thereby generating a significant challenge for health services (Department of Health, 2008b). Effective self-management of an LTC is crucial to the achievement of a healthy and satisfying life and may require the patient to accept the illness; adjust their expectations and change their behaviour (e.g. adhere to treatment regimes, attend medical appointments) (National Health Service Confederation, 2012).

According to the Department of Health (2005), around 70-80% of people with LTCs can be supported to self-manage their condition. However, people with long-term physical health conditions will often have additional psychological needs resulting from the burden of illness-related symptoms and associated disability (NHS Confederation, 2012). Consequently, the prevalence of anxiety and depression is disproportionately higher for those living with an LTC, two to three times higher than in the healthy population (NICE, 2009a). Co-morbid LTCs and common mental health disorders are also associated with higher use of healthcare resources, unnecessary investigations, and increased admissions with longer lengths of stay, and wider costs of sickness absence and lack of employment (NHS Confederation, 2012). Naylor, Parsonage, McDaid, Knapp, Fossey & Galea (2012) calculated that at least £1 in every £8 of NHS spending on LTCs is attributable to the consequences of co-morbid mental health problems alongside LTCs.

The interactions between LTCs and mental health are well documented (Lustman & Clouse 2005, Wroe, Rennie, Gibbon, Hassy & Chapman, 2014), however, many individuals do not receive care that addresses both their physical and psychological needs (NICE, 2009a). There is a growing body of economic evidence to support investment in clinical services which address this co-morbidity (NICE, 2009b, Wroe et al, 2014).

Collaborative care typically involves a multi-professional approach to care, structured management plans, scheduled follow-ups, and enhanced inter-professional communication (Katon et al., 1996). There is a growing body of evidence which demonstrates the efficacy of collaborative care over standard care in the treatment of depression. One of the largest treatment trials for depression in the USA demonstrated that at 12 months about half of the patients receiving a collaborative care approach to the treatment of their depression reported at least a 50% reduction in depressive symptoms, compared with only 19% of those in usual care (Unutzer et al., 2002). Furthermore, the benefits of this intervention persisted one year after the intervention had been completed (Hunkeler et al., 2006). Moreover, in a recent randomised control trial (Katon et al., 2010) a collaborative care intervention demonstrated improved outcomes for both depression and the LTC.

The pilot study reported on in this paper proposes that a collaborative care approach could be implemented within primary care for people with long term conditions and co-morbid common mental health problems. It also proposes that, with some additional practitioner training, outcomes on standard measures for depression and anxiety for this client group would be achieved that were comparable to outcomes across the general population who engage with a low intensity psychological interventions.

The Intervention

Thirteen GP practices signed up to the pilot (serving 81,000 people across both urban and rural areas). Low-intensity psychological interventions were delivered by Psychological Wellbeing Practitioners (PWPs). PWPs are trained to identify and assess common mental health disorders, then devise shared treatment plans with patients. The main focus of the treatment is on supporting the patients to work through self-help material based on cognitive behavioural therapy (CBT) to overcome their problems and achieve their goals (IAPT, 2010). This approach is known as 'guided self-help' (GSH), which research evidence has suggested is more effective than the provision of information alone (Gellatly, Bower, Hennessy, Richards, Gilbody & Lovell, 2007).

The six PWPs recruited attended five additional days of training covering the background and principles of collaborative care, condition-specific information, adaptation of low intensity PWP approaches to this patient group, and use of LTC-specific self-help materials. It was decided that in contrast to the Katon et al., (2010) trial the PWPs would not act as case managers as this was viewed as unsustainable in their standard role. Several of the PWP supervisors also attended one day of this training and an additional Practice Nurse training day. This day included explanation of the aims of the pilot study, an understanding of the role of PWPs and detail on how to identify appropriate referrals for the pilot.

PWPs were assigned to two or three practices. Referrals were accepted from pilot practice Nurses and GPs, and an initial patient discussion between referrer and PWP were encouraged to ensure that
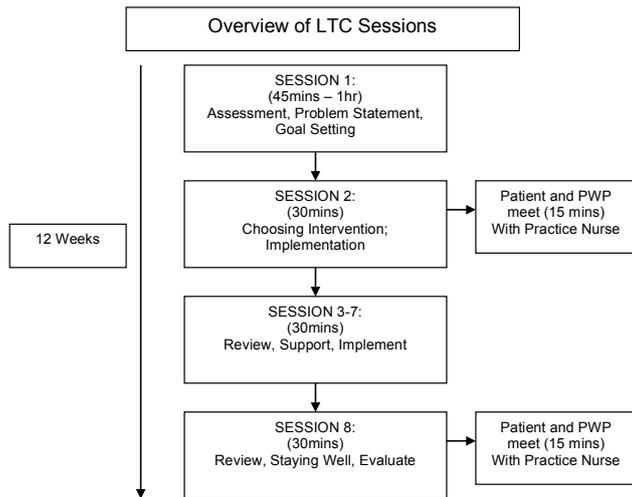
Overview of LTC Sessions

SESSION 1:
(45mins – 1hr)
Assessment, Problem Statement,
Goal Setting

SESSION 2:
(30mins)
Choosing Intervention;
Implementation

Patient and PWP
meet (15 mins)
With Practice Nurse

12 Weeks

SESSION 3-7:
(30mins)
Review, Support, Implement

SESSION 8:
(30mins)
Review, Staying Well, Evaluate

Patient and PWP
meet (15 mins)
With Practice Nurse

Figure 1: Pilot protocol for LI collaborative care

referrals were appropriate for the pilot and to start the collaborative process. Practice Nurses and PWPs explained the pilot nature of the project and consent for treatment was gained from each patient. Ethical approval for the pilot was not required as this was an evaluation of a service development rather than research. The LTC pilot training included the use of a protocol for collaborative practice whereby the Practice Nurse would join the PWP and patient as part of their second session to help with goal planning and then again in the final session as part of a review and planning for ongoing care (Figure 1).

The PWPs received one hour clinical case management supervision per week and two hours of monthly skills-based group supervision as is standard with PWPs. Supervisors had no specific experience or knowledge of working with LTCs other than having attended the training days. Supervision was augmented with an additional one hour a month for operational planning and 'troubleshooting'.

The PWPs used a range of CBT-based self-help materials for depression and anxiety disorder. A self-help manual specifically written for people with diabetes or heart disease who also had depression (Greater Manchester Collaboration for Leadership in Applied Health Research and Care (CLAHRC), 2011) was expanded by the CLAHRC team to include COPD and to include interventions for anxiety. This manual included example case stories and interventions such as behavioural activation, graded exposure and problem solving.

The age range of the 161 patients referred was from 21 to 88 (median age 63, mean age 61); 89 were female, 72 male. Of the 161, 9 patients who failed to engage did not have a LTC recorded, of the

rest 108 had diabetes, 40 had CHD and 26 had COPD. 20 had two LTCs and one had three.

Measures
The study used standard IAPT outcome measures at every session e.g. PHQ-9 for depression (Spitzer, Kroenke and Williams, 1999) and GAD-7 as a proxy for anxiety (Spitzer, Kroenke, Williams, and Lowe, 2006). Although the PWPs were encouraged to discuss physical health markers with patients and with Practice Nurses these were not routinely recorded for the purposes of this pilot

A follow up day for PWPs, supervisors and Practice Nurses was held to review progress of the pilot and give an opportunity to gather feedback and problem solve any difficulties.

Results

Overall Findings
The flow of patients through the pilot is illustrated in Figure 2. A total of 161 patients were referred into the pilot with 81 attending at least two treatment sessions. Two deemed inappropriate for low intensity interventions at assessment, were referred on and a further 12 entered treatment in the pilot but were subsequently stepped up to high intensity CBT or secondary care. Twenty-seven patients only attended the initial session and either declined or disengaged from treatment.
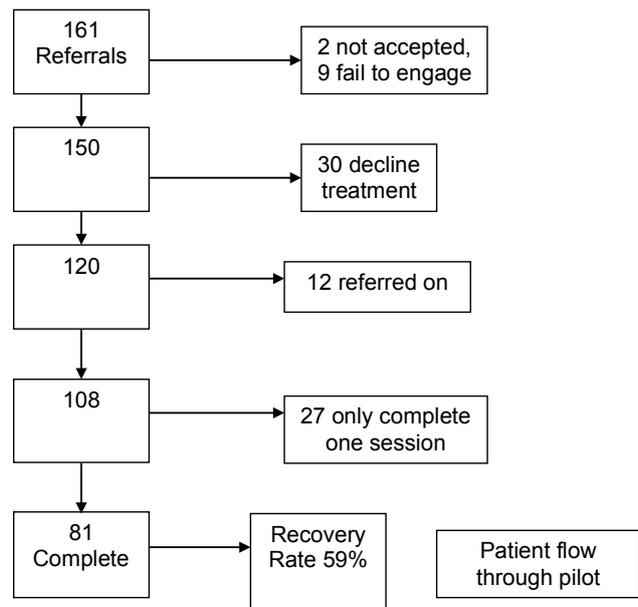
161
Referrals

2 not accepted,
9 fail to engage

150

30 decline
treatment

120

12 referred on

108

27 only complete
one session

81
Complete

Recovery
Rate 59%

Patient flow
through pilot

Figure 2: Flow of patients through the pilot

1 At this time, recovery was defined within IAPT services when a patient enters treatment above 'caseness' on either the PHQ-9 or GAD-7 and leaves treatment after at least two treatment sessions with both final measures below 'caseness'. Caseness is defined as scoring ten or above on the PHQ-9 and eight or above on the GAD-7. A recovery rate is calculated as those who achieve recovery as a percentage of the total entering treatment above caseness (IAPT, 2012).

Table 1: Means and standard deviations for first and final measures

	PHQ-9: mean and standard deviation (n=81)	**GAD-7** mean and standard deviation (n=81)
First measure	12.3 (SD = 5.9)	9.05 (SD = 5.1)
Final measure	6.6 (SD = 5.5)	4.88 (SD = 5.1)

Among the 81 patients treated within the pilot the recovery rate was 59% (n=36)[1]. The pre and post-treatment data for this group are shown in table 1. The paired t-test analysis of first and last scores on both PHQ-9 and GAD-7 for these 81 patients derived a p-value in each case of less than 0.0001. This would indicate that the reduction in scores for depression and anxiety was clearly statistically significant. This figure (n = 81) includes patients who disengaged during therapy but excludes those who were stepped up. Twenty-one patients entered therapy below caseness and so were not included in the recovery calculation but were included in the p value calculation.

A Case Study
As in routine clinical practice, not all of these cases led to fully successful outcomes. Here we include an anonymised illustrative case study from the pilot to illustrate the interventions used, problems encountered and lessons learned.

Background and Diagnoses
Joan (64 years) was retired. Two years earlier she had a Myocardial Infarction (MI), was diagnosed with CHD and had subsequently been encouraged by family members to reduce her activity level. In the same year she found that she was becoming breathless when walking and was diagnosed with COPD. This compounded her decreased engagement in both personal and social activity. Family members moving away from the local area had further reduced positive aspects of Joan's daily routine and constituted the final trigger for the onset of symptoms of depression, for which she was prescribed antidepressant medication. Her Practice Nurse referred her into the LTC pilot requesting treatment for depression but assessment revealed this to be a secondary problem to anxiety.

Severity of anxiety and depression was measured; GAD-7 scored 14/27 and PHQ-9 scored 24/27, indicating moderate anxiety and severe depression. Joan's difficulties were characterised by worry over her family and being asked about her family if she ventured out into public. Her worries about negative outcomes of being in public became more generalised and she began to fear experiencing the emotional and physical symptoms of anxiety. In turn, Joan was avoiding such situations and had become low in mood.

Interventions
At the beginning of Joan's eight sessions she set the goals of increasing her activity level and speaking to people more. The referring Practice Nurse, Joan and her PWP were not able to meet altogether at the start but her Nurse suggested to her PWP the additional goal of increasing the amount of walking Joan was doing. She was amenable to this but less so to the suggestion of achieving it by attending a pulmonary rehabilitation course due to concerns about the anxiety she might experience in a group setting.

Joan and her PWP summarised their shared understanding of her difficulties through the creation of a problem statement. Following this, via psychological education they explored the maintenance role of avoidance behaviour. This led to a rationale for Joan experimenting with situations she was fearful of in order to see whether the negative predictions she made were accurate. Through such experimentation Joan then began to reduce avoidance; starting to go shopping to the supermarket again then progressing to joining a local quiz team. She learned that she could do these things without the perceived assistance of safety behaviours such as avoiding making eye contact. She also learned that feeling anxious did not signify that something very bad would happen to her.

Figure 3: Sessional outcome data for patient with heart disease, COPD and anxiety
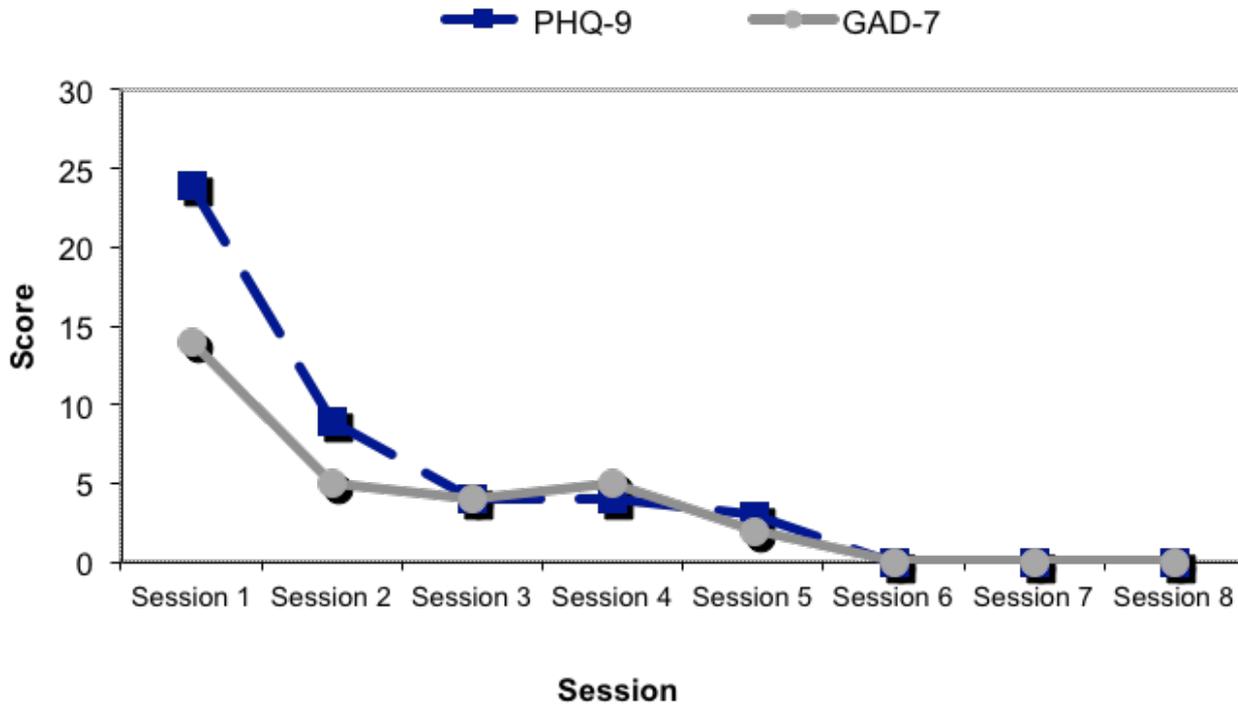
Whilst guided self-help interventions would typically draw on self-help materials to support learning, Joan's inclination was not to read or use these and her PWP accepted this choice. Her Practice Nurse joined Joan's final session when her problem statement, goals and progress were reviewed. Joan had increased her activity level, which included spending time walking. She was also talking more to other people. The intervention was concluded with discussion around maintaining progress.

Outcomes
Anxiety and depression severity measures (GAD-7 scored 0/21 and PHQ-9 scored 0/27), were consistent with the absence of symptoms of either problem. In addition to this Joan's Practice Nurse had carried out a spirometry test, which showed an improvement in her lung capacity. Figure 3 shows the pattern of GAD-7 and PHQ-9 scores over the course of Joan's treatment.

Reflections on Case Study
In this example, as in many others it became evident that a Practice Nurse's knowledge and use of screening measures for anxiety and depression was beneficial. Their use of them helped aid identification of patients suitable for the pilot and outline specific symptoms in referral discussions.

A second crucial learning point came from the types of referrals received. Many patients presented with more than one LTC and it was common for them to be experiencing difficult social and financial circumstances. However, exploring the presenting

clinical problem using the Five Areas Model (Richards and Whyte, 2011) enabled practitioner and patient to agree a focus to sessions and develop realistic goals, irrespective of the complex presentation.

Discussion
This paper has presented outcome data from a project that has implemented Low Intensity interventions for people with Long-Term Conditions through an IAPT service. The recovery rate achieved of 59% compares favourably with the recovery rate of all low intensity interventions within the host IAPT service which was 54% (n = 5604) for the same time period as the pilot

In this pilot 56% of patients who were referred actually entered treatment (defined as attending at least two treatment sessions). This compares with a national figure for IAPT services of 60% (Department of Health, 2012). This is perhaps understandable given the potential difficulties engaging people with LTCs in psychological therapy. Further research into lack of engagement with this client group would be beneficial.

In working in this pilot project, the PWPs found that the first thing LTC patients may have to accept is that their life will continue to be significantly affected by the LTC. The PWPs also found that they needed to socialise patients to the collaborative way of working that is integral in the guided self-help approach.

Setbacks and short-term hospitalisations in this patient group were common. Supervision particularly addressed the management of non-attendance: achieving the fine balance between accommodation

for the management of an LTC and deciding when a patient is not benefitting from therapy due to irregular attendance. The PWPs particularly emphasised offering telephone appointments to patients when they were finding it difficult to attend an appointment but were well enough to engage in a therapy session, e.g. cold weather for somebody with COPD. They also offered every opportunity to discuss difficulties in attending by making multiple attempts to contact patients by telephone. The knowledge that this client group may have difficulties attending sessions could lead to a more proactive, collaborative and problem solving management of this, and perhaps this could be better addressed as one of the tasks of contracting at the start of treatment.

The pilot required that practices involved offered a room for PWP LTC clinics, ideally located near to the Practice Nurse's clinic room and on the same days they were working. PWPs working in practices that were not able to offer these conditions found it much more difficult to establish a working relationship with their Practice Nurse(s). However, even in cases where all three parties, i.e. the patient, Practice Nurse and PWP were willing, sometimes it was simply not possible for the collaborative team meeting to take place at the times recommended by the model. Being flexible in the timing of the first team meeting worked well for responding to patient readiness for treatment, however this could delay goal setting.

Where the first team meeting could not take place, the PWPs adapted the model by liaising with Practice Nurses between sessions. This is less ideal because it moves away from the philosophy of collaborative care working. Such working is closer to the ethos of collaborative care but may be less efficient.

This paper illustrates how collaborative care can potentially be implemented within an IAPT service. It highlights the differences physical and mental healthcare professionals may take in their approaches to delivering care and where these differences can be met through enhanced inter-professional communication to augment care.

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REVIEW
Exercising during dialysis: A reflection on environmental barriers

Leighan Meddick

Abstract
Research has demonstrated that exercise provides several physical and psychological benefits for hemodialysis patients, which include increasing their quality of life. However, implementing intra-dialytic exercise into the patients' care schemes often proves to be a difficult task for dialysis providers, and they often run into barriers. Some of the environmental barriers that are often experienced are discussed herein, in order to raise awareness and provide recommendations which may result in the process of exercise integration running more effectively.

Keywords
barriers; hemodialysis; intra-dialytic exercise; kidney disease; physical functioning; quality of life

Introduction
Patients with end-stage renal disease (ESRD) are placed on dialysis when kidney function is reduced by approximately 85-90% of normal function, and as a result of the disease, their life expectancy is reduced considerably (NHS, 2013). There are estimated to be beyond 60,000 ESRD patients receiving hemodialysis treatment in the UK, with typically 5,000-10,000 new patients beginning treatment annually (Gilg, Pruthi and Fogarty, 2015).

NHS Kidney Care reported that the cost of incorporating dialysis treatment and kidney transplantation for ESRD costs the NHS in England £1.4 billion per year, more than the combined cost of £1.37 billion that is spent on breast, lung, colon and skin cancer (HMRC, 2011). The ideal situation

for both the NHS and its patients is one in which the patients are eventually able to receive a kidney transplant so they no longer have to dialyse. This would assist in both reducing financial strain and increasing quality of life for the patients.

However, a primary issue with ESRD patients is weight gain. ESRD patients typically dialyse three to four times per week, and spend approximately 4 hours in dialysis each session. Following dialysis sessions, patients report feeling fatigued, with this feeling continuing the following day. As a result, exercise is not usually undertaken (Fiaccadori, Sabatino, Schito, Angella, Malagoli, Tucci, Cupist, Capitanini & Regolisti, 2014). This results in weight gain, which jeopardises chances of receiving a transplant, as a BMI of <35 is needed to be considered for the operation (Johansen, 2005; Howden, Fasett, Isbel & Coombes, 2012).

With research highlighting the beneficial effects of exercise in ESRD patients (Martin and Gaffney, 2003; Goodman and Ballou, 2004; Cheema & Singh, 2005; Ouzouni, Kouidi, Grekas & Deligiannis, 2008; Bennett, Breugelmans, Barnard, Agius, Chan, Fraser, McNeill & Potter, 2010; Howden, et al., 2012; Mohseni, Zeydi, Ilali, Adib-Hajbaghery & Makhlough, 2013), and revealing that the poor physical functioning experienced by those on dialysis is potentially addressable through exercise, the idea of intra-dialytic exercise has become more popular. However, there are few Renal Units who have adopted exercise as a form of rehabilitation for the patients; something that has yet to be implemented as standard procedure in ESRD patients' care schemes, although exercise has been included as a recommendation in the UK Renal Association clinical practice guidelines (MacGregor and Taal, 2011).

Unfortunately, medical staff on units implementing intra-dialytic exercise typically run into barriers that restrict them (Bennett, et al., 2010), and most units lack staff qualified in exercise prescription. A solution is the attendance of an exercise professional. The attendance of an exercise professional has been found to maximise patient uptake and adherence to exercise routines (Torkington, MacRae and Isles, 2006). However, not all barriers disappear as a result, and the present study describes core barriers that are faced when attempting to implement intra-dialytic exercise.

Objectives and Rationale

The primary objective as an exercise professional is to get ESRD patients as active as possible, as physical inactivity is a strong predictor of mortality in this population (Goodman and Ballou, 2004; Delgado and Johansen, 2012). The benefits of exercise for ESRD patients have been demonstrated in many studies; with regards to increasing physical functioning, improving psychological state, and consequently increasing quality of life (Martin and Gaffney, 2003; Goodman and Ballou, 2004; Cheema, Singh, Charles, Smith & Singh, 2005; Ouzouni, et al., 2008; Bennett, et al., 2010; Howden, et al., 2012; Mohseni, et al., 2013).

Physical functioning and psychological state can be measured by the Kidney Disease Quality of life (KDQOL-SF™ 1.3) questionnaire (Hays, Kallich, Mapes, Coons, Amin, Carter & Kamberg, 1997). Monitoring these aspects is of importance in order to measure improvements over time (Ouzouni, et al., 2008; Bennett, et al., 2010; Howden, et al., 2012). Alongside this, there is limited research examining the effects of exercise intervention on ESRD patients, especially with regards to resistance training. Within the literature, four out of six studies examining resistance training as an intervention showed improvements in exercise capacity. However, it is currently unclear whether they are substantial enough to be of clinical relevance (Howden, et al., 2012), or indeed transferrable to real life. As a result, there is insufficient research to come to a clear conclusion as to how much resistance training and aerobic training interventions increases physical function and exercise capacity in ESRD patients (e.g. walking capacity, or stair climbing ability) (Orcy, Dias, Seus, Barcellos & Bohlke, 2012). Exploring these methods, and measuring the results, is of importance in order to establish potential benefits.

One of the major aims in a number of patients is reducing BMI so they are eligible for the transplant list. One study has suggested that a higher BMI is associated with improved survival rates in ESRD patients (Kalantar-Zedah, Block, Humphreys & Kopple, 2003). However, this association was formed from reverse epidemiology, which cannot prove cause-and-effect, and reverse causation epidemiology is a known source of bias in epidemiological studies that attempt association without direction of a causal pathway (McLeod and Smith, 2003). The patients themselves know lowering their BMI is necessary to be suitable for transplant; therefore reducing BMI also has a high chance of improving psychological stage, alongside physical functioning in those who are obese.

Finally, restrictions to exercise participation must be examined. Despite proposed guidelines that all dialysis patients should be counselled and regularly encouraged by dialysis staff to increase their level of physical activity (K/DOQI, 2005), the number of ESRD patients who undertake exercise programmes is low, and the compliance rates remain poor (Konstantinidou, Koukouvou, Kouidi, Deligiannia & Tourkantonis, 2002; Cheema, et al., 2005; Ouziuni, et al., 2009; Bohm, Ho and Duhamel, 2010).

Barriers to exercise in ESRD

Many dialysis providers struggle to incorporate exercise into routine treatment for their patients

(Cheema and Singh, 2005; Johansen, 2007; Bennett, et al., 2010; Delgado and Johansen, 2012). The primary environmental barriers, both in the literature and from experience, are listed below.

Medical Staff commitment

The two most important requirements to ensure exercise programmes remain sustained for dialysis patients are 1) Exercise professionals must be present, 2) Both dialysis and medical staff on the ward must be committed to exercise promotion (Bennett, et al, 2010).

Often, there can be disconnect between the nursing staff and the implementation of exercise, and it restricts the implementation of exercise onto the ward, even with an exercise specialist present. With few nurses on the ward committed to the project, if an external exercise facilitator is not present to bring patients the equipment, the majority are unable to exercise. One could argue the nurses may not have the skill-set to set up the bikes. This was found to be a problem in previous research (Painter, Carlson, Carey, Myll & Paul, 2004), but from experience, knowledge of how to set up the equipment does not necessarily lead to it being used.

The issue of staff commitment appears multifactorial. Patients often mentioned 'feeling like a burden' and would avoid asking the nurses for bikes when they appeared busy. Without the patients reminding them, they likely focus on their other workloads. Another issue is related to a lack of education for the nursing staff with regards to the benefits of exercise in ESRD patients. Unfortunately, even when presented with numerous reasons why exercise should be promoted, nurses still often lack the motivation to support exercise projects (Bennett, et al., 2010). As nurses are not qualified in exercise prescription, some were cautious of promoting exercise because they were unsure of its safety, especially in elderly patients. However, a doctor is required to sign an exercise consent form for each patient, so this is no longer an issue. Alongside this, age is no barrier to exercise on hemodialysis (Bennett, et al., 2010), and one of the most successful exercisers on the ward attended by the author is aged >80. Reported in the literature, the older the patient, the higher the compliance rate (Bennett, et al., 2010).

Knowledge of the theory does not always encourage practice when it comes to the nursing staff. Those that assist do not necessarily know why exercise is being introduced; they assist simply because the patient may ask and because they know it is a project on the ward. In some cases it may be necessary for individuals to know the theory in order to make them feel it is worthwhile. An unfortunate reality is that dialysis nurses still view exercise to be a low priority in their workload (Cheema and Singh, 2005). Due to a lack of policy regarding exercise on dialysis, nurses may feel that it is indeed below other jobs in terms of priority.

With maximised uptake and adherence to exercise as a result of the attendance of an exercise specialist to dialysis units, there are potential benefits for both the patients and the NHS. Alongside the increased benefits to be had by the patients, which include the ability to receive a transplant and therefore increase quality of life, the cost to the NHS regarding dialysis will also be lowered. It could be argued that the salary of a full-time exercise specialist would 'pay for itself' with the potential savings to be had by their attendance. Incorporating dialysis treatment and kidney transplantation for ESRD patients costs the NHS in England more than £1.4 billion per year, more than the combined cost of £1.37 billion that is spent on breast, lung, colon and skin cancer (HMRC, 2011). With more patients receiving transplants, the cost to the NHS for long-term dialysis would be lowered.

Unit Guidelines and Policies

Exercise intervention in Renal Units remains a developing area, with few hospitals having guidelines or policies in place regarding exercise. This means nursing staff are unaware of what exercise protocol to follow if a patient wants to exercise when no specialist is present. If these guidelines were to be implemented, it would allow nurses to feel confident guiding the patients without the presence of an exercise specialist.

Exercise Promotion

Promoting exercise on dialysis wards is often a difficult endeavour (Heiwe and Tollin, 2012; Fiaccaddori, et al., 2014), but what has been learnt from experience is that it should not be assumed the language on any promotional documents is simple enough for each patient to understand. This may not be the case, and a better idea would be for the exercise specialist to talk through the documentation with each patient individually. Addressing each patient individually is more likely to result in the patient taking notice of the information that is provided to them.

Exercise Protocol

Forgeron and Valeriote (2001) found that an important requirement for sustainable intra-dialytic exercise programmes is that they need to be interesting and stimulating. However, while the patients had a television to watch while cycling, the cycling itself was a basic routine. Had it been developed so it was more stimulating, perhaps the compliance rates would have increased. Unfortunately, however, there is little variation to be

had with bikes, so perhaps other methods of exercise need to be considered. In the future, more emphasis needs to be placed on developing suitable resistance training programmes.

Patient Motivation

Unfortunately, the biggest barrier of all is that the majority of patients are either uninterested in taking part in exercise routines, or will only do so when the exercise specialist is there. Patients often express the need to have someone to talk to while cycling, and having this request granted often increases patients' acceptance of the exercise routines (Heiwe and Tollin, 2012). This is something the nurses cannot provide as well as a dedicated exercise specialist because they will often have many other jobs to complete. However, the patients, in most cases, will still only begin and comply with exercise routines when the doctor prescribes it. They then start to feel that it is compulsory, and without doctor recommendation, exercise compliance is low. Ideally, if the doctor is responsible for introducing ESRD patients to the concept of exercise, then the NHS is in the position of being responsible for informing the doctors nationwide of the importance of exercise in ESRD patients, and raising the awareness.

Until support comes from those who are in the best position for encouraging sustained activity for the patients, exercise will struggle to be implemented. Doctor recommendations could perhaps turn out to be one of the most effective exercise promotion methods.

Exercise Specialist Attendance

Related to the exercise specialist role itself, Ridley, Hoey & Ballagh-Howes, (1999) recommend that, in order to promote a positive impression on the wards, exercise specialists should be present at least two times per week per patient group. This was not the case in our scenario, with each patient group only being visited once per week. A solution to this would be either a full-time role, or recruiting two students at a time, with both visiting twice a week or more. Based on previous findings, it could provide better results regarding patient adherence than once per week visits (Bennett, et al., 2010), and increased contact time would likely result in increased exercise acceptance because the patients have longer contact time with the students (Heiwe and Tollin, 2012).

Conclusions and Recommendations

The most important requirements to ensure exercise programmes remain sustained for dialysis patients are that exercise professionals must be present, and medical staff on the ward must be committed to exercise promotion (Bennett, et al, 2010). Unfortunately, getting full support from the medical staff can prove challenging as dialysis nurses still view exercise to be a low priority in their workload (Cheema and Singh, 2005). In addition, the patients, in most cases, will only adhere to exercise routines when the doctor prescribes it to them, and when they have someone to talk to while cycling (Heiwe and Tollin, 2012).

If doctors begin to promote exercise to patients, interest in exercise will likely increase. In addition, if nurses understand that patients often shy away from asking them because they do not want to bother them, it may encourage them to approach the patients. If the nurses have any doubts about equipment, they should interact with the exercise specialist in order to become competent.

Instead of handing out promotion articles, the exercise specialist should sit down and talk the patients through them. All of the nursing staff should be provided with the same information in order to increase their theoretical knowledge; hopefully leading on to them understanding why supporting exercise adherence is so crucial. Providing the nurses with the exercise guidelines which were completed during the placement would provide them with the information they need to oversee sessions themselves.

Finally, exercise specialists should be present at least twice a week per patient group in order to promote increased contact time and have a bigger impression upon staff. This is likely to result in increased exercise acceptance and compliance rates among the patients and staff (Heiwe and Tollin, 2012; Bennett, et al., 2010).

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TRAINING
Developing medical professionalism for psychiatry trainees in the North West: A survey of trainee understanding

Adam Joiner & Sam Dearman

Introduction

The terms 'medical professionalism' and 'professionalism' are used interchangeably in the literature and definitions vary (Epstein & Hundert, 2002). However, the authors of this article would suggest that professionalism as a concept is best understood as a competence, involving a complex interaction between knowledge, skills and attitudes applied across various professional situations and contexts.

Developing professionalism at medical school has become an increasing focus of attention as outlined in the General Medical Council (GMC) document *Tomorrow's Doctor* (General Medical Council, 2009). The Royal College of Psychiatrists defines professionalism as one of the three over-arching domains of the core curriculum, "*doctor as professional*" (Royal College of Psychiatry, 2011). Professionalism is one of the six 'essential abilities' of a medical expert, according to CanMEDS (Frank, 2005), and so makes up part of postgraduate curricula around the world. The Royal College of Psychiatrists adopted the CanMEDS framework for the postgraduate curriculum for trainees in the UK (Royal College of Psychiatrists, 2010). By explicitly incorporating professionalism into curricula, the importance of professionalism as an attribute to develop is highlighted (Hafferty, 2008) and it is argued that teaching professionalism will reduce unprofessional conduct and disciplinary action (Papadakis, Teherani, Banach, Knettler, Rattner, Stern, Veloski & Hodgson, 2005).

Passi, Doug, Peile, Thistlethwaite & Johnson (2010) in their systematic review, in support of the development of professionalism, identify five areas for consideration: student selection, adequate curriculum design, adequate teaching and learning methods, appropriate role models and adequate assessment. The evidence with reference to the desired outcomes in terms of the teaching, learning and assessment methods is however unclear.

Using the domains for the Passi et al., (2008) systematic review a survey was conducted investigating whether or not psychiatry trainees in the North West Deanery feel they are getting adequate teaching, learning opportunities and assessment of professionalism, including access to appropriate role models. Trainees were asked whether or not they recognise professionalism as a part of their curriculum, and whether or not they felt learning about professionalism is important.

Participants and responses

Data was collected between September 2013 and February 2014 using an online survey. All psychiatry trainees in the North West deanery were invited to participate. Of 220 trainees invited there were 84 responses, giving a response rate of about 38%. There were representative responses from trainees in different aspects of mental health services including general adult, older adult, child and adolescent, learning disabilities and forensic. There were also representative responses from trainees across the various stages in training, from those new to psychiatry to those about to become consultants.

Results

The significant majority, 76% (64) of trainees felt that development of medical professionalism was part of their curriculum with 7% (6) saying no and 18% (15) saying they didn't know. In addition 92% (77) felt that professionalism is important with only 8% (7) suggesting it was not important or they didn't know. 63% (53) of trainees felt that there are opportunities to learn about professionalism with 20% (20) feeling that they did not have such opportunities and 17% (14) saying they didn't know.

Most trainees felt that their supervisors were good role models for professionalism, 85% (71), with 7% (6) saying they did not feel their supervisors were good role models and 8% (7) not knowing. Interestingly the majority of trainees, 76% (64) felt that they had their professionalism assessed with 10% feeling that they hadn't and 13% (11) saying they didn't know.

There was a significant shift away from positive answers when it came to the actual teaching of professionalism with 74% (62) saying they didn't receive such teaching or that they 'didn't know' and 79% (66) saying that such teaching was not adequate or that they 'didn't know'.

Discussion

The majority of trainees felt professionalism is important and just over three quarters recognised that it is part of the curriculum. Also while all trainees will have the opportunity to learn and develop their professionalism and have their professionalism assessed, just 63% and 76% respectively recognise this. This suggests that there may be less emphasis on encouraging learning and development in medical professionalism compared to other aspects of the curriculum.

Perhaps most significantly the results suggest either a perceived or true lack of teaching available to foster learning and development of professionalism, which in the authors experience is likely to be accurate. This suggests that there is a discrepancy between the trainee's experience of formal learning and perceived experiential learning. Therefore there is scope to address development of professionalism more explicitly and in a planned manner but at this time learning appears to be more opportunistic.

Although superficially it is reassuring that 85% of supervisors are seen as good role models for professionalism, it is also concerning that 15% were not thought of as such, and 7% were considered as definitely not good role models. This is a challenging issue for the training providers and school of psychiatry alike.

A limitation of this study is that the standards used are recommended for ensuring the effective support in developing professionalism in medical students (Passi et al., 2010), rather than postgraduate trainees. The response rate was relatively low, meaning that the results are potentially not conclusive and subject to responding bias, however a response rate of around a third is typical of postal surveys.

How can the results of this survey be used to improve the quality of the educational experience?

These results were presented at the psychiatry trainee and trainer day in October 2014, in order to generate discussion regarding recommendations as part of a workshop. It was noted in the qualitative feedback from the workshops and examples of experience that very similar themes emerged as detailed in the results of the survey. A number of developmental recommendations were suggested:

Formal Learning Changes Recommended:
- Incorporate case discussions (e.g. GMC fitness to practice case discussion; Waddington & Dearman, 2011) into regular teaching programmes (e.g. half a day per year);
- Offering opportunities for trainees to provide teaching/learning for medical students on placement around issues of medical professionalism and

- Peer groups to discuss professionalism issues, similar to Schwartz groups (Kings Fund, 2011; Davies, undated).

Informal Learning Changes recommended
- Educational supervisors taking the lead in bringing up professionalism issues in supervision and highlighting them as such;
- Seeking feedback from patients and colleagues. Discussed the possibility of using iwantgreatcare.org and
- Raise awareness of role modelling and professionalism when training educational supervisors.

Hidden Learning Changes Recommended:
- Increase awareness of the need to develop professionalism from the school of psychiatry and
- Increase in information, including standards, available to trainees (e.g. via website).

Assessment changes recommended:
- Work Place Based Assessment once per six to 12 months with focus on professionalism, or alternatively use of P-MEX (professionalism mini evaluation exercise; Cruess et al., 2006) once per year.

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REFLECTION
Promoting exercise among renal patients

Neil M. Thomas

Abstract

The following report contains a critical overview of some of my experiences during 100 hours of promoting and monitoring exercise among kidney patients at Kendal renal unit. It focuses on barriers to patient participation, the practice of exercise promotion, and finally, some considerations for safe and effective exercise.

Introduction

In 2014 I was given the opportunity to promote and monitor exercise among the patients at Kendal renal unit. My time there afforded me valuable experience applying evidence based theory in a clinical environment, while substantially developing my personal and professional skills. For this I express my gratitude to all the staff and patients involved. Perhaps more importantly, however, I have been able to reflect on my experiences and critically evaluate the practice of physical activity and health promotion among a renal population. The following report, I hope, offers useful information to anyone seeking to encourage exercise in their own renal environment.

Exercise for renal patients?

If you are not already familiar with exercise among the renal community, you may be wondering why on earth anybody would be promoting such an activity. Well, in recent years there has been a wealth of literature highlighting the benefits of exercising during dialysis, and/or on non-dialysis days. Some of these benefits include improved psychological wellbeing (Parsons, Toffelmire & King-VanVlack, 2006); reduced muscular atrophy and improved physical performance (Kouidi et al., 1998); reduced risk of cardiovascular disease and improved cardiovascular fitness and fatigability (Storer, Casaburi, Sawelson & Kopple, 2005; Wilund et al., 2010); and an improvement in urea clearance during dialysis (Mi Rye Suh, Hyuk Jung, Bae Kim, Sik Park & Seok Yang, 2002). Regular exercise thus may help improve quality of life, prevent further illnesses, and improve the efficacy of dialysis treatment. Of course exercise may not be for all renal patients, and in certain circumstances it may not be appropriate at all. However, considering the potential

benefits, the British Renal Society now recommends that patients who are eligible participate in exercise on a regular basis.

Barriers to participation
In 2010, Kendal renal unit purchased a number of stationary exercise bikes for the patients to use during dialysis, and initial exercise uptake was good and feedback from the patients was positive. When I started at the unit however, many of the patients had stopped using the bikes. I was therefore eager to speak with them and to some of those who had never tried exercising, in order to find out why. Through informal conversations I was able to identify a number of key themes, which often tied in with previous literature.

Illness
Two of the patients who had previously dropped out informed me they did so because of medical illness. As I'm sure all will appreciate, individuals with kidney disease often suffer from other health conditions and are at a greater risk of illness and infection due to a weakened immune system (Kato et al., 2008). In such cases, they may be unable to safely perform exercise, and it is important for exercise professionals not to become disheartened. Most patients are appreciative of being given the opportunity to exercise in the first place.

Health education
Goodman & Ballou (2004) have suggested that a lack of information about the benefits of exercise, and lack of knowledge about how to perform exercise are some of the barriers to participation experienced by renal patients. When I spoke to some of the patients who had never exercised during dialysis at the unit, they informed me that they did not know the benefits of exercise, or that they were not aware of how much exercise they should be doing or how to perform it. This was interesting as there are leaflets at Kendal detailing the positives of exercise, and they also contain some exercise guidance. However, the effectiveness of written information is dependent on the health literacy of the reader: "*The cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways that promote health.*" (Nutbeam, 2000).

It was apparent that some of the patients simply did not utilise the information in the leaflets effectively and take it upon themselves to start exercising. I found that the most effective way to engage these patients with exercise was through one on one guidance and encouragement. This mode of intervention is referred to as 'health persuasion', which is directed at the individual and is led by an exercise professional or 'prescriber' (Beattie, 1991).

For example, I was able to reinforce the positive outcomes of exercise, and help and guide the patients on the bikes. Additionally, for those that wanted to exercise on non-dialysis days at home, I provided tailored exercise schedules for them to perform, and demonstrated how to safely complete the exercises involved. This especially helped the patients who were previously unfamiliar with exercise.

Fear of making things worse
Goodman & Ballou (2004) suggest fear of injury, not wanting to become more fatigued and fear of making health worse are reasons which may prevent renal patients from exercising. When I spoke to one patient, he told me he had given up completely because of a negative experience when he was trying a bike out for the first time. I was able to encourage the patient to give it another go, and he subsequently performed 3mins of cycling without any problems, and enjoyed it. This patient's initial bad experience and fear of making things worse was exacerbated by the fact that there was no exercise professional present to encourage him to try again.

Additionally, some of the other patients, especially when they were just beginning exercising, did not feel comfortable doing so on their own in case anything went wrong. Even though the renal staff are always around, they only felt comfortable exercising when I was there. Beattie (1991) suggests personal counselling can be utilised to give an individual the skills and confidence to take more control over their health. I therefore put this into practice by working with the patients to ensure they knew exactly how much exercise they should be doing and when to stop, if they were out of breath for example, and to generally reassure them that exercise is safe given the right strategy. I found this to be effective as most of the patients developed confidence and autonomy, and came to the realisation that they would be okay using the bikes.

Challenges of exercising in the renal environment
One of the patients was interested in using the bike during dialysis, however she was not comfortable exercising in front of the other patients. She would also not perform exercise at home as she worked during her off days. A member of staff suggested that we close the curtain around her bed, which she was happy with and this was effective in subsequent exercise sessions – a simple but very workable solution.

Another issue which arose was positioning the beds correctly. The beds move into a variety of positions and finding a comfortable one which is suitable for exercise can be difficult. Some of the patients were able to achieve this on their own with ease, whereas others, at least in the beginning, could not do so without my presence. On one occasion a

patient slid down the bed and was not able to push herself back up because of the fistula in her arm. We did remedy this; however, it demonstrates the benefits of having someone there with enough time to stay with the patient, especially when they are just starting out. After all, the patient may have been put off from exercising completely.

Additionally, I was informed by a member of staff that there were some patients who did not wish to trouble the nurses by asking for the bike and that sometimes the nurses did not remove the bike when they had finished exercising. Painter, Carlson, Carey, Myll & Paul (2004) suggest that renal staff sometimes take the perception that it is not their responsibility to help the patients with exercise. I therefore liaised with the nurses, who reiterated to the patient that they are always happy to set up and remove the bikes on request. Furthermore, many of the nurses often encouraged regular exercisers who had not asked for the bike to do some cycling. This highlights the fact that support from all healthcare staff helps to maximise exercise adherence.

The practice of exercise promotion
As an exercise professional, it is considered best practice to perform a needs analysis with any client in order to determine levels of current physical activity and interests, especially for medical patients (Balady et al., 2000). However, it is perhaps not always feasible for renal staff to achieve this as they often do not have enough time, or necessarily the expertise. It took me all morning to speak to each patient and determine their individual needs. I did find this to be an important part of getting the patients exercising, particularly for those who wished to perform exercise routines at home. If there were no needs analysis, this would not have been discovered and I would not have been able to tailor a plan to each individual.

In terms of best practice, a needs analysis should be followed up with an appropriate exercise schedule. For renal patients, this typically means starting at an easy level and gradually building up duration and intensity. When I started working with some of the patients, they were not able to perform 5mins of cycling without becoming out of breath. It goes without saying that not everybody will enjoy this, and reassurance that "after a few sessions things will get better" is often needed.

Goal setting can be an effective way of maintaining exercise adherence (Wilson & Brookfield, 2009). I found it very useful to place an exercise log in each of the patients' kardexes and to write down a target for when I was not at the unit, so that the patients and staff could monitor exercise progression. This proved to be a valuable tool, as during one session a regular exerciser had asked for the bike but had to stop cycling because he felt faint. When I checked his log, he had increased from 15mins of cycling to an hour

during the previous session. He had pushed himself too hard. I produced a visual representation of this in the form of a graph to show him, in order to ensure he would be more careful in the future.

Progress
Throughout the course of my time at the unit, the patients gradually increased the duration of exercise and with practice came the confidence to perform exercise without me. By week nine, many of the patients were regularly exercising for around an hour, which is especially good considering some of them could barely perform 5mins when they started.

Safety considerations
There are a number of safety issues to think about as an exercise professional working with renal patients. For example, exercise during the first two hours of dialysis before 3 litres of fluid have been removed has been shown to be safe; however, outside of this time period it can lead to hypotension and cramps (Karmiel, 1997; Moore, Painter, Brinker, Stray-Gundersen & Mitchell, 1998). Further, patients with kidney disease often take beta blockers which depress heart rate (Karmiel, 1997) and may have autonomic dysfunction (Torkington, MacRae & Isles, 2006). As a consequence, heart rate cannot be relied upon as an indicator of exercise intensity and therefore a subjective rating of perceived exertion scale should be used instead (ACSM, 1994; ACSM, 2004). Additionally, exercise during dialysis should not be intense; it is not an appropriate time to 'physically push' the patients. More moderate exercise should be reserved for non-dialysis days, and only after personal circumstances have been taken into account (Johansen, 2007). That being said, if guidelines and best practice are followed, there is no reason why effective and safe exercise cannot be sustained among eligible kidney patients (Johansen, 2007) and this is what I discovered.

I will refer the reader to two documents which I believe offer a good starting point for those seeking to perform or promote exercise with dialysis patients. The first is the easy bike program (Karmiel, 1997). It suggests five stages of cycling, ranging from 3-40 minutes, adding 1 minute during each treatment. The second is a 28-page document produced by Leicester hospital, which details a variety of strength, mobility, flexibility and cardiovascular exercises for renal patients to perform on non-dialysis days (University Hospitals Leicester, 2009). I indeed utilised these documents a number of times and found them to be more than adequate.

Conclusion
This report has highlighted some of the barriers to participation experienced by renal patients and some

of the causes of exercise drop out. One of the key themes to have arisen is that of inadequate health education. Often written information is not sufficient to engage patients with exercise and in these cases, one on one persuasion followed by personal counselling is effective in first getting the patients to start exercising and subsequently enabling them to develop autonomy and have the skills and confidence to exercise on their own. Another major theme is that the presence of an exercise professional will help with all aspects of exercise in the renal environment, especially for tasks which the renal staff may not have the time to complete, e.g. performing need analyses, constructing exercise plans and encouraging patients who may have negative experiences. However, where this is not possible, simple encouragement can only be beneficial and in my experience, it definitely motivated some of the patients to exercise when I was not around. If you can create a buzz on the ward and if there are patients who regularly exercise, others often follow suit.

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