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Knowledge, attitudes and practices relating to fertility among nurses working in primary health care

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KEY WORDS

practice nurses, primary health care, health promotion, fertility, reproductive health

ABSTRACT

Objective
To explore knowledge, attitudes and practice relating to factors that affect fertility among nurses working in general practice and other primary health care settings.

Design
Anonymous online survey.

Setting
Primary care.

Subjects
Members of the Australian Primary Health Care Nurses Association (APNA). Main outcome measures: Fertility-related knowledge, attitudes and practice.

Results
102 individuals completed the survey. More than half overestimated the age when male and female fertility declines and the chance of women conceiving with IVF. Most knew that smoking affects a man's sperm but only one quarter that smoking halves a woman's fertility. The majority recognised obesity and STI's as detrimental for fertility and agreed that educating patients about fertility is part of primary health care nurses' role to ask people of reproductive age about their reproductive life plan and alert them to the factors that influence fertility. The most commonly cited barrier for discussing fertility with patients was perceived lack of knowledge about the subject.

Conclusion
This study identified opportunities and barriers for nurses working in primary health care to proactively discuss fertility and the factors that influence the chance of conceiving with their patients. Appropriate educational resources to improve knowledge and support from general practitioners (GPs) can enable nurses working in general practice and other primary health care settings to provide effective fertility related education as part of their role as health promoters.

INTRODUCTION

Most people want and expect to have children some time in their life (Holton et al 2011a; Langdridge et al 2005). For some, life circumstances beyond their personal control such as the lack of a partner, chronic illness or infertility, prevent them from realising this life goal (Holton et al 2011b). For others however, potentially modifiable factors reduce their chance of having children or the number of children they wished to have. These include parental age, body weight, tobacco use, and knowledge about the time in the menstrual cycle when a woman is able to conceive (Homan et al 2007; Wilcox et al 1995).

Female fertility starts to decline around age 32 and the decline becomes more rapid after age 35. Between the ages of 30 and 40 the monthly chance of conception for women decreases from 20% to 5% (Cooke and Nelson 2011). Male age also influences fertility; a study of more than 8,000 pregnancies found that, after adjusting for female age, conception during a 12-month period was 30% less likely for men over the age of 40 compared with men younger than 30 years (Hassan and Killick 2003). The common belief that assisted reproductive technology (ART) treatment such as in-vitro fertilization (IVF) can overcome age-related infertility is erroneous. In 2012 in Australia and New Zealand the chance of a live birth per initiated treatment cycle decreased from 24.8% for women aged between 30 and 34 years to 6.1% for those aged between 40 and 44 years (Macaldowie et al 2014).

The negative impact on fertility and reproductive outcomes of parental obesity and tobacco use is also well documented (Lane et al 2014; Homan et al 2007). Conversely, knowledge about the fertile time in the menstrual cycle and timing intercourse to coincide with this increases the chance of and reduces the time to pregnancy (Stanford 2015).

Studies of people's knowledge about factors that influence fertility consistently point to considerable knowledge gaps (Bunting et al 2013; Hammarberg et al 2013). It has been suggested that GPs should promote knowledge about the impact on fertility of age and lifestyle factors (RACGP 2012; Chapman et al 2006). However, barriers, including time constrains, can prevent GPs from proactively discussing reproductive planning with their patients (Mazza et al 2013). More than 60% of Australia's general practices employ one or more Practice Nurses and their role includes health promotion and lifestyle education (APNA). As experts in preventive care, nurses working in general practice and other primary health care settings are well placed to promote awareness about factors that influence fertility to help people of reproductive age achieve their reproductive goals. However, it is not known whether nurses working in primary health care have sufficient knowledge about fertility or believe that it is part of their role to discuss fertility with their patients.

'Your Fertility' is a national, public education program to improve knowledge about factors that affect fertility and pregnancy health to allow people to make timely and informed decisions about childbearing. It is funded by the Australian Government Department of Health and the Victorian Department of Health and Human Services (Your Fertility). One of the aims of the program is to support primary health care professionals with educational resources to help them discuss reproductive life planning and fertility with their patients.

To inform the development of resources for nurses in primary health care the aim of this study was to establish what nurses working in general practice and other primary health care settings know about factors that influence fertility; whether and under what circumstances they talk to patients about fertility and reproductive life planning; and what resources might help them start a conversation about fertility with their patients.

METHOD

The study was approved by Monash University Human Research Ethics Committee.

Study population

This was an anonymous online survey. An invitation to take part in the study and a link to the survey was advertised in the Australian Primary Health Care Nurses Association's (APNA) e-newsletter in October and November 2014.

Material

The study-specific questionnaire included demographic characteristics and fixed-choice response questions gauging: knowledge about factors that influence male and female fertility; attitudes about the role of nurses in fertility health promotion; and practice relating to fertility health promotion.

Data management and analysis

Data were analysed in SPSS for Windows v 20 using descriptive statistics and Student's t-test to test for differences between group means. Participants' correct responses to the 13 knowledge questions were added to produce a score with a possible range of 0 to 13. Mean scores were compared between: age-groups (<45 versus ≥ 45 years); geographic location (urban versus regional/rural/remote); and type of organisation (general practice versus all others).

FINDINGS

The survey was completed by 102 respondents. Their characteristics are shown in table 1.

Table 1: Characteristics of respondents (*n=102*)

Characteristic	No (%)
Female	100 (98)
Male	2 (2)
Age group	
<35 years	19 (19)
35-44 years	20 (20)
45-54 years	35 (34)
55-64 years	26 (26)
65 years or older	2 (2)
Current professional qualification	
Registered nurse/Registered midwife	82 (81)
Enrolled nurse	7 (7)
Nurse practitioner	1 (1)
Other	12 (12)
Practicing state	
ACT	2 (2)
NSW	42 (41)
Qld	10 (10)
SA	2 (2)
Tas	3 (3)
Vic	42 (41)
WA	1 (1)
Practicing setting	
Urban	46 (45)
Regional/Rural	53 (52)
Remote	3 (3)
Type of organisation	
General practice	77 (76)
Community controlled health services	15 (15)
Other	10 (10)

Responses to the knowledge questions are displayed in table 2. The mean score for correct answers to the 13 questions was 7.2. More than 1 in 5 respondents (22%) scored <6, 75% scored between 6 and 10, and only 3% scored >10. There were no statistically significant differences in knowledge scores relating to respondents' age, geographical location or the type of organisation they worked in. More than half of the respondents overestimated or were unaware of the age when female and male fertility start to decline. Most respondents knew that smoking affects a man's sperm but only one quarter correctly identified that smoking halves a woman's fertility. Obesity and sexually transmitted infection (STIs) were recognised by almost all respondents as detrimental for fertility. While only just over half of the respondents were aware that having irregular menstrual cycles reduces a woman's fertility, more than three quarters correctly identified the fertile window in the menstrual cycle. A majority of respondents overestimated or stated that they did not know the chance of a live birth after one IVF treatment cycle.

Table 2: Respondents' fertility-related knowledge

Question (bold denotes correct answer)	N (%)
How would you rate your knowledge about factors that influence fertility	
Confident/fairly confident I know what I need to know	19 (19)
I wish I knew more/I know very little	83 (81)
At what age does female fertility start to decline	
<30 years	8 (8)
30-34 years	**35 (34)**
≥ 35 years/ Age doesn't matter/Don't know	59 (58)
At what age does male fertility start to decline	
< 40 years	19 (19)
40-44 years	**18 (18)**
≥ 45 years/Age doesn't matter/Don't know	65 (64)
Does smoking cigarettes reduce a woman's fertility	
No/ Not if she smokes <10 cigarettes per day	3 (3)
Yes, smoking reduces fertility by 10%	74 (73)
Yes smoking halves the chance of pregnancy	**25 (24)**
Does passive smoking reduce a woman's fertility	
No/Don't know	28 (27)
Yes, a bit	37 (36)
Yes as much as active smoking	**37 (36)**
Does smoking affect a man's fertility	
No/Don't know	11 (11)
Yes smoking affects a man's sperm	**91 (89)**
Does obesity reduce a woman's fertility	
No/Maybe	6 (6)
Yes	**96 (94)**
Does obesity affect a man's fertility	
No/Maybe/Don't know	26 (25)
Yes	**76 (75)**
Can STIs affect a woman's fertility	
No/Maybe	3 (3)
Yes	**99 (97)**
Can STIs affect a man's fertility	
No/Maybe/Don't know	17 (17)
Yes	**85 (83)**
Does having irregular cycles (>6 weeks between periods) reduce a woman's fertility	
No/Maybe/Don't know	49 (48)
Yes	**53 (52)**

If a woman has 28 day cycles, when is she most likely to conceive	
Day 1-5	2 (2)
Day 6-10	2 (2)
Day 11-15	**77 (75)**
Day 16-20	15 (15)
Day 21-25	2 (2)
It can happen any time	2 (2)
Don't know	2 (2)
What is the chance of having a baby with IVF after one treatment cycle for women aged less than 35 years	
35%/45%/Don't know	73 (72)
15%	14 (14)
25%	**15 (15**)
What is the chance of having a baby with IVF after one treatment cycle for women aged between 40 and 44 years	
18%/27%/35%/Don't know	57 (56)
9%	15 (15)
7%	**30 (29)**

Respondents' attitudes towards nurses working in primary health care engaging in fertility health promotion are shown in table 3. Almost universally respondents agreed that it is part of their role to ask people of reproductive age about their reproductive life plan and alert them to the factors that influence fertility. The most commonly cited barrier for discussing fertility with patients was perceived lack of knowledge about the subject.

Table 3: Respondents' attitudes towards providing fertility education

Question	N (%)*
Is it the role of nurses to ask people of reproductive age about their 'reproductive life plan'?	
Yes	75 (75)
Yes, but only if the patient brings up the subject	17 (17)
No/Don't know	8 (8)
Is it the role of nurses to discuss factors that affect fertility with people of reproductive age?	
Yes	48 (48)
Yes, if the patient brings up the subject	46 (46)
No/Don't know	6 (6)
In your view, what are the barriers for discussing fertility with patients?#	
Lack of knowledge	65 (64)
Time constraints	53 (52)
Difficult to bring up unless asked	35 (34)
Not part of Nurses' role	8 (8)

*Not all participants responded to all questions, percentages are of those who responded

More than one could be endorsed

Less than one third of respondents stated they felt confident about their level of knowledge about fertility. In spite of this, almost half discussed fertility with patients in their daily practice, either routinely or opportunistically when consulted about reproductive health matters (table 4). Almost all respondents agreed access to fertility related information would enhance their confidence about talking to patients about fertility. Fact sheets to give to patients and a trustworthy website to refer them to for more information were resources most respondents believed would help them talk to patients about fertility in their daily practice.

Table 4: Respondents' fertility health promotion practices

Question	N (%) *
In your daily practice, do you bring up the subject of fertility with patients?	
Routinely	3 (3)
Opportunistically when consulted about reproductive health matters	42 (45)
Only when patients ask for advice	58 (52)
Do you feel confident in your level of knowledge about fertility to bring up the subject with patients?	
Yes	28 (30)
No/Don't know	65 (70)
Would access to more information about fertility make you more confident to talk to patients about fertility?	
Yes	87 (94)
Which of the following resource would help you talk to patients about fertility?#	
Webinar (live, interactive internet-based information session)	34 (33)
Information session in Podcast format	25 (25)
Fact sheets to give to patients	85 (83)
Trustworthy website to refer patients to	73 (72)

*Not all participants responded to all questions, percentages are of those who responded

More than one could be endorsed

DISCUSSION

This study identified opportunities and barriers for nurses working in primary health care to proactively discuss fertility and the factors that influence the chance of conceiving with their patients. Opportunities include the findings that most respondents believed it is part of their role to educate people about fertility and almost half do this in their daily practice. This suggests it is feasible to expect nurses working in general practice and other primary health care settings to incorporate fertility education in their health promotion repertoire. Obvious barriers are the apparent existing knowledge gaps and the self-reported lack of knowledge and confidence about discussing fertility with patients.

The most concerning knowledge gaps relate to the impact of age on fertility. Firstly, more than half of respondents overestimated or were unaware of the age when male and female fertility declines. Secondly, the majority of respondents overrated the chance of younger and older women giving birth as a result of one IVF treatment cycle. Perceptions that the reproductive life-span is becoming longer and that IVF can overcome age-related infertility are reinforced by media reports of women (often celebrities) having 'miracle babies' late in life. The reality is that the chance of having a baby with IVF after age 40 is minuscule (Macaldowie et al 2014).

Keleher et al (2007) assert there is insufficient information about the scope of general practice nurses' practice and its outcomes and argue for an 'educational framework to advance nurses' skills and knowledge' (p108). Such a framework should include education about fertility, the role of lifestyle factors in reproductive outcomes, and the limitations of reproductive technologies such as IVF in overcoming age-related infertility. This would provide nurses with the knowledge they need to talk confidently about fertility-related matters and discuss reproductive life planning with their patients.

APNA recently developed a 'Family Planning Decision Support Tool' with funding from the Australia Government Department of Health to assist primary health care nurses in their consultations with patients to promote effective family planning throughout reproductive life (APNA). This tool includes comprehensive information about the factors that influence fertility and what to discuss with women and men who attend for a preconception health check. While this is a step in the right direction, fertility-related information and advice should also

be offered to people who are not currently planning pregnancy but may wish to have children in the future to allow them to make informed decisions about how they prepare for and time childbearing.

This study has strengths and limitations. There is no way of knowing if respondents were representative of all nurses working in primary health care. However, they included people from all Australian states and territories (except Northern Territory) who were diverse in terms of age, and the settings and types of organisation they worked in. Online surveys do not allow detailed exploration but they are a feasible tool for research questions which require broad, summary, information relating to a particular matter in groups with specific characteristics. They are cheap to undertake, easy for respondents to complete, and likely to generate honest responses when they are anonymous.

The findings of this study have informed the development of resources to help nurses working in primary health care settings discuss modifiable factors that influence fertility with their patients. These are housed on the 'Your Fertility' website and include educational webinars, videos, podcasts and factsheets; a Think GP module; links to relevant clinical guidelines; and factsheets for lay audiences that can be downloaded and shared with patients (Your Fertility). Future initiatives will target specific knowledge gaps identified in this study and through collaboration with APNA these will be disseminated to nurses in general practice and other primary health care settings throughout Australia.

As experts in preventive care, nurses working in primary health care are well placed to promote awareness about factors that influence fertility and reproductive life planning to help people achieve their reproductive goals. With access to educational resources and support from GPs it is feasible to expect nurses to incorporate fertility education in their health promotion repertoire.

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A mental health nursing transition program for enrolled nurses at a forensic mental health hospital

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ABSTRACT

Objective
There are difficulties in recruiting enrolled nurses to mental health positions. A six month program was developed with the aim to bridge possible knowledge gaps for enrolled nurses, and to provide them practical support to consolidate skills and knowledge for nursing in a forensic mental health hospital.

Setting
The setting was a 116 bed secure forensic mental health hospital in the state of Victoria, Australia.

Subjects
Nine enrolled nurses who had completed a Diploma of Nursing, were recruited into the program.

Primary argument
There is a national decrease in enrolled nursing supply, and a paucity of data exploring the training needs of enrolled nurses transitioning from the Diploma to a mental health nursing role. Nursing programs are required to assist enrolled nurses with the knowledge and skills, and support required to effectively make their transition into mental health nursing.

Conclusion
The results demonstrate the importance in providing a program to assist enrolled nurses transition to mental health and that the mental health course requirements within the Diploma of Nursing and placement length may not be adequate in preparing enrolled nurses for direct entry to mental health nursing. Providing a structured transition program for a group of enrolled nurses is a useful strategy to improve knowledge, skills, and retention.

INTRODUCTION

Within Australia there are two nursing levels. These are Registered Nurses (RNs) and Enrolled Nurses (ENs). There are some similarities in the activities performed however there are notable differences in knowledge depth, the capacity to assess, plan and implement nursing care (Kerr et al 2012; Blay and Donoghue 2007). Essentially the role of the EN is to provide person centred care under the supervision of a RN while remaining professionally responsible that the care they deliver, is within their scope of practice (ANMC 2002). Qualifying as an EN requires the completion of a Diploma of Nursing (Diploma), an 18 month course including a dedicated mental health unit required to address the Mental Health Act; how to respond effectively to signs of mental illness; contribute to nursing care plans and care for people experiencing mental illness and to assist in evaluating care (Australian Government 2012).

There is a paucity of data exploring the training needs of ENs transitioning from the Diploma to a mental health nursing role. A search of the data bases Ebscohost, ScienceDirect, and Scopus, using combinations of the keywords 'enrolled nurse; Australia; mental health' with limitations of 'full text' and published after the year 2000, failed to retrieve any Australian published research examining programs for, or the experiences of, ENs entering a mental health program.

Furthermore is the lack of evidence that the Diploma curricular has been evaluated. As such the question of whether the mental health unit adequately prepares ENs for the mental health workforce remains unanswered. In the absence of evaluation, one might expect the clinical and theoretical content devoted to the mental health unit has been provided similar importance and weighting within the overall content of the course to that seen in undergraduate nurse training for RNs that has been described as minimal and unsatisfactory (Clinton and Hazelton 2000; Wynaden et al 2000). Adding to this are inadequate mental health placement opportunities for ENs to gain the much needed experience they require to assist them consolidate their knowledge and expose them to future career roles in mental health (Cleary and Happell 2005). A further factor impacting on the ability to attract ENs to the mental health workforce is the decrease in EN supply, with a decrease in EN supply nationally of 3.9% between 2009 and 2012 (AIHW 2013). The decline in EN numbers having a direct bearing on the recruitment of ENs to mental health positions. As such there is an urgent need for services to consider recruitment strategies such as transition programs to attract and support ENs to a mental health career.

A six month program was developed with the aim to bridge possible knowledge gaps for ENs and to provide them practical support for nursing in a Forensic mental health hospital. A three week orientation occurred at the commencement of the program that included clinical based educational sessions (see table 1). The ENs were supported by a Clinical Nurse Educator (CNE) and each EN was provided a preceptor. There were two three month clinical placements during the program for each EN to provide them with an experience of both an acute and longer stay Unit. Objective meetings occurred with the CNE for each placement to provide support and guidance for the EN and to assist them with their personal clinical goals.

METHOD

Participants and setting

A total of 20 ENs were interviewed, all had completed a Diploma. Nine were successful in gaining a position in the program. There were eight females and one male. Their age ranging from 21 to 50 years. Six had completed their training within a two year period of the program commencement. Two of the nine reported more than two years of mental health nursing experience, one greater than five years with the remaining six having limited experience that occurred during clinical placements whilst completing their Diploma.

Table 1: 3 Week Orientation - Educational sessions

• Mental health nursing • Therapeutic communication and relationships • Recovery orientated care • Mental state examinations • Role of the associate nurse • Medication administration and competencies • Role of the surgery and surgery assist nurse	• Professional boundaries • Infection prevention and control • Documentation and online files • Aggression management workshop • Risk assessment and management • Security issues for mental health nurses • Escorting leave competency and responsibilities	• MHPOD topics: • Documentation • Therapeutic Relationships • Legislation • Confidentiality • Risks • Mental health history and MSE • Biopsychosocial factors

Consent procedures

All participants were adults. The assumption that they were competent and able to make a decision whether to participate or to decline participation in the evaluation (Polit and Beck 2013). All ENs participating in the program had been informed of the evaluation processes, and choosing to participate was voluntary. Returning completed de-identified questionnaires implied consent.

Setting

The setting was a 116 bed secure Forensic mental health hospital. Typically the function of such hospitals is to provide mental health treatment and care for adults who experience mental illness and have had contact with the criminal justice system.

Instruments/measures

Three post activity questionnaires were constructed by the researchers to evaluate the program, to provide a snapshot of the experiences of the ENs during the program (Polit and Beck 2013). Questions consisted of both quantitative questions and scales, and qualitative questions seeking views and opinions. Care was taken to ensure that questions asked for both positive aspects and shortcomings of the program.

The first questionnaire was administered during the 3 week orientation. The second evaluation occurred 2-4 weeks following orientation, to evaluate whether the orientation was adequate in preparing them for their roles on the Units and whether they were experiencing adequate support from their preceptor and CNE. The final questionnaire was administered as the ENs completed the program. This final questionnaire focussed on their overall experience of the program, the support structures, and the ongoing educational components of the program.

Data sources

Data were collected using the developed questionnaires which were provided directly to participants. To protect their anonymity, the ENs were not required to identify themselves on the questionnaires and returned completed surveys to the principal researcher in pre-addressed envelopes.

Ethical considerations

A research application was submitted and approved by Forensicare's Operational Research Committee. An ethics application was then made to the Department of Health and Department of Human Services Human Ethics Committee. The ethics committee considered the project to be a low risk, service evaluation, not requiring ethical approval.

FINDINGS

Questionnaire 1

The ENs were asked to provide feedback following each session of the orientation. The results from the clinical education sessions are reported along with the experience of supernumerary clinical time on the Units.

Mental health nursing

The content included philosophical underpinnings of mental health nursing, the therapeutic use of self, therapeutic relationships, core responsibilities, scope and standards of practice. The topic was reported as being very useful in improving knowledge about the art of mental health nursing. Five of the ENs highlighting that from their experience there was a lack of mental health nursing content in their Diploma.

Therapeutic communication and relationships

Content from this session aimed to assist the ENs to understand the experiences of consumers and to incorporate a person centred strengths based approach to care. The responses indicated that the session was very useful. However the ENs stated they lacked confidence with their skills and ability to communicate in a therapeutic manner with consumers. They also indicated an understanding of the importance in building therapeutic relationships with consumers.

Recovery orientated care

This topic explored key Recovery concepts such as hope, agency, responsibility and opportunity. The need to appreciate the uniqueness of the consumer, and the role of nurses to develop helpful and respectful partnerships with consumers. The concept of Recovery was not one that any of the ENs were familiar with.

Mental State Examinations (MSEs)

The ability to conduct an assessment of a consumer's mental state is critical to the role of nurses in mental health settings. The session was considered by them as very useful, however the process for conducting an MSE represented new knowledge for the ENs.

Professional boundaries

Understanding professional boundaries, signs of boundary violations and boundary maintenance strategies were the focus of this session. Responses such as remaining professional, not discussing personal details with consumers, and ensuring therapeutic relationships are for the benefit of the consumer, indicated a sound understanding of professional boundary maintenance.

Role of associate nurse

Session content covered the primary nursing model of care at the hospital. Within this model, the associate nurse (commonly performed by ENs) works as an adjunct to the primary nurse, supporting and ensuring implementation of the consumer's care and treatment needs. While the ENs indicated that the session was helpful, they also wanted a list of typical tasks the role performs, so they would be better informed and prepared when commencing in the role.

Medication administration and competencies

This session covered knowledge and skills, and Acts which govern the legal aspects of medication administration. An overview regarding the indications and common side effects of psychotropic medication, non-adherence and diverting of medications, and the reporting of medication errors also occurred. Completing the medication competency and supervision package was considered by them to be useful in improving their competence and confidence in administrating medications.

Role of surgery nurse and surgery assist nurse

The responsibilities of the surgery nurse for administering medications safely were well understood by the ENs. Having a surgery assist nurse with the role to supervise consumers taking their medication to reduce the risks of non-adherence or diversion of medications, was one role they had not experienced previously but was a role considered important.

Infection prevention and control (IPaC)

The content of this session covered the responsibilities of nurses towards IPaC, such as standard precautions, aseptic technique, clinical waste, sharps handling and disposal, environmental and equipment cleaning and hand hygiene. Their responses revealed that the ENs already possessed adequate IPaC knowledge.

Documentation and online files

The purpose and standards of documentation, and what should be documented and what to avoid were discussed in this session. Understanding freedom of information, and access to files were also covered. The ENs indicated they wanted examples of notes written by other nurses to help them better understand the type of information recorded. Suggestions were made by them for the provision of supervision regarding their documentation when they commence on the Units.

Risk assessment and management

Assessing consumer risk to self, others and the community is an important clinical concern, where the consequences of poor risk assessment and management can be catastrophic. Most of the ENs indicated the session was useful. A common comment from ENs was that the session could be improved with the provision of case scenarios, and an opportunity to practice assessment skills.

Aggression management workshop

This workshop taught the ENs the importance of creating a safe environment, the use of de-escalation and early intervention strategies, and restraint practices employed at the hospital. All reported the information presented to be highly useful, along with the opportunity to practice skills taught. The importance of safety for clinicians and consumers was well understood by the ENs from this training. As was the need to recognise consumer distress at an early stage to allow for effective early interventions such as de-escalation and calming strategies.

Security issues for mental health nurses

The content of the session covered physical, procedural, and relational security. The importance of knowing the consumer, their risks, their state of mind and sharing information was the focus of the topic. The information was new for the ENs however their responses indicated their appreciation to the importance of maintaining security in a Forensic hospital. The session also covered the importance of adhering to security policy, and the need to be security conscious and vigilant. Topics such as managing contraband and searching rooms were covered. Half of the ENs had never searched a consumer's room, however their understanding to the importance of being thorough in conducting searches, and to be mindful of safety issues was well understood.

Escorting leave competency and responsibilities

Escorting consumers on leave to legal and medical appointments and to facilitate community rehabilitation needs is an important role nurses provide. The ENs reported the session was very useful. They discussed the shortcomings that embedding the content of the session into practice will occur at a later time when required to escort consumers.

MHPOD competencies

MHPOD is an online mental health professional development resource that has been based on national practice standards (MHPOD 2013) and designed to meet the needs of entry level clinicians. Overall, the responses to the relevance of the MHPOD topics (see table 1) suggests that topic content was relevant, and for the most part represented new knowledge.

Supernumerary time on units

The ENs reported the supernumerary time was a "fantastic" opportunity and a "great" way to learn, with excellent staff support from preceptors and the CNE. They were able to learn hands on, participating without the responsibility of being counted as part of the usual staffing profile.

Questionnaire 2

The second questionnaire occurred two weeks following orientation. At this time, the ENs had now been working on the units no longer in a supernumerary capacity. The purpose of the questionnaire was to seek the views of the ENs about the effectiveness of the orientation, the support of the CNE and preceptors, and their overall opinions of the program to date. The ENs discussed the bond that had formed between themselves as a group. The advantages of having a group starting together as opposed to individual appointments at different times were frequently cited. The ENs also made mention of the welcoming they received from other clinicians and the support and leadership available to them from the CNE and the nurse education department. Standout topics such as the aggression management training and the topics with a mental health nursing focus were considered most valuable in providing them with knowledge and skills for their nursing role.

The ENs were asked to consider topics that could be included or omitted to improve the orientation. They stated that incident reporting and documentation could be omitted and be taught on the Units. To improve the orientation the ENs indicated they would like more sessions on mental health nursing, greater detailed information on the day to day roles for ENs along with supernumerary time in the afternoon to improve their understanding of what is required of them after hours. The ENs also wanted greater content on the Mental Health Act.

All nine ENs indicated they were having regular meetings with their preceptor. All reporting positive support from the preceptors, who were described as being approachable and available to meet their new learning needs. However, the ENs reported that finding time to meet with their preceptor was difficult due to conflicting rosters, competing clinical demands and activities on the Unit.

The ENs also reported they were frequently meeting in person with the CNE and via email. Describing the CNE as supportive, knowledgeable and reliable. Overall, at this early stage of the program, the ENs were reporting they were feeling valued by others in the treating team and sense they were part of the team.

Questionnaire Part 3

The ENs were asked to reflect on the past six month program, and consider the standout positive features of the program. As with previous evaluations, the orientation, group recruitment, supportive staff and the support of the designated CNE, were key standout positive features. The ENs were also asked to identify any shortcomings of the program. More Unit rotations, along with more supernumerary time were further suggested improvements. When asked whether the experience with their preceptor had been a positive experience the comments were positive highlighting the knowledge and friendly nature of the preceptors. The ENs described the CNE as an approachable and supportive person, who was always available to them and considered the CNE as a credit to the program.

Critical to the success of the program was understanding whether the program provided the ENs with the skills and knowledge they required to work in mental health. Some expressed that their knowledge and skills will continue to develop with time and continued exposure to clinical situations. One stated she was very glad for the opportunity to be part of the program as she does not think she would have "lasted a week" without the support of the program. The compulsory competencies were considered by them as "very good", and "very helpful", as was the appreciation they had for the orientation and the provision of a preceptor for the length of the program.

The ENs were asked to share any additional thoughts regarding the program. Some suggested the need to include specific training on the role of the Associate Nurse. The ENs were asked to consider and share the areas of their practice they would still like to develop. They discussed the need to better understand 'Recovery' and what this means for consumers, more aggression management sessions to increase confidence in de-escalation and restraining practices. There was also the need to better understand specific nursing roles such as the Associate Nurse role and, to better understand legal processes.

Discussing their future, three of the ENs stated they are currently considering extending their career to become Registered Nurses. Three stating that they have successfully accepted positions with (a local University) to commence a Bachelor of Nursing in 2015. Others discussed taking on extra responsibilities at the hospital. One completed the QUIT training and will act as a co-trainer within the hospital to assist consumers and staff with strategies to cease smoking. One is interested in becoming a Gender Sensitive and Safety trainer within the hospital, and three ENs have become IPaC Link Nurse.

DISCUSSION

The program was established to bridge possible knowledge gaps for ENs and to provide them practical support to consolidate skills and knowledge to assist them to transition to nursing in a Forensic mental health hospital. The EN participants all identified clear advantages for them in being part of a larger group of ENs commencing in mental health together as opposed to individual appointments. They experienced satisfaction with the program and their role, and expressed that staff were accepting of them and welcomed their clinical input. These were important positive aspects of the program and is consistent with the report by Heartfield and Gibson (2005) where ENs reported that being part of a team and working with others in the provision of care was significant and important to the professional sense of self for ENs. Furthermore, the sense of belonging to a supportive team has been described as the number one factor for nurse retention (McGillis Hall et al 2011). The ENs also described the level of support from their preceptor and the CNE as highly important to the experience in the program. Hill (2011) reports that a positive supervisor relationship resulted in improved job satisfaction and retention of nurses. The program, while a new endeavour for ENs, was not dissimilar to transition programs for RNs. Where it has been reported that transition programs create supportive environments for nurses, who experience job satisfaction and results in increased retention (Missen et al 2014).

The level of satisfaction with their experience of being part of the program had a strong bearing on the future career plans for the ENs. None of the ENs reported dissatisfaction with nursing at the hospital or revealed plans to "move on". All but one of the ENs have taken on either extra responsibilities at the hospital or have expressed that they are enrolled in training to become an RN embracing the life-long learning tenants for EN registration (ANMC 2002), and adds further support to the findings of Jacob et al (2014) where educators held views that the Diploma of Nursing provides a strong foundation for ENs wanting to continue their nurse education to Undergraduate level.

A surprising finding was the lack of knowledge the ENs had regarding core foundations of mental health nursing such as the use of therapeutic communication and the need to development therapeutic relationships (Browne et al 2014; Peplau 1952) where they were unsure of their skills and abilities. They were also unsure of how to conduct a mental state examination which is a vital assessment skill in mental health. Furthermore the concept of recovery, which underpins contemporary mental health treatment approaches (Slade et al 2014), and is considered an important aspect of mental health nursing education (Happell et al 2015), represented new information to them. The ENs reported that during their Diploma content devoted to mental health nursing was not provided the importance equal to that of other areas of nursing. This shortcoming was reportedly coupled with inadequate mental health placements during the Diploma, resulting in reduced opportunity to practice mental health nursing skills, lack of confidence in engaging with consumers and building therapeutic relationships, and poor confidence in performing MSEs. This may well reflect the content preparing the ENs for more preferable clinical areas which is not surprising given that less than 2.5% of ENs identify mental health as their clinical speciality (Della and Fraser 2006).

CONCLUSION

There are positive benefits in a group recruitment mental health nursing transition program for ENs. The support of a dedicated CNE bolstered by individual preceptors is a vital support structure for the success of such programs. The structured orientation that included topics central to the practice of ENs in a mental health environment were an important feature of the program due to the poor knowledge base, and lack of personal confidence in their skill base. The results of this mental health program where the ENs experienced clinical support and good job satisfaction, provides further support that increased retention and future career development for ENs can result from specific mental health transition programs.

RECOMMENDATIONS

Given the small sample size of nine ENs and that the program evaluation occurred in the one Forensic mental health hospital the findings may not represent the views of ENs in similar programs and environments. Furthermore, the findings reflect reported rather than observed behaviour. There is the risk of participants censoring their responses or offering responses they believe to be acceptable rather than reporting their actual practice or experiences. The evaluation of the program suggests the mental health unit in the Diploma does not adequately prepare ENs to enter the mental health workforce without the support of a transition program. Mental health nursing transition programs for ENs are crucial in supporting and retaining ENs. Further research is required to evaluate the content of the mental health unit within the Diploma and strategies to improve the placement for student ENs to improve their exposure to mental health and mental health nursing.

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Flooded with evidence: using a 'spillway' model to improve research implementation in nursing practice

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ABSTRACT

Objective
To identify barriers to implementing evidence-based practice initiatives in small to medium sub-acute facilities in Queensland.

Design
The study uses a qualitative methodology in which field observations and convergent interviews were employed to generate data.

Setting
Four south-east Queensland sub-acute care facilities participated in the study. Observational and interview data were collected.

Subjects
Field observations were recorded across the sites. Five research fellows collected observational data on evidence-based practice implementation across a period of six months. Nine clinicians participated in in-depth, convergent interviews at the end of the period of observation.

Main outcome measures
The authors analysed observational and interview data using qualitative thematic analysis.

Results
Three themes emerged which described the needs of clinicians when evidence-based practice initiatives were being implemented: (1) valuing evidence; (2) risk prioritisation; and (3) controlling the flow of evidence. A 'Spillway Model' is proposed as a mechanism for targeting clinical priorities using integrated risk management.

Conclusion
This study supports the use of integrated risk management as part of a Spillway Model to guide the introduction of evidence-based practice initiatives in the clinical setting.

INTRODUCTION

Although evidence-based practice (EBP) is generally viewed as an overwhelmingly positive initiative in nursing, the complexity of contemporary healthcare has resulted in some well documented failures (Grou Volpe et al 2014; Kmietowicz 2014; Metsälä and Vaherkoski 2014; JCCfTH 2009). While some models like the PARIHS framework provide guidance for utilising evidence (Kitson et al 2008), the information age has resulted in a flood of data that is unwieldy for nurses to effectively engage with. Recent studies have endeavoured to explore whether the volume of evidence can impact on the clarity of effective clinical decision-making (Moloney 2013). Runciman et al (2006) notes when new problems are encountered, clinicians are more inclined to make decisions that are familiar and comfortable than to thoroughly investigate what is best practice from a plethora of available evidence.

Intriguingly, EBP has become a process as much about risk-managing the volume of information available as it is about determining what is best practice (Moloney 2013). Poorly managed EBP in practice is often linked with extant organisational or cultural issues and is considered a genuine barrier to the delivery of quality healthcare (Kitson et al 2008; Averis and Pearson 2003). The impact of this phenomenon is not well understood in sub-acute care facilities in regional Queensland and is a trigger to action for this study.

METHOD

Phenomenographic research facilitates studying the experience of participants in order to appreciate the variation of the experience itself, and the adaptation of meaning of the research utilisation encounter for the participants (Pringle et al 2011). Numerous studies focusing on nurses' experiences of EBP implementation have been guided by a phenomenological design (Kaasalainen et al 2010; Estabrooks et al 2003).

Ethical approval was obtained from the Human Research Ethics Committee of the health service where participants were working (Approval no. EC00341:2013:26). All participants gave written informed consent prior to participation, and were advised of their right to withdraw without penalty or prejudice at any time.

Participants were recruited from four nominated trial sites in South East Queensland via purposive sampling. These sites included aged and community healthcare agencies in Bundaberg, Hervey Bay, Toowoomba and Brisbane. Five research fellows collected field notes in the form of diary entries from their observations of implemented EBP initiatives over a six month period across the organisations. Field notes observed detailed barriers and enablers of implemented EBP initiatives and impact on clinicians.

In total, nine clinicians were interviewed at the end of the observational period to further explore clinicians' experience of implementing EBP initiatives. Data were collected using the technique of convergent interviewing in which the researcher collects, analyse, and interpret the participant's lived experience, opinions, attitudes, beliefs, and knowledge that converge around a series of interviews. Convergent interviewing enables in-depth interrogation by advancing a cyclical research method requiring continuing analysis as part of the whole approach (Driedger 2008; Riege and Nair 2004). Interview prompts such as "tell me about EBP initiatives your facility is implementing at the current time" were asked. Recordings from interviews were transcribed verbatim. Field notes from observations were merged with transcribed interview data and analysed.

Copies of transcripts were returned to each participant for verification interviews prior to analysis as supported in phenomenographic interviewing (Meyrick 2006). Written transcripts were fractured using line-by-line coding and subsequent categorisation led to the identification of themes (Saldana 2012). A concept map of individual interviews using qualitative data analysis software was subsequently produced and disseminated to encourage participant involvement in the analysis phase (Ralph et al 2014).

FINDINGS

Analysis of the findings revealed that participants referred to the need to treat risks and EBP initiatives in the same way a spillway is used in a dam. While EBP initiatives were valued among participants unilaterally (theme 1), the need to target the evidence where it is needed most through a systematic audit process (theme 2) was clearly recognised. The mechanism for achieving this was through the use of a spillway-styled approach (theme 3) in which resultant workload and practice issues were offset by accounting for the activity of EBP.

Concept 1: Valuing evidence

It was clear that nurses understood the need to maintain a foundational knowledge base for their own practices. While the importance of evidence was recognised, nurses reported experiencing difficulty at times in knowing how to approaching the literature and implementing it into their own scope and sphere of practice. While participants recognised the importance of EBP from their university education, the desire to use research to enhance knowledge was confounded by an overall uncertainty and a lack of confidence in approaching the evidence-base:

> "I know from my uni [sic] training that EBP is important. But since working full time I find it difficult to incorporate into my practice...I know I need to inform my practice and update my knowledge, but often I don't know how...Where do I start and how to I decide which topic is most important? I know there is a link between knowledge and EBP – I need to have the key knowledge prior to being able to look at the correct process [of how to utilise research] for EBP."

Although research utilisation was valued because of its role in increasing knowledge for practice, participants strongly identified with the idea that knowledge growth translated to practice improvement:

> "I think there are strong links to EBP and my own standards of practice."

Despite attitudes towards increasing levels of EBP, participants consistently viewed organisational constraints as a key barrier to achieving as much. Organisations appeared to prioritise nurses "doing" practice more highly than nurses "thinking" about practice with many participants perceiving that research utilisation was something separate to what nurses were primarily employed to do:

> "I just wished they had realistic expectations [about providing workload for research utilisation activities] so that we could actually achieve something...our organisation needs to make all evidenced-based activities more targeted and achievable."

Concept 2: Risk prioritisation

Participants highly valued the concept of EBP. However, there was a desire to couch EBP initiatives in terms of identifying specific risks within the organisation and responding to them through utilising quality research. A general lack of awareness within the organisation regarding the prioritisation of ongoing issues and how they were addressed through EBP was apparent amongst participants:

> "I would like to know how we prioritised our new focus of attention...I never agree with the priorities set by our organisation for research activity, I see other issues in my patient care that I think need more attention...surely our biggest risks should drive what we focus on for research...I once engaged in an infection control audit...although we found issues which I think were large,

the organisation then prioritised other activities. Given the escalating incidents we have seen in our areas surely they are priorities over anything the organisation wants us to engage in."

A strong theme of concern resonated across participants who voiced concern that a lack of comprehensive risk analysis was resulting in evidence utilisation becoming more of a feel-good concept than a meaningful endeavour. They voiced the need for organisations to specifically and systematically identify high-risk issues related to patient care and cluster EBP initiatives through a process of audit-based risk prioritisation:

"Not once in my time here in 10 years have I witnessed a clinical audit…I don't think we have enough data to decide what [quality improvement activities] should be a priority, perhaps we need more audits…I think they [clinical audits] have a place in determining what our staff should be looking at in improving patient care and decreasing risk…If the organisation informed where the infection control priorities were…it would decrease risk."

Determining evidentiary needs through a risk management lens was a feature of participant responses as staff viewed it as a means to appropriately direct organisational research priorities. Participants reported the danger of becoming distracted by priorities that were popular rather than reflective of the immediate needs of the organisation:

"I would like to know how we prioritised our new focus of attention…there are often multiple requests from staff and others and I need to know I am focusing on the right issues at that time. I see these distractions as a risk."

"We report a lot of risk, but I wonder why the risks we talk about are never part of the new activities coming through…. where I used to work they used the risk management process to drive what was a key focus at the time."

As a consequence of unclear priority-setting, there was a strong perception among participants that organisations often tended towards a reactionary response rather than a proactive approach to preventing risk:

"I only see the organisation seek and implement changes based on new evidence when risk management considerations advise them that without it the factors of consequence may be severe. If the organisation informed us where the priorities are that we need concentrate on, it would likely decrease risk. At present I don't know where to start with this nursing portfolio."

A whole-of-organisation approach to implementing evidence-based strategies to specifically target key risks to the safety and efficacy of care was strongly supported among participants. Participants reported feeling frustrated with poorly defined EBP initiatives, particularly where a lack of focused initiatives was observed:

"Better clarification of the key issues is required and I would like some training on evidence based changes. We need to move away from the way we have always done things and towards best evidence. Otherwise I believe the organisation is at risk."

In the absence of specifically directing the focus of the organisation towards using evidence to mitigate key risks in practice, EBP was perceived as an overwhelming activity that was ineffective when not aligned to

organisational risks. Participants felt as though it contributed to staff workload increases and limited the capacity of clinicians to capably address the specific needs of the organisation they worked in:

> *"They should be ensuring we have the capacity to finish something though before asking us to take on another," "Staff want the capacity and the time to fit in new initiatives, I just don't have the capacity at the moment to fit into my day. The organisation needs to free our time and stop focusing on so many things all at once."*

Time constraints were frequently raised by participants as a major barrier to engaging with evidence-based initiatives within the organisation by better prioritising workload associated with its implementation:

> *"Managers should ask, "have we done this before?" when approached with ideas and issues. They should be ensuring nurses have the capacity to finish something though before asking us to take on another…we just need more time to do research."*

Concept 3: Controlling the flow of evidence

Intriguingly, participants use the analogy of a spillway to represent how their perceptions of EBP should be implemented. In the context of limited time and seemingly unlimited EBP initiatives, there was broad consensus among participants that workload was either never or seldom given to account for EBP as nurses need to be 'practicing' rather than 'thinking' about best-practice. Not having sufficient time to start, progress or even finish any evidence-based initiatives was a constant source of frustration and resulted in nurses feeling overloaded or "flooded" with too many tasks at once.

> *"We are often flooded with requests to engage in new activities I just wish someone would control the flood. You know a bit like a dam wall… Lately I just feel overloaded. Research is just another task we don't have time for. I think the organisation has no idea how much overload of information comes our way at times. I wish we could just focus on one task sometimes; I am juggling a lot at the moment I go home feeling overloaded. Sometimes I feel like I am juggling lots of things at once."*

Nurses very clearly recognised research utilisation and implementation as a major facet in addressing the priorities of care more tangibly amidst calls for it to be specifically recognised in the role of a nurse through workload allocation:

> *"Different nursing settings will need different approaches, and some creative thinking may be needed. However, it should be borne in mind that unless freed up time is earmarked for research implementation; other activities are likely to take priority."*

The use of the spillway analogy by participants was novel and resulted in the development of a model in which research utilisation, organisational priorities and integrated risk management are considered in the broader context of EBP.

DISCUSSION

This research has cast a spotlight on the tension between the benefits of EBP initiatives and how the wealth of evidence is managed to target clinical risks. The following discussion will address three main points: the

complexity of effectively implementing EBP initiatives; the role of nurses in communicating around EBP initiatives; and potential Spillway mechanisms to control the flow of evidence towards identified risks.

The rise of EBP initiatives in the clinical environment have been well studied in the literature (Kitson et al 2008; Pearson et al 2005; Estabrooks et al 2003; Rogers 2002). However, there are emerging concerns about how the influx of EBP initiatives should be addressed to effectively challenge targeted specific clinical issues (Moloney 2013). This issue is represented by study data showing that while nursing staff had a good grasp on clinical risks and were eager to engage in EBP to mitigate clinical risks, an overload of these initiatives overwhelmed the implementation process resulting in broad perceptions of failure. The resultant outcome meant there was a reported decrease in staff capacity to utilise evidence effectively.

More broadly, there are clear deficits in the dissemination and utilisation of multiple EBP practice initiatives concurrently in smaller organisations. Current implementation models have not factored in the broader influences on risk-prioritisation and its relationship with EBP (Pearson et al 2005). Health services need to consider what their key clinical risks are when considering what EBP initiatives to emphasise (Blackwood et al 2011).

If healthcare professionals are questioning decision-making from their leadership groups, then clinician engagement in EBP has been sub-optimal with respect to decision-making processes. Decisions typically made by senior health managers regarding EBP initiatives should be inclusive of staff longitudinally, throughout its implementation (Rogers 2002). The results of Timmins et al (2012) align with this study as both findings raise questions around the type of leadership for evidence-implementation within the facility and how it is communicated to ensure it impacts the point-of-care positively.

Ironically, very few studies directly consider personal and organisational risk prioritisation skills and or leadership attributes in their recommended processes. A review of the literature reveals that the highest priorities to nurses were 'standards of patient care' and a 'reduction of harm' with significant challenges in evidence utilisation and controlling the flow of information in the clinical setting (Morley et al 2014; Wilkes et al 2013). To appropriately focus the implementation of evidence, Smith et al (2009) argues that researchers and decision-makers must spend more time developing EBP implementation initiatives collaboratively. Furthermore, these initiatives must be targeted to the most pressing clinical risks, meaning nurses at the point-of-care should have a vocal role in deciding where and how evidence implementation initiatives are prioritised (Mandleco and Schwartz 2002).

Consequently, healthcare leaders and researchers need to view integrated risk management and EBP implementation as an opportunity to create strong synergies between the two. For this to occur, healthcare organisations need to be sensitive and responsive to core staff concerns around clinical risks and the time taken to utilise evidence to mitigate them effectively (Rangachari et al 2015; Lavis et al 2003). For the nursing profession, the results of this study and that of Moloney (2013) support the role of a nursing 'gatekeeper' to articulate the hidden workload involved with EBP initiatives and clinical risk mitigation.

From this study, a basic representation of the need to control the flow of evidence is offered to articulate the ideal process of how EBP initiatives are implemented in the clinical environment. The Spillway Model (see figure 1) - directly derived from the data – is proposed as a means of structuring evidence uptake, identifying risks, and proposing an appropriately staged intervention so as not to overwhelm clinicians.

Figure 1: The Spillway Model
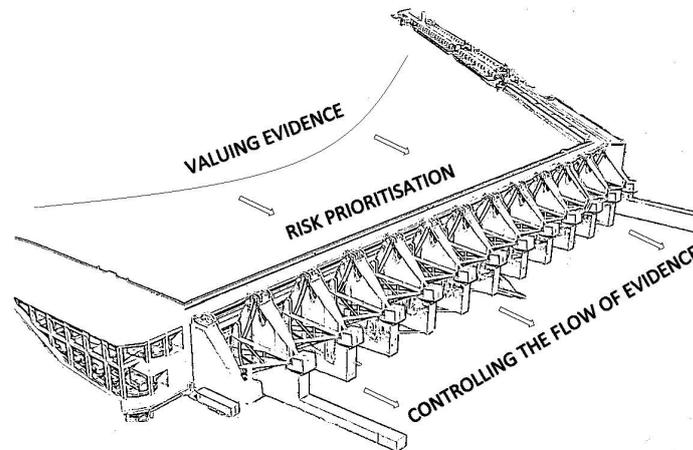
A Spillway Model is necessary to control the flow of evidence and appropriately prioritise risk. While a variety of mechanisms could be used as the spillway 'gate', there needs to be clear channels for how EBP initiatives are implemented along with justifiable rationales. The participants clearly pointed to a system where a mechanism such as integrated risk management acted as a way of controlling the flow of EBP initiatives. The use of clinical audits, as raised by participants, can form an integral part of any integrated risk management system in which risks are prioritised to guide the implementation of EBP initiatives in the clinical setting.

Figure 2: From Integrated Risk Management to EBP Implementation
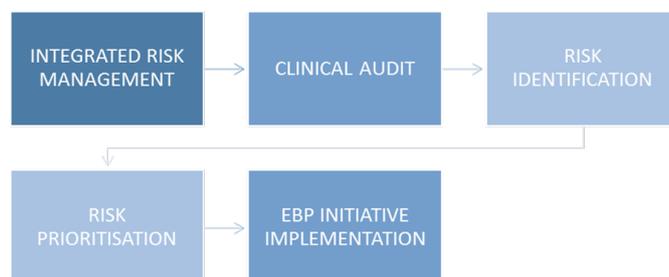
While this process presents *one* possible mechanism for using a Spillway Model, a pragmatic approach to long term evaluation of successes and failures for EBP initiatives is required to ensure that risk management, EBP and quality assurance become integrated processes. A longitudinal evaluation of the process proposed by the Spillway model is therefore warranted. As this research has cast a spotlight on a significant gap in the domain of putting EBP into practice, a challenge has now been tendered; will healthcare organisations now work more effectively with the nursing profession to translate these initiatives to the point-of-care more effectively?

LIMITATIONS

This study may be limited by its location and length. It is not known whether similar circumstances exist outside of south-east Queensland. Likewise, although data were collected over a six-month period, it is not known whether controlling the flow of evidence improves after this period.

CONCLUSION

This study emphasises the clinical environment in which nurses work require a discrete structured filtering mechanism that controls the flow of different evidence-based activities impacting on their workloads. In doing so, nurses may then be able to channel EBP initiatives according to risk rather than other, arguably dubious, rationales. As natural attorneys of change, nurses need to take a proactive leading role in prioritising EBP initiatives, ensuring that, as internal stakeholders, they maintain clear lines of communication to key organisational touch points to articulate the risks and needs of each clinical setting.

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Stoma and shame: engaging affect in the adaptation to a medical device

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ABSTRACT

Objective
The objective is to understand difficulties some patients have with their adaptation to a medical device, specifically a stoma and an ostomy appliance, following gastro-enterologic surgery. A partial or total colectomy is typically performed in cases of digestive cancers, Crohn's disease, or anal incontinence. A psychotherapeutic application deduced from this understanding is described. The therapeutic approach is informed by Lacanian psychoanalysis.

Setting
The setting is the digestive surgery services section of a large public teaching hospital in France. The clinical team conducting the interventions described perform their work with patients post-operatively.

Subjects
Selected cases are chosen to provide brief illustrations of the analysis and the psychotherapeutic approach developed.

Primary argument
This study focuses on the impact of the stoma and the ostomy appliance on the subjectivity of the patient and shows how the affect of shame can appear. It is noted that the affect of shame in the adaptation to an ostomy appliance has not been investigated to date. This affect can in turn have psychological effects on the gastro-enterologic treatment itself, even to the point of the patient's abandonment of ongoing care. The analysis reported here explores the recognition of shame when it might be present, and the process of accompanying the patient therapeutically, engaging the logic of the transference.

Conclusion
Shame cannot be treated by ignorance or by indifference. A psychotherapeutic application engaging the transference between the patient and members of the nursing and psychotherapeutic team, helps patients support shame and adapt well to the ostomy bag.

INTRODUCTION

In cases where a colostomy or ileostomy is performed as treatment for gastroenterological disease, the effect of the intervention involving a stoma[1] with an ostomy bag often presents some difficulties for the medical team. It is not so much that there are difficulties arising from the medical device itself, but rather difficulties for the patients who must then adjust to living with the stoma and the ostomy appliance, with its requirements of drainage and changing. Our analysis of the lived experience of patients who have received either a colostomy or an ileostomy appliance, indicates the difficulties and related affects are similar in each case. Our group has observed how a patient, who apparently does not think about the stoma and the ostomy bag, can become isolated, sometimes for some years and sometimes even resulting in suicide.

There is a small but growing focus on the question of the experience of stoma and the introduction of an ostomy appliance in the nursing literature, researching how nurses might understand, treat and care for patients living with a colostomy or ileostomy bag. The question of acceptance has been addressed in a number of studies. The intervention of the bag has been described as a 'challenge' (Popek et al 2010; Krouse et al 2009), through to identifying a 'negative impact' due to the difficulty of acceptance (Thorpe et al 2014; Ang Seng Giap et al 2013; Kimura et al 2013(a) 2013(b); Siew Hoon et al 2013; Jeanroy-Beretta 2011; Krouse et al 2007; Northouse et al 1999). These studies, however, do not address the nature of this difficulty.

A comprehensive literature search found that the issue of shame[2] is considered in only two articles. In one, it is given a passing mention: Johnsen et al (2009) acknowledge the significance of this 'sense of shame' for patients, as this emerged from their research, but without proposing an analysis of this sense of shame in therapeutic terms. There is one study in the French literature (Jeanroy-Beretta 2011) that offers a remarkable reading of the stoma from the point of view of a concern regarding shame and sexual modesty. Although Jeanroy-Beretta addresses the issue of what is involved in the act of looking at, or into, the stoma, she does not draw out the psychodynamic consequences. Within the psychoanalytic paradigm, Freud (1910) considered that the look is different from the organ, the eye. The look is a partial drive (Freud, 1915), with its partial jouissance[3]. Jeanroy-Beretta confines herself to the issue of the sight of faeces in the bag on the stomach, but misses the significance of the drive of the look. In our clinical practice, we note that what the patient typically says he or she first **sees** is the flesh of the abdomen ('my own flesh outside'), or some faecal matter, or some blood, etc; sometimes it is the bag itself.

The problems of adapting to the bag are most often linked to the impossibility of accepting the sight of the stoma on the abdomen. In turn, this impossibility is what drives carers to engage patients on the question of their perception of this sight, a perception that will be specific to each individual patient.

We find these visual perceptions to be the main ways of discovery most frequently encountered with patients post-operatively, and they invariably refer to shame. Shame concerns the look of the 'other', and the imagined view the individual has of him or herself through the gaze of the 'other'. Shame does not necessarily, or immediately, involve guilt. According to psychoanalyst Jacques Lacan (1964, p98), shame passes by the drive of the look or gaze. Therefore, the question is posed how a practitioner might work with shame, from the moment of a traumatic shock of the look that captures the patient.

Research with patients recovering from curative colorectal cancer surgery, reported by Taylor et al (2010), investigates patients' fears about cancer returning. They present a model of a movement from an initial

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[1]   See glossary for explanation of 'colostomy', 'ileostomy' and 'stoma'.

[2]   See glossary of terms.

[3]   See the glossary for an explanation of the terms 'jouissance' and 'the partial drive'.

disembodiment to embodiment as a process of therapeutic recovery involving a regaining of control. They propose two opposing positions – guarding and resolution. "Guarding" refers to the difficulties patients face during the transition towards recovery, involving a reaction of a kind of hyper-vigilance. Focussing on the shock of the visual sight, and the shame that the intervention of a stoma elicits, we intend to show how patients might pass from guarding to resolution.

All studies reviewed emphasise the importance of the nursing relationship developed with patients (Ferreira-Umpiérrez 2014; Thorpe et al 2014; Ang Seng Giap et al 2013; Zheng et al 2013; Landers 2012), or that of health care professionals more generally (Taylor et al 2011; Krouse et al 2009; Northouse et al 1999). However, no study explores the dynamic of the relationship, nor questions what approach would be most beneficial for the patient.

In psychoanalytic terms, a relationship between two persons, particularly where there is a perceived and apparent difference in knowledge or expertise, involves transference[4], positive or negative, which is an unconscious dimension of the relationship. Transference is not addressed in the studies reviewed. One study recommends that patients have access to psychologists before and after the surgical procedure (Krouse et al 2009, p232), without addressing the issue of transference in the relationship. In the nurse–patient relationship, the two persons involved are the nurse, who is not ill, and the ill person; this is an asymmetric relationship. From a psychoanalytic point of view, if transference is not taken into account, the treatment will be ignoring an important aspect of the therapeutic process.

Evans (2007) explores the importance of transference in the nurse–patient relationship. The patient, feeling weakened by his or her illness, is often in a position of recognising the supposed knowledge of the nurse or the doctor. In Evans' terms, with reference to Lacan, "transference, then, can be recognized by the emergence of a subject who is 'supposed to know'" (Evans 2007, p5); the 'subject' here being present in the form of the nurse or doctor. The one-on-one relationship, as is the case in stoma care, encourages the health care professional to grasp what is happening in this relation with the patient. Evans (2007) claims the nature of the transference that can develop between the nurse and the patient depends on the distance between the two partners, a distance concerning the unconscious[5] link: "When the nurse is positioned as distant to the patient and involved with the more technical aspects of care; (*sic*) that is, as technician, it is more difficult to privilege listening to the patient, thus making it more difficult to hear the particular meaning each patient attributes to his/her illness" (Evans 2007, p2). The position of distance does not enable the therapeutic relationship; a position of an inappropriate closeness can introduce anxiety. Distance or proximity have to be evaluated in relation to each patient, because it concerns the unconscious of the patient.

As Evans explains, if and when the transference develops, the nurse who is initially a stranger to the patient, "might be positioned, for example, as someone who the subject can trust, love and respect, or the person might be positioned as someone who the subject feels they can never please" (Evans 2007, p4). These kinds of positioning indicate precisely that transference is operative in the relationship.

Our clinical practice aims to incorporate an understanding of the transference. We are concerned to reflect on the way the lived experience of patients might be affected by this medical externalisation in the case of colostomy or ileostomy. What is happening psychically regarding the introduction of these medical devices? The suffering experienced by patients guides our reflections. It appears clear that all professionals involved in surgical-related care in gastroenterology will meet such situations. However, none of the research to date

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4   See glossary of terms.

5   See glossary of terms.

begins their study in the hospital, with the patient at the time of the discovery of the stoma on the abdomen, with the nurse who cares, nor considers how to practise care through accompanying this suffering. This is our qualitative focus.

SHAME AND SUBJECTIVITY: THE FELT, THE SAID, AND THE SEEING

The starting point for our approach is immediately post-operative, when the patient confronts the stoma through to the time when an adaptation has been achieved. Our experience has demonstrated that there are two versions of the stoma, that of the surgical team and that of the patient. In perceiving this distinction, we follow the notion of Georges Canguilhem (1966/1989) that there are two versions of a disease, as two sides of the same knowledge. The distinction is necessary as the disease of the patient is not the anatomical medical disease. Indeed, since the early 1980s the distinction between the discourse of medicine and the narrative of the patient, building on the work of Canguilhem (1966) and Merleau-Ponty (1968), has become a prominent basis for social research focusing on medicine, health and illness. For example, Mishler (1984) developed the dual construct of the voice of medicine and the voice of the life-world.

In this way, we differentiate the medical professionals' version of the stoma from the patient's version. The medical version of the stoma is a surgical solution to a failed function of the colon, surgically creating a junction of the colon or the ileum towards the abdominal skin. A temporary stoma protects the anastomosis following a large or small bowel resection and prevents suppuration pending healing, for example in the case of radiotherapy treatment for cancer, an ostomy appliance is added. A permanent stoma usually involves the introduction of an ostomy appliance.

In the narrative of the patient, the stoma is a singular representation that the subject constructs about this experience: how he or she lived and felt is expressed in what he or she says. From the perspective of Lacanian psychoanalysis, the person who speaks is a 'subject', and the subject is a speaking-being (*'parlêtre'*), a term coined by Lacan (1975, p56)[6].

Although the experience of the stoma is singular for each patient, there is an element that appears to be more or less constant and that is the affect of shame. I now offer some brief illustrations from our practice.

A patient, aged 50, suffering from colorectal cancer had a colostomy bag. He would shop in a large supermarket, but began to fear that his colostomy bag would open itself when he was out shopping and that the retained liquid would spill on him. After evoking this feared scene, he said, "people would think I wet myself." This was so outrageous for him to contemplate that he gave up his shopping outings, seized by the shame of a potential flow.

The feeling of shame refers to a shame experienced and lived by the patient. This 'felt shame' can be said to be in the background of the enunciation of the patient, which in turn re-actualises an affect of shame. In the field of linguistics, it is common to distinguish the statement, or utterance (what is said) from the enunciation (that which can be deduced from what is said) (Benveniste 1958). For this patient, we distinguish the 'felt shame' from the 'said shame'. Over the course of a period of four days, and through the psychic work between sessions, he speaks of a shame felt when out shopping. He speaks of this shame in a way that fixes the shame in a certain utterance "people would think I wet myself." The 'felt shame' can be heard by the clinician in the background of the statement. Then later in a different register he is able to say: "I am ashamed, embarrassed ...". We are referring to this as 'said shame'.

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[6]   See the glossary for an explanation of 'Lacanian psychoanalysis' and 'parlêtre'.

It is also striking that the shame, both 'felt' and 'said', in this instance is rooted in an anticipation of the gaze of others, what they might see. In our clinical experience it is most often the case that the shame has its genesis in the look. Another patient told the psychologist "it disgusts me to look. I would not be able to change it myself. It repulses me [...]".

Here the statement refers to the problematic of the look (or the eyes as the site of the look). Indeed, this patient can no longer see the side of his body where the stoma is placed; he does not look at it. He seems to make a half turn. This avoidance of the look is a constant we observe for a considerable number of patients.

The patient encounters his or her own gaze. This look "reduces him to the feeling of shame" (Lacan, 1964, p98). In this way, shame indicates or signals the expression of an affect coming from a weakness in the constitution of the specular image of the body. We find evidence for this hypothesis in the relationships felt, and said, by patients in our clinic. In other words, this is an imaginary identification, through which shame appears as the privileged affect. Generally, shame signals an effect and an affect, in terms of the representations idealised by the patient. This affect refers to a certain moral conscience of the subject.

MOVING ON FROM THE SHOCK OF THE GAZE

Mrs. B., 78 years, has just undergone a definitive colectomy[7] and discovered postoperatively, without prior warning, that she now has a colostomy bag. Our first meeting takes place on day six after the operation. She is curled up in her bed, seeming gaunt, even emaciated. The nurses had warned the psychologist of a possible "syndrome of sliding" referring to a possibility the patient was giving up, mentally. In this case it meant she was no longer accepting food. Immediately after introducing myself (LD), and after a silence, she manages to say: "It's horrible," and repeats "it's horrible," while looking towards the other side of her body relative to her stoma. Her curled body seems twisted, as if she turned partially so as not to see one side of her body. She seems desperate and stunned. I stand on the side where her gaze is directed, meeting her where she can look. I say "You said to me it's horrible, it's horrible, could you explain...". She answers "I don't want to see it ... I don't look at it ...". The clinician can hypothesise this is 'felt shame'? It is starting from this look that she begins to speak about it; from the look, she chooses to speak.

In our hospital setting there are a number of different roles involved in patient care, therefore together we construct a situation of multiple transferences. While cleaning and dressing the area around the stoma for the patient, the nurses are asked by the psychologist (who manages the transference) to take a long time over this process, all the time talking to the patient – about everything and nothing – inviting him or her to speak, but also to be able to look at the stoma site in their own time, at their own rhythm. This creates a care more prolonged than usual, and in the process there is a restoring of a "bath of language" (Mannoni 1970, p240). If the patient cannot look, at least he or she can hear someone talking about the care being given.

It is important for the patient to look at the stoma and/or the ostomy bag, and for this to take place with someone. Practising in this way we often observe positive results whereby the patient appropriates[8] the medical device over time. But in the case of this patient, she cannot grasp it. Transference is constructed after the first meeting. I meet her for a second clinical interview; she talks about what she likes including singing, which had become her activity in the retirement home in her village.

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[7]   See glossary of terms.

[8]   The term 'appropriate' is used here as a verb to evoke the way successful adaptation to the medical device will involve the patient being able to make the ostomy appliance his or her own, incorporating it into his or her body schema, to accept it.

She explains that she does not want to eat: "I don't want to see the bag fill itself." There was a kind of dysaphagia, which led to the maintenance of parenteral nutrition. She talks about "this block", which in French is 'ça bouche'. I can also hear this as her mouth ('sa bouche'). There are two reasons for this: firstly in French 'ça bouche' (this block) and 'sa bouche' (meaning her or his mouth) sound exactly the same when spoken; secondly, the word stoma is from the word for mouth in Greek. The patient sees the stoma, the opening, and, because of anxiety, can no longer take food in her mouth. The noticeable connection between these words, in the first instance because of their homophony in French, enables the practitioner to point towards a possible unconscious process preventing the patient from eating. This modality of practice for recovery insists on the equivocation of language, a central feature of Lacanian psychoanalysis. She answers "that makes a ball in my throat." This statement designates an anxiety. I say "you feel an anxiety…" She agrees with this interpretation.

Gradually, she seems to become increasingly calm, having talked about what she likes, who she is. In the next session, in showing her colostomy bag, she says: "I'm not normal like everyone else … I'm ashamed of what I have" – shame is present and is said. The statement joins the enunciation. She calls her colostomy "Laffreuse[9]", which means "the awful". Then, she tells of an event with her mother when she was a child: "I was afraid to cross an obstacle, and my mother told me gently 'go ahead'". I end the interview on this utterance: "With food, as your mother had told you, go ahead."

In parallel, the nurses continue their particular cares, more pronounced around the stoma. After three meetings, the state of abandonment has ceased. After the last nursing care, I meet Mrs B. for the fourth time. She tells me: "I've eaten a little." The mother's statement to "go ahead", which has been internalised, suffices to reactivate her ability to take food and in the same movement she can appropriate the stoma.

Then she is able to evoke what she had seen the first day, on her belly: "I saw a piece of flesh of my own flesh". Shock! Tumescence of the real body! She said "it's part of me now," touching the colostomy bag. Then she adds: "I saw the bag change." I asked her what she saw … She places her hand with spread fingers before her mouth and, with a small smile, she said "I saw a little." I emphasise her gesture. I do the same. She smiles. The living being was re-engaged. She can leave the hospital some days later, to stay at a convalescent home.

This clinical picture shows how the solution of a medical device such as an ostomy appliance is one requiring not only a process of accommodation that is entirely singular to the patient, but also one that he or she can appropriate visually. The patient, Mrs B., re-linked this process to an utterance made by her mother. If the stoma is more or less traumatic it is because this intervention is the second time, one that repeats in some way a first time when the subject was questioning in childhood (Freud 1895). At the current point of the second time, the stoma re-actualises this first moment. Subjects succeed in answering this question in childhood, with the singular theory that they invent; but now, with the stoma, they fix it at the level of the Imaginary[10].

The patient can no longer recognise him or herself in the body image from which he or she is alienated. It is a drama whereby the return of an object of the drive projects the patient into shock: a drive coming from the Real[11], through the look. The return of the drive explains the shock as well as the way out of the stunned state it induces. What was unified by the specular image does not hold anymore! The patient discovers "the piece of flesh" on the belly; the breaking through of the Real. For another patient it is the sight of the faecal

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9   "Laffreuse" in French is not a word as such. This signifier results from combining a definite article ('la', which is 'the' in English) and an adjective ('affreuse'). While 'l'affreuse' lacks a noun, this signifier 'laffreuse' creates a noun to personify something she saw; it is a poetic way of naming, invented by her.

10   See glossary of terms.

11   See glossary of terms.

matter. It happens through the partial objects, as in the drive, in which the gaze is implicated each time. This sight, or image, refers to the Imaginary and may provoke a re-actualisation of shame, of submitting to the look of others. This look that the subject imagines or supposes from others, refers above all to his or her own looking. There is an alienation of the subject in the specular image (Lacan 1966). The clinician promotes the detachment from the shock, in knowing well this function of unconscious alienation. We called this detachment 'de-sideration'[12]. So, the patient's desire appears again and then the subject is able to say something about the shock. Another patient can name the stoma and ostomy bag, indicating a "that", to which the clinician responds, and the patient adds, "this shit" … In this desperate look, "shit" is a signifier, found by a subject, a metonymic[13] signifier. Another calls it "Laffreuse", or "Moricette" or "piece of flesh". There is a passing from the stunning of the shock to the shame felt, beginning with the distressed look, to the said shame. And the subject can then name the colostomy. In this sense, the representation of the shock comes unstuck, and is able to see itself, and say itself. A "parlêtre", or speaking-being, has to use language to translate his or her feeling and to transform the shock into singular signifiers.

IN CONCLUSION

One way of approaching psycho-pathology that might appear in the process of encountering the stoma, when this pathology is centred on the gaze, identifies the significance of the specular image of the body. With this unconscious image appears an affect, shame, and the subject is alienated to this image. The Other, as the locus of language and culture beyond the subject, must validate the mirror image of the patient, even if others have not been able to see what the patient sees. In other words, through the Other, in turn through the transference, the patient is enabled to appropriate the ostomy appliance. In clinical sessions with patients we therefore start with, and follow, their utterances to lead them toward representations that are susceptible to reducing anxiety.

Our clinical experience suggests thinking about the medical phenomenon of colostomy or ileostomy in terms of subjective structures; approaching patients one by one. Through a clinical application with a team of health professionals, engaging the affect of shame, it is possible to accompany the patient in some kind of restitution of psychic continuity[14].

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[12] Sideration in French means shock or stunned, stupefied in English. Thus de-sideration is a progressive diminishing of this shock.

[13] In the case of a metonymic signifier, the part stands for the whole: shit is both faecal matter collected in bag and a denotation of the stoma and ostomy bag.

[14] There is a double meaning here in French: *"Remise en continuité"* is a French medical term, used in gastro-enterological surgery, meaning to reconstitute the normal way of the colon, when possible.

GLOSSARY

Colectomy

surgical removal of the whole (total colectomy) or part (partial colectomy) of the colon.

Colostomy

a surgical operation in which a part of the colon (large intestine) is brought through the abdominal wall, creating an opening called a stoma. The opening of the colon, is performed in order to drain or decompress the intestine. The colostomy may be temporary or permanent. An ostomy appliance, or bag, is usually worn over the colostomy opening. (See also stoma.)

Ileostomy

a surgical operation in which the ileum (lowest of three sections of the small intestine) is brought through the abdominal wall creating an opening for the discharge of contents, bypassing the colon. An ostomy appliance, or bag, is usually worn over the ileostomy opening. (See also stoma.)

Imaginary

a register of the subject, concerning the effects of the formative nature of the image (see Lacanian psychoanalysis).

Jouissance

is a French word meaning enjoyment. However, in the Lacanian psychoanalytic field it is generally not translated into English because Lacan has a particular rendition of the term involving a state of excitation, even a traumatic intrusion, where intensification of pleasure becomes painful as it reaches a limit. Jouissance concerns that which has not been thought or represented as such by the subject, and which is experienced physiologically in the body.

Lacanian psychoanalysis

an approach to psychoanalytic theory and practice developed by Jacques Lacan (1901-1981), who claimed to return to Freud. His focus is primarily on how we are 'parlêtres', that is, how our way of being human is fundamentally grounded in the fact of language, as beings who speak. This being is a subject, with both consciousness and an unconscious, constructed through the demands of the parent(s), or caregivers, and is traversed by three registers: real, symbolic and imaginary.

Parlêtre

a neologism coined by Lacan (1975, p.56), combining the notions of 'speaking' and 'being' into one word in French. He develops this concept to avoid a substantialist notion of being, such as within phenomenology, privileging rather the subject's formation through its relation to language. For this concept he draws on the work of linguists such as Ferdinand de Saussure, Roman Jacobson, Emile Benveniste, and Michel Arrivé. As such, the subject is not a substance but a fact, or effect, of language: "it is in and through language that man (sic) constitutes himself as 'subject'" (Benveniste 1958, p.259).

Partial drive

the drive comes from sensations in the body, deriving its support from the corporeal orifices. The drive's aim is to circle around the object of the drive rather than achieving some imagined goal of full satisfaction. The concept of the drive is central to Freud's theory of sexuality. Both Freud and Lacan distinguish the drive from instinct, in other words it is not a fixed, biologically innate relation to an object, but rather a relation that varies between subjects and is contingent on their specific histories. For Lacan, all drives are partial drives because they only ever partially represent the sexuality of the subject.

Real

is a register of the subject, concerning that which is impossible to represent, to symbolise, to put into words (see Lacanian psychoanalysis).

Shame

in psychoanalysis shame is an affect constituted on the unconscious traces of early experiences of satisfaction or pain. It relates to the perception and meaning attributed to the look or gaze of the Other. Referring to a feeling of shame experience by Sartre, Lacan (1964, p.98) explained that the look "that surprises him in his role as voyeur" is "a look my ego imagined coming from the field of the Other." Shame is thus situated in the imaginary register.

Stoma

is a generic term for a surgical opening of a tube such as the colon or ileum that has been brought to the surface on the abdomen. This term is specialised in relation to the localisation of the affected tube, thus colostomy (for a stoma of the colon) and ileostomy (for a stoma of the ileum).

Transference

Freud noted the influence, indeed effects that the medical doctor can have on the ill person through suggestion. Such an influence becomes possible through a process of transference involving a displacement from another situation deriving from the ill person's past, to the current relation with the health professional. Transference is therefore a resource insofar as something, sometimes from earliest childhood, is set in motion, which is then replayed in the relationship between the ill person and the carer. "Like Freud (1900/1976), Lacan (1988) argued that transference is how the unconscious is given form" (Evans 2007, p.193).

Unconscious

The unconscious is a central concept of psychoanalysis, concerning a part of the topological organisation of the psychic apparatus. According to Freud, unconscious formations might mark their presence in slips of the tongue, bungled actions, dreams, symptoms, etc. Unconscious processes indicate a return of infantile theories. The unconscious is present in the transference.

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Access to healthcare services for people living with HIV experiencing homelessness – a literature review

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ABSTRACT

Objective
People living with HIV (PLHIV) who are homeless or at risk of homelessness experience significantly worse health outcomes than those in stable housing. They are more likely to be diagnosed late, use substances, engage in high–risk sexual activities and have difficulty adhering to treatments. This review identifies strategies described and evaluated in the international social science literature which can improve access to HIV–treatment and care for PLHIV who are homeless or at risk of homelessness, to inform policy and service development in Australia.

Setting
The principle research question addressed in this review is:

- What strategies enhance the ability of PLHIV who are homeless to access health care services, in particular community nursing services?

A literature review of social science research relating to the research question in the international and Australian contexts was conducted.

Primary argument
No literature was identified that addressed access to community nursing services for PLHIV experiencing homelessness in Australia, and very little internationally. Community–based nursing organisations are well–placed and experienced in engaging marginalised groups in health care. Specific interventions need not always be developed: rather, better use could be made of existing services that utilise assertive outreach models of care and co–location with other services.

Conclusion
HIV–specialist community nursing services could be better integrated with homelessness services to enhance access to care, link PLHIV into the health system and keep them engaged in care. The absence of research on engagement with HIV specialist community nursing services demands exploration.

INTRODUCTION

By end 2014, there were approximately 27,000 people living with HIV in Australia; over 70% of these are men who have sex with men and approximately 10% are women. Fewer than 2% can be attributed to sharing injecting equipment (The Kirby Institute 2015).

Data is limited on the numbers of homeless people living with HIV in Australia. However, the Australian Bureau of Statistics (ABS) 2014 General Survey indicated that lesbian, gay or people of 'other' sexual orientation were more likely to report at least one episode of homelessness than were heterosexual people (ABS 2014), and a 2013 study from the University of Adelaide concluded that lesbian, gay, bisexual, transgender and intersex (LGBTI) people are over-represented in homeless populations (Oakley and Bletsas 2013). Homelessness and unstable housing amongst youth have been associated internationally with increased HIV infection risk (Marshall et al 2009).

In some Australian states, specific housing associations have been established representing the interests of people living with HIV, indicating that housing and homelessness are significant concerns for this population. For example, in Victoria, the AIDS Housing Action Group was established in 1990 and in a recent parliamentary inquiry, this group described specific issues such as same sex domestic violence, refugee and asylum seeker status, stigma, discrimination and violence against people living with HIV within public housing, the impact of living with a chronic, complex and life threatening illness, social isolation and ostracisation from family and community, ageing with HIV and a range of other issues potentially contributing to housing instability and homelessness (AIDS Housing Action Group 2011).

Internationally, HIV prevalence is highest among the marginalised (Wakeman et al 2009). There are high rates of homelessness amongst PLHIV and high rates of HIV amongst the homeless (Cheever 2007; Douaihy et al 2005). PLHIV who are homeless or at risk of homelessness experience significantly worse health outcomes than those in stable housing (Cheever 2007), and are at greater risk of hospitalisation (Nosyk et al 2007). Homeless PLHIV are more likely to be diagnosed late (Nelson et al 2010), to use substances, engage in high–risk sexual activities and have difficulties with treatment adherence (Roy et al 2011; Friedman et al 2009; Stein et al 2009; Marshall et al 2008; Metraux et al 2004). These factors mean they can risk transmitting HIV to others, with reduced access to HIV prevention education (Stein et al 2009). The prevalence of HIV infection amongst the homeless has been estimated to range from 0.3% to 21.1% (Beijer et al 2012). One study conducted jointly in Australia and the United States of America (USA) indicated that 2% of homeless youth in both countries self-reported that they had HIV infection (Milburn et al 2006), and rates of up to 20% have been reported in the USA (National Coalition for the Homeless 2007).

It is also known that in the USA at least 20% of PLHIV are unaware of their infection with much higher figures amongst the most marginalised (Chen et al 2012). In Australia, it is estimated that about 14% (range 11-21%) of all HIV infections are undiagnosed (The Kirby Institute 2014). Access to care for this group is a significant public health issue worldwide (Beijer et al 2012).

It is documented that homeless PLHIV experience reduced access to health care including HIV primary care, and a range of interventions has been explored to improve or increase their access to HIV care, and to retain them in care (Thompson et al 2012). Little published research deals specifically with their access to specialist HIV community nursing services.

In the Australian setting, the Victorian HIV Strategy states:

'Sub–groups of people with HIV/AIDS continue to experience difficulties in accessing treatment care and support services. Agencies are encouraged to identify vulnerable groups of people with HIV/AIDS and to

design a range of strategies and services to better meet their needs. These strategies include:

- Making existing services more flexible and available to people from marginalised sub–groups.

- Developing collaborative partnerships between HIV/AIDS services and mental health, migrant health, homeless youth, Needle and Syringe Programs and women's health services' (Victorian Department of Human Services 2002, p26).

Community nursing services in Australia are often central to linking people into HIV medical care and primary health care. In several states, community nursing services have close partnerships with AIDS Councils (referred to internationally as AIDS Service Organisations [ASOs]) (Crock and Frecker 2008). Homeless PLHIV may come in contact with ASOs and be linked in with community nursing organisations, or they may come in contact with the nursing service first through specialist programs or following hospital admission. Enabling them to access HIV care and retaining them in care can be challenging, but community nursing services with expertise in HIV are well–placed to play a significant role in engagement in HIV primary care (Purcell et al 2006).

The principle research question addressed in this review is:

- What strategies enhance the ability of PLHIV who are homeless to access health care services, in particular community nursing services?

Secondary questions considered for this review include:

- What are the barriers to access to health care services for PLHIV who are homeless?

- What factors contribute to retention in care for PLHIV who are homeless or at risk of homelessness or marginalised for other reasons?

SEARCH STRATEGIES

A literature review of social science research relating to the research questions in the international and Australian contexts was conducted (2002-2012). The search strategy included the use of the electronic databases Global Science, SCOPUS, Social Work, PsycINFO, CINAHL and the Australian HIV/AIDS Database. Search terms used were: HIV and/or AIDS, homeless or homelessness, access to HIV care, access to services, barriers to access, and community nursing. Further research was conducted seeking publications on the National Centre in HIV Social Research website and the Australian Federation of AIDS Organisations' websites, including the journal 'HIV Australia'.

Little information on HIV and homelessness in Australia was found, hence this review draws principally from international literature. No literature was located that specifically addresses strategies to enhance access to HIV specialist community nursing, so the focus was broadened to include strategies to enhance access to and engagement with HIV primary care and health services generally for the homeless and for people marginalised for other reasons such as injecting drug use, minority status, mental health problems, or all of these. The terms 'retention in HIV care', 'engagement' and 'marginalised' in various combinations were subsequently added to the original searches. Twenty one articles were located that were considered relevant to the subject area, and of these, eight were considered relevant for more in–depth review to address the research questions.

SUMMARY AND ANALYSIS

Two studies reported on research into PLHIV living in single room occupancy hotels (SROs). SROs in New York City are used as emergency housing for homeless PLHIV.

The first of these examined service utilisation patterns amongst chemically dependent homeless PLHIV to evaluate the program theory that engagement with outreach services is 'a mediating variable that increases service utilisation' (Shepard 2007, p26). This study comes from a positivist paradigm, although it examined a model of care and outreach (harm reduction) that contrasts with a medical model and promotes empowerment and self–determination (Shepard 2007).

The population studied was a group of homeless PLHIV with a history of chemical dependence residing in SROs in New York City. Two cohorts were compared – individuals who were engaged through 'harm reduction outreach' and those who 'walk–in' to a drop in centre (Shepard 2007, p26). Outreach was defined as a model including: crisis intervention; addressing problems; skills building; education; risk reduction education; and discussion, through: medical providers and peer workers working together; evening outreach hours; and tools (e.g. syringe exchange, consistent services, transportation) (Shepard 2007). Outreach interventions were based on three theoretical frameworks – individual behaviour change, community and social networks, and relationship–building between provider and client (Shepard 2007, p27). Once a trusting relationship was established, services were provided in clients' rooms, or at the hospital or drop–in centre.

'Data mining' was the method used – secondary analysis of data already collected for other purposes – in this case, service utilisation patterns among participants engaged through outreach, compared with those engaged at the drop–in centre (Shepard 2007, p28). The hypothesis tested was that harm reduction outreach allows a hard–to reach population of PLHIV to access health care services.

Significant relationships between harm reduction services, medical care, housing placement and access to health care were identified. The authors concluded that their program theory was upheld by the data – harm reduction outreach, designed to reduce barriers to services and offering tools for better health, does increase access to medical care and provides strategies to reduce barriers. Limitations included that data mining excludes those outside the system, and does not include participants' perspectives.

The second study into PLHIV in SROs (Sohler et al 2009) examined gender disparities in HIV health care among the severely disadvantaged in the Bronx and Manhattan, New York City. Within a positivist paradigm, the researchers hypothesised that women are less likely to engage in optimal HIV care utilisation than men, and sought to explore reasons for disparities. They asked whether gender–based disparities in HIV related health care utilisation exist, and if so, whether they could be explained by participants' characteristics (education level, insurance status, drug use, housing) and/or their attitudes towards the health care system (such as trust in providers, engagement with workers, perceptions of access to care).

Methods used included interviews with a convenience sample of HIV–infected women and men living in 14 different single occupancy hotels in Manhattan and the Bronx in New York, between August 2004 and June 2005. Potential participants resided in an SRO, were HIV positive, at least 18 years of age, and English– or Spanish–speaking. Interviews were administered using Audio–Computer–Assisted Self–Interviewing (ACASI) technology. Standardised questionnaire items included health status, drug and alcohol use, and socio–demographic information and use of HIV health services. Measures of attitudes to the health system and providers were included, encompassing perceptions of access, mistrust of health care system, trust in providers, engagement, and perceptions of personal treatment control.

Medical records were reviewed over the previous six month period and quantitative data extracted on HIV visits and CD4 counts. Analyses compared women and men on three outcome variables – use of primary HIV care services; use of emergency departments; and hospitalisations. Data was compared for women and men on demographic, socio–economic and behavioural characteristics.

Women were significantly less likely than men to engage in optimal HIV care. The observed disparity could not be explained, even after adjusting for further disadvantage (lower educational level, decreased likelihood of having health insurance). The researchers postulated that women's greater care–giving responsibilities may help explain the disparity – women may prioritise care of others over their own health care, although the study did not directly address this.

Findings suggest that strategies to improve access to HIV services need to consider possible gender differences and attempt to address them accordingly, and the study provides evidence for inequitable HIV care access for homeless women.

Another study explored factors associated with engaging marginalised PLHIV in care (Rumptz et al 2007). This study was situated within a constructivist paradigm, recognising that social determinants of health affect ability to engage in care. In some ways, however, the study can be described as 'cross–theoretical' (Bourgois 2002, p259), because it used strictly quantitative methods including epidemiological analysis, aligned with a positivist paradigm. This study provided a profile of PLHIV not fully engaged in HIV care, examined barriers to engagement and evaluated outreach interventions. It can be described as descriptive, evaluative or action research (Ovretveit 2002).

The populations studied were: sporadic users of HIV care; those receiving no care; and those who were engaged in care. The sample was recruited from 10 urban sites with outreach and advocacy interventions in place. Various outreach approaches existed, including mobile vans and street outreach.

Methods used were face–to–face questionnaire completion, with a purposive sample of 984 participants (at intake and 12–month follow up) and review of medical chart data.

Those who were not engaged in care, or only 'somewhat engaged' were more likely to report: drug use in the past 30 days; practical barriers to care (finding convenient appointment times, having no phone), health belief barriers to care ('faith will help', 'too healthy', 'no cure for HIV'); and to have a greater number of unmet needs than those engaged in care (Rumptz et al 2007, pS–35). The authors concluded that interventions addressing structural barriers and unmet needs, negative health beliefs and drug use are promising strategies to engage marginalised PLHIV in HIV care.

Another USA study examined characteristics of homeless HIV–positive outreach responders and their success in HIV primary care (Tommasello et al 2006). This study sits within the positivist paradigm.

The population accessed was homeless PLHIV with mental illness and substance use disorders in Baltimore, Maryland. The study was descriptive, utilising quantitative survey research methods to ascertain the intervention's effects on engagement with health services.

The intervention comprised intensive street outreach to homeless PLHIV with substance use and/or mental health disorders in soup kitchens, shelters, abandoned buildings shooting galleries and prisons. Workers built relationships with clients and provided items to meet immediate needs, whilst assessing for HIV risks, mental illness and drug use problems. Those who then came to the clinic received integrated health care, social services and case management.

Participants were assessed for changes to health measures over a 12–month period. Health surveys were conducted face–to–face (Medical Outcomes Study Health Survey and Patient Health Questionnaire) at baseline and scheduled for follow–up at 12 months, at 11 January 1998 and at 30 August 2001, with 110 clients enrolled.

Almost half of those enrolled in the study engaged with clinic services. At baseline, they had few service

connections, and the majority returned for follow-up interview 12 months later. Clients' need for services declined in almost every area; mental health and drug use showed significant improvement. The authors speculated that success was based on the development of reciprocal, caring relationships between outreach workers and clients, stating that 'in some cases, the relationship with the outreach worker may have been the most meaningful one in the client's life' (Tommasello et al 2006, p915). Generalisations cannot be made, due to potential sample bias and the lack of a comparison group.

A USA-based qualitative study examined the role of outreach in engaging and retaining PLHIV in medical care, from the perspective of PLHIV (Rajabiun et al 2007). This study belongs to the interpretivist paradigm (Sale et al 2002).

The population sampling frame was 'underserved' and 'hard to reach' PLHIV from seven sites participating in a funded Outreach Initiative. Seventy six participants were recruited purposively (Coyne 1997) for in-depth interviews from six cities, each site recruiting 8–16 participants. Those considered at high risk of disengagement or with limited access to health care were prioritised for inclusion.

Interviews were transcribed and analysed using QSR NVivo software and a grounded theory approach. Coding was undertaken and codes were collapsed into conceptual categories. The researchers sought to identify participants' history of health-seeking behaviour and experience within the health care system, barriers and facilitators to care, and the role of outreach interventions in assisting with engagement and retention in HIV care (Rajabiun et al 2007).

Data analysis indicated that study participants tended to 'cycle in and out of care' (Rajabiun et al 2007, pS-23). Factors identified as influencing engagement and retention in care included: level of acceptance of HIV status; ability to cope with stigma; substance use and mental health; health care provider relationships; presence of external support; and addressing systemic barriers. For instance, those who were not in care or unstable in care often denied their diagnosis or didn't see it as a priority. Those in care preferred to manage their HIV proactively. Participants who were not in care or unstable in care described experiences of discrimination and stigmatisation in healthcare, whereas those in care seemed to have coping strategies to deal with stigma, such as ignoring others' perceptions about HIV. Positive health care provider relationships were critical for those in care; in contrast, those not in care described negative experiences with providers.

Helpful outreach program strategies identified by PLHIV included: dispelling myths about HIV; improving knowledge; providing help and support with HIV care; building skills and ability to deal with HIV; reducing barriers to services (e.g. by organising transport, food, identification cards) and providing support networks. The important insight offered by this research was that engagement with HIV care services can be cyclical for homeless PLHIV.

A secondary publication drawing upon data derived from the same in-depth interview described above, examined the provider role in engagement (Mallinson et al 2007). Using a grounded theory approach, hence interpretivist in nature, narrative data from the interviews was analysed. Health care provider behaviours that clients perceived as validating, engaging and partnering enhanced and facilitated engagement and retention in care, whereas behaviours viewed as patronising or paternalistic hindered engagement and retention. Communication skills and empathy were also perceived as beneficial to engagement.

A Canadian study reported on a peer-driven intervention to improve access to HIV care and treatment for street-entrenched HIV-positive women, including transgender women (Deering et al 2009). The research design and methods used to evaluate the model indicate a strong commitment to positivism.

The model entailed four elements: weekly peer support meetings with the women; training for the women to become health advocates or 'buddies' for each other; a peer outreach service and a drop-in nursing service (Deering et al 2009, p604). Data collection consisted of three questionnaires – baseline intake assessment by a nurse, weekly questionnaire administered by the health advocates and a 3-monthly health questionnaire. Women were recruited through self-referral or through referral from other HIV providers, other health provider or friends in January through to August 2007 according to specific eligibility criteria.

Data from 20 participants were analysed, with trends of adherence to antiretroviral therapy by several behaviour variables known to affect adherence being examined (housing stability, drug use), exposure to the intervention and adherence, and the relationship between self-reported adherence and pharmacy recorded adherence. Viral load outcome measures (measures of HIV replication in the blood) were also recorded and analysed. Results indicated that the peer-driven intervention may have had a positive effect on adherence, since adherence either increased or remained the same for 75% of the women enrolled, and viral load measures decreased (compared with the year prior to enrolment). For higher risk women, the intervention may have been even more beneficial.

With a small sample size, statistical power was poor, but the authors reported the women involved appreciated the small group for peer support group meetings to promote cohesiveness and close bonds between them. Unfortunately, the purely quantitative approach precluded analysis of the women's own perspectives on the program which may have provided richer data with such a small group of participants.

Two Australian papers addressed issues of barriers to access to services for marginalised PLHIV within the context of service descriptions. The first utilised a case study-based approach, describing difficulties accessing housing, support, aged care, neuropsychological assessments and other services experienced by a Vietnamese injecting drug user with a criminal history, and a severe physical disability due to HIV-related cerebral toxoplasmosis (Crock et al 2011). The authors adopted a critical stance in articulating and describing structural barriers experienced by their client, and as such the research can be described as belonging to a critical paradigm (Willis 2007). These authors identified barriers to access based on covert, systematic discrimination and stigma, and emphasised the need for persistent advocacy, collaboration with the criminal justice system, a commitment to social justice, equity in health care, strong advocacy, with the case study as illustration, leading to stability and a positive outcome (Crock et al 2011). The case study approach enabled the authors to draw out in-depth personal data in narrative form and themes to be identified that helped to overcome barriers.

The second Australian paper described a community-based nursing role in caring for PLHIV that enhanced the care of PLHIV who have difficulty accessing health care. Located within a team of HIV specialist nurses in a not-for-profit community nursing organisation in Melbourne, Australia and operating within a flexible model of care, this new role complemented the existing program by providing HIV specialist nursing assessment and continuity of care to address the growing number of HIV clients with complex needs. This was primarily a descriptive study, within a post-positivist or constructivist paradigm. The roles described involve assertive outreach, care-coordination and inter-agency collaboration. Using case studies and interviews with specialist HIV nurses, the authors highlight the importance of a client and family-centred approach, participatory care planning and care coordination, cultural competence, and adherence to principles of social justice and equity.

Interestingly, these two papers which were principally descriptive in nature, provide insight into strategies used by community nurses to engage marginalised PLHIV in care, and how, in turn, the community nurses guide and assist PLHIV to gain confidence to navigate the wider health care system. 'HIV system navigation' has been proposed in other settings as a way to improve access to HIV care for marginalised PLHIV (Bradford

et al 2007, pS-49). This area requires further research as it is a little understood element of the HIV service system in Australia. It is noteworthy that a recent report documenting models of access and service delivery for PLHIV in the Australian setting omits discussion of specialist HIV community nursing services and their role in engaging PLHIV in care or in retaining people in care (Savage 2009).

CONCLUSION

This review identifies strategies described and evaluated in the social science literature which can improve access to HIV-care services for PLHIV who are homeless, at risk of homelessness or marginalised in other ways, partially answering the research questions. No literature was found that specifically addressed access to community nursing services for homeless PLHIV in the Australian setting, and very little internationally. Community-based nursing organisations can be well-placed and experienced in engaging groups such as these in care, indeed they have a long history of doing so (Archer 1904). This may mean that specific outreach interventions may not need to be developed in some settings, but rather, better use may be made of existing services that utilise assertive outreach models of care and co-location with other services (Bennett 2010). There is room to suggest that HIV-specific community nursing services could be better integrated with homelessness services to enhance access to care and link into the HIV medical and health system (see for example The Haymarket Foundation Inc 2011).

A broad range of quantitative and qualitative methods was used in the papers reviewed – survey research, in-depth interviews, case studies, epidemiological, and descriptive and comparative statistics, with most using quantitative methods. Many studies, although clearly social science, were situated in positivist paradigms, with an emphasis on measurement, quantification and statistical analysis of potential factors affecting engagement and retention in HIV care. Qualitative work including the use of in-depth interviewing and case studies provide additional insights into clients' and staff's perspectives into the research questions.

Assertive outreach (versus drop-in), harm reduction outreach, peer-driven outreach, case management, and interpersonal relationships between health workers and homeless PLHIV were significant factors that resulted in better engagement, improvement in access to and retention in HIV care. Reductions in drug use, structural barriers and number of unmet needs were all associated with engagement with services. Homeless PLHIV identified practices such as dispelling myths about HIV, improving knowledge, providing help and support with HIV care, building skills, providing practical support, and developing relationships as helpful to engagement. They appreciated validating and partnering relationships, and found patronising attitudes unhelpful. Philosophical and ethical approaches that focus on equity, social justice and structural advocacy provide promising but limited evidence for improved access to HIV care and other services. The establishment of HIV-specific roles within existing community nursing services can help to improve access to services for this group. The role of stigma and discrimination in deterring homeless PLHIV from accessing care was raised in all studies reviewed.

Barriers to access to services for homeless PLHIV have been identified in the literature. Poverty, negative past experiences, health beliefs (denial of HIV), recent drug use, mental health problems, drug use, were confirmed in this literature review. Experiences of HIV-related stigma and discrimination within the health care system compounded these issues for participants in some studies reviewed (Crock et al 2011, Rajabiun et al 2007). Some women with HIV including transgender women, may experience even poorer access to HIV care (Sohler et al 2009).

The broad range of methods described in this review provide insights into strategies to enhance and improve access to and engagement in HIV care. Further qualitative research into the complex issues faced by homeless

PLHIV requiring care could provide deeper knowledge of barriers they confront, and strategies that may promote and enhance their ability to access care. The absence of specific research into engagement with HIV specialist community nursing services demands further exploration.

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Nurse empathy and the care of people with dementia

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ABSTRACT

Objective
Empathy is widely accepted as an essential nursing attribute yet the relationship between nurse empathy and the care of people with dementia in the hospital setting has rarely been explored. A number of themes have emerged from the relevant literature regarding the influences which shape a nurse's ability to deliver empathetic care to this patient cohort. These issues include a lack of hospital resources, an organisational focus on operational issues such as patient flow and risk management, and widespread stigmatisation of dementia in society.

Setting
Acute and sub-acute facilities.

Subjects
In-patients with dementia and nurses

Primary argument
Although there is widespread acknowledgment that nurses require empathy to deliver quality care, the complexity of caring for people with dementia in hospital creates further challenges for both nurses and patients. This issue has been discussed previously but there is little evidence that the situation has improved.

Conclusion
This paper details the relevant influences on the ability of nurses to care empathetically for people with dementia in hospital. The recognition that there are distinct factors related to this patient cohort is an important one and may assist nurses and health organisations to identify systemic and individual problems associated with hospitalisation and lead to the implementation of supportive strategies. Appropriate nurse-patient ratios which consider the additional workload attached to caring for people with dementia, clinical supervision and targeted nurse education must be considered to ensure health systems deliver appropriate person-centred care to people with dementia.

INTRODUCTION

A sign of our ageing population is the increased prevalence of dementia (Access Economics 2009). Dementia is defined by the World Health Organization (WHO) as, '...a syndrome due to disease of the brain – usually of a chronic or progressive nature – in which there is a disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement' (WHO 2012, p7). It is projected that globally the number of people with dementia will nearly double every 20 years to 65.7 million in 2030 and 155.4 million in 2050 (WHO 2012). Despite extensive research, there is currently no cure for dementia and no effective prevention strategy (van Norden et al 2012), making quality nursing care an important component of treatment.

It is not possible for nurses to care appropriately for patients without the vital ingredient of empathy. One description of empathy is "understanding, sharing and creating an internal space to accept the other person, hence helping them to feel understood and not alone" (Cunico et al 2012, p2016). Empathy has been described as a necessary component of all caring relationships (Mercer and Reynolds 2002). If empathy is lacking, nurses are unable to understand the patient's perspective, create trust, and deliver person-centred care (Griffiths et al 2012). May (1990) questioned if it was realistic to expect nurses to be empathetic considering the increasing demands placed on the role. More than 20 years later factors which facilitate nurses to deliver high quality, compassionate inpatient care continue to be debated (Bridges et al 2013).

Patients with dementia are commonly admitted to hospital with acute illnesses and dementia is a co-morbidity to the presenting problem (Hermann et al 2015). Despite many articles being written about the concept of empathy, many that refer to people with dementia are contextually in residential care. People with dementia are more than twice as likely to be admitted to Australian hospitals as those without (AIHW 2013), however there has been very little written about the relationships between staff and inpatients with dementia. The argument presented in this paper is that there are multiple factors which shape nurses' ability to deliver empathetic care to patients with dementia, in particular the work environment, organisational support, economic issues and societal influences. These factors must be addressed in relation to the care of people with dementia. The aim of this discussion paper is to examine nurse empathy in the context of caring for people with dementia in hospitals and suggest strategies for overcoming the barriers to the delivery of empathetic nursing care to this patient group.

DISCUSSION

The concept of empathy

The concept of empathy has been difficult to define but is generally understood to mean that an environment is created in which a person feels understood and accepted, by the demonstration of kindness and warmth (Griffiths et al 2012). An expanded explanation is that empathy involves 'understanding, sharing and creating an internal space to accept the other person, hence helping them to feel understood and not alone' (Cunico et al 2012, p2,016). Compassionate care is then a result of having empathy for another person and responding to their needs with humanity, relieving pain and distress: in other words, compassion implies that we not only understand a person's suffering but that we respond to it (Straughair 2012). To empathise with a person with dementia therefore involves gaining insight into a fragmented and confused world which may be changing, unpredictable and sometimes frightening (Cunningham 2006).

It has been suggested that nurses should work with empathy and compassion but retain a degree of detachment in order to allow the nurse's concern for the patient to be evident but maintain an emotional separateness (Edberg and Edfors 2008). This is to protect the nurse from losing objectivity and may decrease the likelihood

of burnout (Maslach et al 2001). It is important to recognise that caring empathetically can render the nurse emotionally vulnerable, and consequently the benefit to the patient is not without cost, therefore to be most effective nurses must find an appropriate balance between engagement and detachment (Austin 2011).

Factors influencing empathy with people with dementia in hospital

The specific issues of people with dementia and the relationship with nurses in the hospital setting has received very little attention. Previous research has focussed mainly on residential care facilities where it is estimated that in Australia approximately 50% of the residents have dementia (AIHW 2012) with similar figures in other developed countries (Wimo and Prince 2010). The hospital environment can be noisy, busy and unfamiliar which may exacerbate the person with dementia's problems with spatial disorientation which can worsen anxiety and make care more challenging (Marquardt 2011). People with dementia may have attributes which make connection with other people more difficult because their ability to communicate and understand the needs of others can be impaired (Moreau et al 2015). This may impact on the nurse/patient relationship which is already strained because of time constraints, lack of understanding about dementia and inappropriate ward environment (Turner et al 2015).

Stigmatisation

There is evidence that both old age and dementia are conditions that are stigmatised by society, often in subtle and unacknowledged ways (Phillipson et al 2012). Stigmatisation of people with dementia by nurses and other health care providers, can be apparent although it is less prevalent in those with more education and hence a greater understanding of the condition (Mukadam and Livingston 2012). Despite this, educated health professionals can also demonstrate prejudice against people with mental health conditions including dementia (Blay and Peluso 2010). Judging and labelling patients can perpetuate stigma about people which influence the nurses' attitude towards patients and consequently their care (Scodellaro and Pin 2013). Demonstrations of stigmatisation of people with dementia include insinuating that the behavioural symptoms of dementia are deliberate and in the control of the person rather than a symptom of the condition or a demonstration of unmet need (Mukadam and Livingston 2012). For instance a person with dementia who is shouting 'Brian, Brian!' constantly may be interpreted by a nurse with poor insight into the condition as being wilful and irritating, whereas the person may in fact have a physical need such as thirst or pain which they are unable to express in a conventional way. The media must take responsibility for some of the negative projections of dementia in society including the emphasis on decline and the loss of capacity, and the burden on the community and families, despite the fact that many families actually feel satisfied in their caring role (Van Gorp 2012). The prevalence of these negative attitudes permeates all levels of society, influencing the ability of health professionals to see people with dementia as worthy of person-centred empathetic care (Milne 2010).

Nurse stress

Frustration and emotional exhaustion are common among nurses caring for people with dementia (Griffiths et al 2014). Because of the fast pace in hospital settings the problem is augmented by the complex needs of the patients with dementia and the limitations on what nurses can achieve during a working day (Fukuda et al 2015). Nurses need to be cared for and supported from an organisational perspective to empower them to care sensitively for their patients (Maben et al 2012b). Disharmony can be evident when the hospital environment is at odds with the requirements needed to care for people with dementia sensitively (Sánchez et al 2013). Flawed organisational priorities can also be blamed for the frustration and 'workplace suffering' generated by the gap between what nurses are able to do in terms of care and treatment and what they feel they should do (Biquand and Zittel 2012). Nurses may be distressed by the recognition of the needs of the person with dementia while faced with organizational constraints which prevent them from delivering

appropriate care (Bridges et al 2013). A higher level of stress in nurses is closely linked with their self-efficacy and well-being which in turn impacts on their ability to care empathetically (Austin 2012).

In some cases nurses who have been the victims of violent behaviour from patients can show a high incidence of depersonalisation, burnout and psychological stress which reduces their capacity to deliver empathetic care (Scott et al 2011). Furthermore, a correlation has been demonstrated between nurse working characteristics and patient behavioural symptoms: people with dementia who are cared for by nurses who experience a lower degree of job strain show a lower incidence of disruptive behaviours (Edvardsson et al 2008).

Nurses can experience increased stress levels if patients are aggressive (Scott et al 2011). This aggressive behaviour can make the process of caring effectively even more difficult, however if the nurse is able to see that the patient is not responsible for their behaviour and can contextualise it in terms of the illness, they are less likely to be personally affected and more likely to continue the delivery of appropriate care (Ostaszkiewicz et al 2015). Nurses' Emotional Intelligence (EI) which is a measure of their emotional, personal and social abilities and skills is relevant to their capacity to care for their patients with empathy and compassion. Nurses who have a higher EI score have the propensity to be more empathetic especially when this quality is developed through education and support (Austin 2012).

Furthermore, nurses' stress has been shown to negatively impact on the behaviour of people with dementia (Edvardsson et al 2012), and lead to high staff turnover (Chenoweth et al 2014). It is not uncommon to find that patients with dementia are cared for by overworked staff who do not believe that the patients have the capacity to engage in personal interactions, and who consequently focus on the physical tasks (Blagg and Petty 2015). Protests from the patients are then seen as a symptom of the disease rather than being due to inappropriate treatment (Sabat et al 2011). This unsatisfactory relationship between staff and patient behaviour was termed 'malignant social psychology' (Kitwood 1997, p.45) and is demonstrated by staff who see people with dementia as 'personless' and unworthy of engagement (Penrod et al 2007). Nurses may demonstrate this by treating the person with dementia with dehumanising attitudes such as objectification, disempowerment and stigmatisation (Kitwood 1997). Carers of people with dementia who consider them to be valueless or empty consequently see their work as worthless and futile, which impacts on their ability to empathise with people (Chenoweth et al 2014). Nurses who feel disempowered are similarly unable to relate meaningfully to the patients and instead focus on the technical aspects of care (Terrizzi DeFrino 2009). It is important to note that nurses who are more empathetic and therefore have the ability to understand the person's feelings have greater job satisfaction (Lim et al 2011).

Resources and operational priorities

The nurses' ability to deliver ethical care can be constrained by the diminishing healthcare resources and tight fiscal restraint (Sanchez et al 2015). Nurses can feel that they are treated as a commodity rather than contributing team members in a culture which underplays the role of the nurse and engaged humanistic care (Austin 2011). Quality of care is directly linked to nurse-patient ratios, staff support and staff turnover, with comforting and talking to patients the tasks most often left undone when workload and other pressures increase (Duffield et al 2011). However it has been demonstrated that consistency of staff over a period of time can allow the connection between the staff and the person with dementia to develop and the relational aspects of care are then prioritised above the completion of tasks (Clissett et al 2013). The pressure to increase the flow of patients through the hospital system decreases the opportunities for nurses to develop a connection with patients which interferes with the therapeutic nurse/ patient relationship (Goodrich 2012). Significantly these time pressures can also lead to an increase in medical errors and ineffective care delivery (McSherry et al 2012).

The effect of technology

There has been speculation that empathy in nurses has declined with a rise in the technological and biomedical approach to care due to the decreased focus on the human perspective (Watson 2009). The relationship between the nurse and the patient is changed with the dependence on technology, and it is increasingly difficult (but still possible) to prioritise the human factor in the relationship (Buckner and Gregory 2011). Both the increasing demands of technology and the rise of consumerism put pressure on nurses to practice nursing in other non-traditional ways (Schantz 2007) and the 'softer' nursing qualities such as empathy and listening have also been described as at odds with 'academic' nursing related to technology and biomedical aspects of care (Griffiths et al 2012). It is important that empathetic care is not gradually eroded over time as the nursing culture becomes more technology dependent.

Risk management and relational practices

According to Austin (2011) relational practices of nurses have deteriorated not only in response to excessive workload but to the change in culture of nursing as a 'caring profession' to one of a customer/ service-provider model. The focus on customer satisfaction which stems from commercialism reframes the definition of nursing, and scripts nurses to respond to patient needs in ways which satisfy the model often to the detriment of sincerity (Austin 2011). As concepts such as empathy and compassion are difficult to measure (Yu and Kirk 2009) nurses spend their time 'ticking boxes' rather than listening to and comforting the patients (Bradshaw 2009).

Health services across the world, including Australia, have experienced rapid change in the past 50 years however in the light of these changes the essence of nursing has evolved from one in which the first premise is caring, to a new paradigm which has a focus on risk mitigation, accountability and patient flow (Roch et al 2014). There is a danger that the traditional nursing values which heavily emphasised empathetic care and patient comfort are being superseded in a society which values efficiency.

Strategies to improve empathetic care

The two major factors needed to improve empathetic care for people with dementia involve education and support for nurses and other staff (Cunico et al 2012). On-going education about dementia is essential for nurses who care for people with dementia so that they have the knowledge and the required strategies to care effectively for people with dementia in hospitals (Nayton et al 2014). Without a good understanding of the dementia condition, nurses are compromised in their ability to recognise the behaviour and respond to the patients appropriately (Chenoweth et al 2014). Appropriate on-going education improves care but also has a positive impact on nurse retention and improves nurses' job satisfaction as they not only become more masterful in the role but feel valued and supported by their organisation (Chenoweth et al 2014). Furthermore it is important to ensure that the nurses feel well supported by managers and their colleagues when they are caring for those who have concurrent acute medical illnesses as well as dementia, as this creates additional challenges (Clissett et al 2013). Appropriate education can include improving communication between nurses and patients, especially in the case of patients with dementia where communication can be difficult. Empathy must not only be felt by the nurse, but communicated to the patient or it loses its meaning (Webster 2010). It has been shown that nurses can be taught to develop their rapport with patients (Dewar 2011). However some believe that empathy is an innate quality which cannot be learned, although it can be recognised and encouraged (Richardson et al 2015). Nurses who are taught to be more aware of how their own beliefs and values influence their relationship with patients are more likely to change their attitudes positively (Harper and Jones-Schenk 2012). It is recommended that 'relational practices' warrant a higher place on the educational and competency agendas in order to support nurses to deliver appropriate compassionate care (Dewar and Nolan 2013).

Support for nurses

The need for emotional and practical support is particularly evident in nurses who care for people with dementia. Nurses have been shown to benefit considerably from clinical supervision in which individuals are given the opportunity to meet regularly with more senior or experienced practitioners in order to receive relationship-based support and guidance, and engage in reflective practice (Pearce et al 2013). Nurses who are provided with regular opportunities to discuss their workplace challenges have greater job satisfaction and a lower incidence of burn-out (Kemp and Baker 2013).

Actions which express the concern and support of managers for the nurses is very important in that it shows that there is a team approach to care and the difficulties are acknowledged (Moyle et al 2011). The understanding of the word 'team' can be extended to the whole of the organisation and health system as demonstrated in a study of the United Kingdom National Health Service performance which revealed '...cultures of engagement, positivity, caring, compassion and respect for all – staff, patients and the public – provide the ideal environment within which to care of the health of the nation' (West and Dawson 2012). Nurses who feel they are not alone in the challenges they face (Maben et al 2012a) and who feel valued and supported by the organisation will derive greater satisfaction from their work (Chenoweth et al 2014).

CONCLUSION

Dementia adds complexity to the nurse-patient relationship in hospital and requires specialised understanding in order to enable quality care to be delivered. In this paper empathy has been discussed in relation to the barriers and enablers to caring empathetically for people with dementia in hospital from a nursing perspective.

The barriers are multi-factorial but include society's stigmatisation of people with mental health problems which permeates into the health arena and cause nurses to unwittingly discriminate against people with dementia. The increasing pressure from fiscal restraint, increased patient flow-through and technology experienced by nurses impact on their ability to relate effectively to the people in their care. Lack of time and resources to support nurses leads to dissatisfaction with the role; a problem which is ultimately reflected in the quality of care delivered to the patients.

RECOMMENDATIONS

Health services will continue to care for a greater number of patients with dementia as the population ages. Traditional nursing values which include empathy must be supported despite the challenges of the modern healthcare environment. Nurse empathy has been demonstrated to be a vital ingredient in the provision of quality care for people with dementia in hospital. In order to improve this situation, nurses require organisational backing which includes an understanding of the increased needs of people with dementia reflected in nurse-patient ratios. Organisational initiatives including ensuring there are opportunities for clinical supervision must be implemented and sustained if nurses are to receive the support they need. Targeted education about dementia would increase nurses' understanding of the condition and enable a more objective appreciation of patient behaviour, allowing nurses to maintain an empathetic approach in the face of challenging behaviour. Improving the support for nurses will advance the care of patients with dementia in hospital.

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Doctoral education for nurses today: the PhD or professional doctorate?

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ABSTRACT

Objective
This paper seeks to stimulate discussion and debate about the future of doctoral education for nurses in Australia.

Setting
A large Magnet recognised acute care private hospital in New South Wales and a large regional university in Australia.

Primary argument
Healthcare today and into the future is increasingly more complex and requires ever more highly skilled healthcare professionals to meet the challenges of providing safe, quality care. Doctoral research and education based in the workplace and designed to improve healthcare while skilling up nurses and other professionals in research methods has never been more relevant and appropriate.

Conclusion
Nurses have generally not seen the PhD as the best fit for their higher professional development. The professional doctorate offers a compelling and dynamic alternative to the more academic focus of the PhD and prepares 'inquiry-driven leaders' for tomorrow's challenges.

INTRODUCTION

In the context of delegitimation [of the metanarratives of modernity], universities and the institutions of higher learning are called upon to create skills, and no longer ideals. The transmission of knowledge is no longer designed to train an elite capable of guiding the nation towards emancipation, but to supply the system with players capable of fulfilling their roles at the pragmatic posts required by its institutions (Lyotard 1987).

In Australia today nurses confront an ever-increasing complexity of the healthcare services in which they work (Jacob et al 2015). This complexity is driven by a number of intersecting issues such as:

- an ageing population with rising demands and expectations of the healthcare they receive (Dall et al 2013);

- an equally ageing workface with different desires and needs in terms of the ways they will be able and want to work (Heidemeier and Staudinger 2015);

- a more sophisticated workforce especially in respect of the younger generations of health professionals who will not necessarily live out their work life in the one organisation (Wood 1999);

- rapidly rising awareness that the funding and economic imperatives of constrained budgets but more expensive technologies and treatment modalities are destined to cripple the healthcare system in the not so distant future (Baal et al 2014); and

- a pressing need in light of this uncomfortable reality that new models of care, new and more effective and efficient delivery of services and new ways of thinking and doing healthcare work (Elf et al 2014);

are considerable pressures that must be dealt with. Of course it is the healthcare leaders of the future who will be tasked with addressing these issues and concerns and indeed, many of our current leadership are doing just that (Weberg 2012) as they realise that doing 'more of the same' is simply not good enough anymore (if it ever was).

It is because of the constant need to innovate and improve the quality and safety, as well as the effectiveness and efficiency of healthcare that we feel compelled to advance a case for a new paradigm in the ways in which we prepare our nurses for the looming challenges just outlined. While Australia is fortunate to have a generally well qualified and high functioning healthcare workforce it is imperative to ensure that they are as best equipped as they can be to take healthcare forward in the 21st century, something this paper focus's on (WHO 2016).

Many nurses are prepared now at the graduate diploma and masters level and many medicos also seek post-graduate training through their speciality colleges or university programs, it is still relatively unusual to see more than only one or two doctorally prepared professionals in the healthcare services themselves (Morgan and Somera 2014). As all four authors of this paper are doctorally prepared nurses, we propose that the professional doctorate degree is an exemplary training program specifically designed to keep our best and brightest working in the healthcare workplace while also adding significant value to their portfolios of responsibility in respect of the application of their learning in these programs. In light of this claim, the authors launched, in 2014 a Doctor of Health program in Sydney as industry and higher education partners and already 14 senior, mid and late career nurses have enrolled and new cohorts in Hobart and Launceston, Tasmania, are due to commence in 2016. This strongly suggests the program is meeting an unmet need for this group of nurse managers, educators and clinicians. In what follows, the authors lay out a discussion about the relative merits (and challenges) of doctoral level education and research training for mid-career and senior nurses

with a view to encouraging more discussion on this important debate. Importantly too, are the implications of the very recently released report on the future of higher degree by research training system in Australia compiled by the Australian Council of Learned Academies (McGagh et al 2016). Essentially, this document puts a strong case for the tertiary sector to collaborate much more strongly with industry to better prepare professionals from all spheres of work for the challenges of life in the 21st century. As stated in the report:

> "Research training has the potential to drive closer and broader engagement between industry and the university research sector, and contribute to reversing Australia's unacceptable international performance in this area. Increased industry linkages during research training through placements with industry partners and undertaking industry-defined research projects, will drive the establishment of long-term relationships between industry and researchers. This will help overcome the cultural differences that stand in the way of increased collaboration (McGagh et al 2016)".

As discussed in this manuscript, the professional doctorate in health is the exemplary vehicle for achieving such a goal for nursing specifically and healthcare, more generally.

DISCUSSION

Doctoral degrees: the emergence of the professional doctorate

Doctoral education has a long and distinguished history dating back to the 12th century at the universities of Paris and Bologna (Kot and Hendel 2012). The original orientation of the doctoral degree enabled a 'scholar to become a full participating member of the guild' and thus it had 'an explicit professional orientation' (Buchanan and Hérubel 1995). These days, of course, the PhD is seen as the proverbial 'gold standard' of research higher degrees, is marked by independent research training, and is expected to make 'an original contribution to knowledge' (Cleary et al 2011). It can be done via the traditional method of a major research project that is written up into a thesis or dissertation; conversely, and increasingly so, universities are also offering a PhD 'by publication' comprising a 'coherent compilation of referred and published research papers with an accompanying document to provide context for the work' (Cleary et al 2011).

The professional doctorate as distinguished from the PhD, however, has a rather less ancient and august provenance, dating back to the 1950s in the United States of America (USA) (Ellis 2005) although McVicar et al (2006) suggest they date as far back as the 1920s and in Canada even further back to a Doctorate in Education in 1894. In Australia and the United Kingdom (UK) programs only surfaced in the 1990s (Watson et al 2011) although Kot and Hendel (2012) note that the first Australian professional doctorate can be tracked back to 1984 when the University of Wollongong established the Doctor of Creative Arts.

Rolfe and Davies (2009) make two important points in respect of the development of the professional doctorate: 'Professional doctorates have arisen out of dissatisfaction with the traditional PhD which is perceived as too distant from practice; study at doctoral level is now increasingly relevant to those working outside academe'. Unfortunately however, as Kot and Hendel (2012) comment, 'unlike the PhD, the professional doctorate seems to have no standard definition'. Hessling (1986) describes the PhD, for example, as 'a traditional credential attribute of an individual awarded by an institute of higher education after successful defence of a dissertation, recording the candidate's independent and original contribution to knowledge'. The PhD then, is clearly and not problematically, the degree of choice for someone seeking a career in the academy or as a professional researcher.

Kot and Hendel (2012) note on the other hand, that the development of the professional doctorate in Australia 'is linked to factors [such as] employability of holders of doctoral degrees, criticisms of the PhD, the growth of the knowledge economy, the changing role of higher education and government involvement'. Importantly, they

further comment on the significant expansion in professional doctorates since the mid-1990s with increases in psychology (267%), health (250%) and administration (200%). This expansion was due to not only the growth in programs but also the number of universities offering the Prof Doc and the numbers of students enrolled in them paralleled this growth. Importantly, for this study, in a report for the Australian Government Department of Education, Science and Training, the author noted that '[d]octoral education in Australia is currently under pressure to become more industry focussed and advocated that professional doctorates may be able to fulfil this role by developing and sustaining closer collaboration between universities and industry (Fink 2006). As noted above, it is timely then that in the ten years that has elapsed since this suggestion was advanced it has re-surfaced in the latest review of higher degree by research training (McGagh et al 2016).

Sadly however, as Pearson (1999) noted some 15 years ago, 'the continuing debate about the status of professional doctorates shows how the view of the traditional PhD is entrenched as primarily an individual student's research project ... and how inherently conservative the response to change has been despite the extent of innovative initiatives'. Some antagonists of the professional doctorate have pointed to its perceived lack of scholarly rigour compared with the PhD (Maxwell 2011; Wellington and Sykes 2006). As Watson et al (2011) suggest 'it is hard to escape the view that the professional doctorate is viewed as being an easier route to doctorate in the UK.' Clearly then, some confusion persists around the relative merits of the two modes of doctoral education and training and the outcomes they produce in terms of a doctorate. This paper suggests that for healthcare professionals generally and nurses specifically wishing to stay in the healthcare setting, there is really no argument as to which qualification is best fit for purpose.

Doctoral education: from global to regional

In Europe in the 1990s, a process began in Bologna, Italy, to ensure consistency and compatibility in respect of standards and quality of higher educational qualifications across the European countries. In 2003 at a meeting of education ministers, it was decided to extend this process to a so-called third 'cycle': the doctoral qualification. Importantly, it was emphasised at this meeting that doctoral programs be viewed in the wider context of higher education and should be linked more explicitly to the two preceding cycles of the Bachelor and Master programs. Moreover, the character of doctoral programs should be modified, for example, by incorporating more taught courses and training elements, and also broadened, for example, by embracing practice-based PhDs and professional doctorates (Green and Powell 2005).

These shifts in thinking have of course, been informed by wider influences including, but not limited to: The emergence of a so-called 'knowledge society'; globalisation; and other social, economic and cultural transformations internationally. These influences have exerted a number of pressures for doctoral education to change and in the words of Scott (2006), 'the boundaries for doctoral education have become fuzzier – with master programs on the one hand and professional development and lifelong learning on the other, and even the highest levels of adult and continuing education ... the whole higher education system, and also the research system, have been stretched and, at the same time, become more diffuse and permeable' (Scott 2006).

Such fuzziness and permeability at the boundaries of doctoral education suggest that there is an equally confounding blurring of what comprises doctoral education at all. If doctorate holders are to be able to respond to the imperatives and challenges of a globalised, information-saturated and ever more diverse socio-economic and political world then their doctorates need to reflect their fitness for purpose and not be compelled to conform to a 'one-size-fits-all' product as once might have been the case.

Turing our gaze more locally Neumann (2007) remarks that 'for the most part of Australian higher education, doctoral education has been peripheral'. Neumann further notes that policy has often been implicit rather

than the obverse and more often than not merely a 'subordinate component of higher education funding, or incorporated in overall research policy in most major government reviews since the 1950s' (2007). The growth in students undertaking doctoral degrees (from 9,298 in 1990 to 37,685 in 2004) suggests that this has 'effectively led to the massification of doctoral education' (Pearson et al 1997). Consequently, government's response has been to focus on accountability and quality with a more formalised framework of rules and procedures for doctoral studies (e.g. the Australian Qualifications Framework), more regulation of supervisory practices and more overt structuring of the doctoral curriculum. That said it is increasingly recognised that what forms of scholarship as well as the theoretical and practical outcomes doctoral programs produce and what knowledges and skills doctorate holders embody, need to be adaptable to an ever-changing knowledge economy. As Pearson et al (1997) emphasise 'diversity in doctoral research practice is essential for a robust doctoral sector with the capacity to be flexible and productive in a volatile education market and a globally competitive research environment'.

Professional development via healthcare improvement

In healthcare, increasingly it is recognised that professional development (PD) is both a right and a responsibility; a right in that organisations are expected to provide PD opportunities to advance the skills and knowledge of its staff but also a responsibility, on the part of health professionals, to stay abreast of the trends and developments in their area of speciality. The professional doctorate enables staff to become what Bourner et al (2001) have called 'researching professionals' (as opposed to 'professional researchers') or similarly, Gregory's (1997) notion of 'scholarly professionals' (vis-à-vis 'professional scholars'). It does this by providing students with the same quality of supervision from a team of doctorally prepared scholars a PhD candidate would expect to receive and during which they learn the rigours of conducting a high-level research project and all the skills that are required to undertake such a challenge. These include, for example, selecting the appropriate methods for data collection, learning the skills of advanced analysis of data, the very important skills of writing for publication as well as writing up the end product of a thesis for examination.

As Ellis (2005) notes in her research 'the professional doctorate [in health] was introduced for the advancement and improvement of practice, indeed this being their 'hallmark''. In later research Ellis (2007) also reports that Prof Doc 'enthusiasts saw [them] as a *real* alternative to PhD that offered a program of study highly relevant to professional practice with the benefits of shared learning'. Moreover, in respect of the emphasis on improvements in practice noted above, in the conclusion to her paper she points out that '[the] application of knowledge to clinical practice is at the core of clinical or taught doctorates and explains why increasing numbers of clinicians are interested in pursuing this form of doctorate over the more traditional PhD'. While many nurses are qualified at the masters level, a doctorate takes their knowledge and skills to a much higher plane and it opens career opportunities now increasingly more sophisticated such as the academic embedded in the practice setting.

Exactly what is a professional doctorate then?

McVicar et al (2006) provide some useful defining criteria as follows:

- the research focus is 'the solution of problems in practice and the generation of new knowledge to inform improvements in practice (Galvin and Carr 2003). Importantly this criterion recognises 'practice as scholarship' (Ramcharan et al 2001; Newman 1997; Pearson et al 1997);

- it is interventionist in relationship to the topic being investigated; and

- it adopts an applied, problem-focused, or action-based approach to proposing or implementing change in the organisations in which the candidate is involved.

They further note that while these features could equally appear in a PhD the differentiation between the two is that 'the focus on addressing the needs of the candidate's own organisation is *the* critical factor' (McVicar et al 2006). Bourner et al (2001) further note that 'a student commences the research by an understanding of their practice, leading to an identification of an issue for investigation, and finishes by applying their learning in resolving the issue' (McVicar et al 2006).

McVicar et al (2006) also point out that 'although the professional doctorate commences from a different position to that of a PhD, the end-point in terms of the critical benchmarks observed in doctoral theses are comparable, including originality, depth of analysis and level of synthesis. Similarly, there is an expectation students will publish their findings'. Trafford and Lesham (2002a; 2002b) echo these sentiments by suggesting that while their design may differ, the PhD and professional doctorate 'should share similarities that characterise scholarship, enquiry and externally verified standards, and of course lead to an original contribution either by filling a gap in, or by extending, knowledge' (McVicar et al 2006). In conclusion to this section, the Australian Qualifications Framework (AQF 2011) defines the two dominant forms of the Australian doctorate as follows:

> *The research Doctoral degree (typically referred to as a PhD) makes a significant and original contribution to knowledge; the professional Doctoral Degree (typically titled Doctor of (field of study)) makes a significant and original contribution to knowledge in **the context of professional practice** (AQF 2011: emphasis added).*

Further epistemological considerations and refinements

Several commentators (Maxwell 2011; Rolfe and Davies 2009; Crasswell 2007; Wallgren and Dahlgren 2005) have advanced the work of Gibbons et al (1994) as a very helpful taxonomy of knowledge-production in distinguishing the epistemological contours that differentiate the PhD from the professional doctorate; in the interests of the pedagogy of doctoral education more broadly we think it is a useful heuristic to draw on.

This paper argues the 'traditional' PhD is more marked by Mode 1 knowledge-production than the professional doctorate, which conversely, derives its epistemological (as well as socio-political) capital from Mode 2 knowledge–production. As Rolfe and Davies (2009) explain Mode 1 knowledge production is 'driven by an academic agenda, categorised by the associated disciplines … residing in the University, where they are guarded by an academic elite'). Furthermore, under this mode 'students are inducted into the disciplinary knowledge and practice of the University and to be successful they must align themselves to the theoretical and methodological frameworks which characterise these'. It is not hard to read from this set of distinctions that the PhD is a product of and for the University rather than any other place; this is reinforced by Maxwell and Kupczyck-Romanczuk (2009) who acknowledge that the 'focus of professional doctorate work is the community of practice, as opposed to the community of academics … an important distinction'.

In contrast, suggest Rolfe and Davies (2009), Mode 2 knowledge-production is characterised by:

> *A constant flow back and forth between the fundamental and the applied, between the theoretical and the practical. Typically, discovery occurs in the contexts where knowledge is developed and put to use, while results – which would have been traditionally characterised as applied – fuel further theoretical advances.*

On the other hand, put a slightly different way by Nowotny et al (2005) in contrast with Wallgren and Dahlgren (2005):

- In Mode 1 problems are solved in a context governed by the largely academic interests of a specific community. By contrast, in Mode 2 knowledge is produced in the context of application.

- Mode 1 is disciplinary while Mode 2 is transdisciplinary.

- Mode 1 is characterised by relative homogeneity of skills while Mode 2 is characterised by heterogeneity of skills.

- In organisational terms, Mode 1 is hierarchical while in Mode 2 the preference is for flatter organisational structures.

- Mode 2 is more socially accountable and reflexive than Mode 1.

The AQF level 10 (Doctoral Degree) criteria (graduate attributes) specify:

Summary	Graduates at this level will have systematic and critical understanding of a complex field of learning and specialised research skills for the advancement of learning and/or professional practice
Knowledge	Graduates at this level will have systematic and critical understanding of a substantial and complex body of knowledge at the frontier of a discipline or area of professional practice
Skills	Graduates at this level will have expert, specialised cognitive, technical and research skills in a discipline area to independently and systematically: • Engage in critical reflection , synthesis and evaluation • Develop, adapt and implement research methodologies to extend and refine existing knowledge or professional practice • Disseminate and promote new insights to peers and the community • Generate original knowledge and understanding to make a substantial contribution to a discipline or area of professional practice
Application of knowledge and skills	Graduates at this level will apply knowledge and skills to demonstrate autonomy, authoritative judgement, adaptability and responsibility as an expert and leading practitioner or scholar

Who does a professional doctorate rather than a PhD?

It is important to note that the types of candidates for the two doctoral programs tend to vary both in kind and in degree (pun intended). The PhD as Fink (2006) has suggested, and ironically in light of the discussions herein, is a 'professional doctorate for academics'.

Typically, in many disciplines (less so in nursing and midwifery), candidates enter the PhD through a 'fast-track' route of three-year bachelor degree and straight on to a fourth year Bachelor with Hons degree and then straight in to PhD. This means many graduates have very little 'life experience' and are very knowledgeable about an often very narrow topic; science, engineering, arts and other more traditional university disciplines feature prominently in this type of PhD candidate and graduate. These processes as Fink (2006) asserts are 'linked to and driven by the university'.

Professional doctorate candidates on the other hand, usually possess a 'higher degree [such as a master in clinical nursing] that is not necessarily research-based, and importantly possess professional experience ... The candidate maintains links with the university as well as industry and works collaboratively with a group from industry' (Fink 2006: 37). Additionally, in contrast with other professions, these students have considerable professional and life experience that contributes to their doctorate experience, as well as the doctorate itself.

Neumann's (2005) student informants made it very clear that 'in nearly all cases students had deliberately elected to enrol in a professional doctorate, despite maintaining that they could have undertaken their research within a PhD program. The closer affinity, promoted in recruitment brochures, between research requirements and the profession was particularly appealing'.

Last words

Olson and Clark (2009) have written cogently about the concept of a 'signature pedagogy' in doctoral education and the creation of what they call a 'leader-scholar community'. Taking the term from Shulman (2005) 'signature pedagogy' describes 'the characteristic forms of teaching and learning ... that organise the fundamental ways in which future practitioners are educated for their new professions' (Olsen and Clark

2009). In respect of doctoral education then, signature pedagogies 'are credited with socialising doctoral students into the discourse community of the profession, providing practice in articulating a summary and critique of research literature, helping faculty and students keep up with the latest literature and with active controversies in their fields, making connections around disciplinary boundaries and helping doctoral students discover and claim a topic and direction for their dissertation projects' (Golde 2007).

CONCLUSION

The authors believe this paper demonstrates a clear disparity between the two main forms of doctoral education and research training for healthcare professionals generally, and nurses, specifically. While the very long history of the PhD has positioned it as the so-called 'gold standard', for education and training at the highest level, it is not necessarily the best suited to healthcare professionals and nurses who wish to remain in the healthcare workforce but elevates their repertoire of knowledge and skills to the same level as, say, a professor in a university setting.

The professional doctorate is a combination of rigorous coursework and a major piece of research. Together these activities have the express aim of producing what others, and the authors have called 'researching professionals 'as opposed to professional researchers. The distinction is important insofar as it recognises the primary aim of the professional doctorate is to improve healthcare through the actions of the researchers undertaking their doctorate. A PhD can, but does not usually, have such an emphasis on the context *in situ* of healthcare and the systems and processes required to deliver that health care to the very highest standards possible. The professional doctorally prepared nurse, however, is able to do exactly that.

RECOMMENDATIONS

A robust and sustained discussion and debate should be conducted by our current healthcare leaders as to the merits of the professional doctorate versus the traditional doctor of philosophy degree for nurses. Health academics and senior managers, educators and clinicians should meet in a series of forums nationally in order to elevate the profile of the two main forms of doctoral education and stimulate others to consider their own professional development needs in response to these colloquia.

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