

EXAMPLE ESSAYS FOR
Critical Thinking and Writing for Nursing Students

Bob Price and Anne Harrington

CONTENTS:

Example analytical essay - page 1
Example reflective essay - page 11

EXAMPLE ANALYTICAL ESSAY

*This example of an analytical essay is presented in association with **Price, B and Harrington, A (2010) Critical Thinking and Writing for Nursing Students, Exeter, Learning Matters**. Readers are introduced to the process of critical and reflective thinking and the translation of these into coursework that will help them to achieve better grades in nursing courses. Stewart, Raymet, Fatima and Gina are four students who share their learning journey throughout the chapters of the book. In this essay on the evaluation of different sorts of evidence, **Stewart** demonstrates his writing skills near the end of his course. Stewart was set the task of evaluating different sorts of evidence within nursing and making a case regarding how the nurse might proceed. At the end of the essay we offer notes that explain the critical thinking and writing features of Stewart's work.*

N.B. Remember, copying essays such as this, submitting them as a whole or in part for assessment purposes, without attributing the source of the material, may leave you open to the charge of plagiarism. Significant sanctions may follow for nurses who do this, including referral to the Nursing and Midwifery Council.

Evaluating evidence in nursing

For reasons of patient safety and the improvements in the quality of healthcare, nurses are urged to base their practice on evidence (Barker, 2009). Evidence too may be argued as a basis for arranging the most cost effective care, using limited resources to best effect. I define evidence here as consisting of that information that the nurse can point to as authoritative, being more than simple opinion or predilection to practice in a particular way. In practice, the availability of evidence may be limited, some evidence may contradict other evidence and the nurse must therefore make judgements about what is found (Jolley, 2009). It is necessary to note that different sorts of evidence may be used to different purpose. For example, evidence of how patients experience illness can tell the nurse about how patients feel and what matters most to them. It cannot guide the nurse on what sorts of care are most effective. Statistical evidence, especially that originating from robust experiments, might help the nurse to determine what causes a particular effect and to decide whether to arrange care differently. Not all evidence is the same then, some is more powerful than others, and a fit between evidence and practice

needs to be determined (Brotchie et al, 2010).

In this paper I first review the different types of evidence that may be available to the nurse. I then use the work of Proctor and Rosen (2004) to highlight possible fits between evidence and efforts to improve practice. The third part of this paper summarises points about how best to judge the different evidence available—the criteria to be used will differ, dependent on the evidence considered. I argue the case that the nurse evaluates evidence well where he or she understands the nature of the evidence, establishes where that evidence might serve well and makes wise judgements on the authority, completeness and coherence of the evidence available.

Types of evidence

Whilst evidence can be classified in different ways, I suggest here that it is useful to make distinctions between research and experiential evidence in the first instance and then within research evidence to note that there are different research designs that affect the nature of evidence presented. It may seem contentious to think of experience as a form of evidence, but in practice it is frequently called upon as just that (e.g. Finlay, 2009; Beam et al, 2010). At its weakest, groups of nurses develop a working impression of how patients cope, how care is delivered and what consequences emerge if nursing is delivered in particular ways. In my experience, nurses might refer to this as practice wisdom, a collective know how that seems to work well with given groups of patients. Such evidence provides at best a first impression, and overview of issues. It is enhanced where the nurse plans reflection and observation more carefully, with reference to particular questions and focusing perhaps on case studies that allow matters to be mapped and discussed (Leach, 2007). It increases stature, as evidence, to the degree that information is gathered in a disciplined and organised way, and with a stated purpose in mind. That experiential evidence is important in healthcare is illustrated by the analysis of case studies in care and especially those associated with risk management (e.g. Stewart, 2010). Nurses and others may analyse cases in some depth to establish what went wrong, what was missed or misinterpreted, all with the aim of avoiding mistakes and of improving performance in the future.

The more familiar form of evidence that most colleagues refer to when discussing evidence-based practice is that which emerges from research (Barker, 2009). Research produces evidence precisely because of the disciplined way in which enquiries are arranged and the efforts made to gather data that attend to the aims, questions or hypotheses of the research project. Designs are influential here. Research that has been designed within the positivist tradition works assiduously to remove the risk of researcher bias and to gather sufficient data of the right type to make claims about a population of people. There is an emphasis upon impartial enquiry, with the researcher arranging checks by others such as critical reviewers to ensure that assumptions are not prematurely made about what is found (Grix, 2004).

Other research is conducted within the naturalistic or interpretive tradition (e.g. phenomenology, grounded theory, some forms of ethnography) and here the work proceeds differently. The researcher argues that it is more important to conduct work that is authentic to healthcare, than to conduct a study that has excluding all possible forms of bias (Silverman, 2004). The goal of such research is often to help others portray their experience of health, illness or care and to help

nurses understand what patients and others might need or hope for (Brotchie et al, 2010). The researcher might suggest that it is impossible to completely disassociate themselves from perspectives or views that could shape the line of enquiry. A third research design may be described as critical theory (Swartz, 1997). The researcher starts with acknowledged goals to correct inequalities in health or care and to make a case for the disadvantaged. Feminist research for example acknowledges that the researcher will not stand dispassionately aside when deliberating on what needs to be discovered or how evidence might support a case for change. Sometimes naturalistic and critical theory research is grouped together as 'qualitative research' because they often produce qualitative data and in contrast to the quantitative data that sometimes emerges from positivist research (Green and Thorogood, 2009).

What seems significant in this overview of different research designs, is that there is no universally agreed goal of research, nor is the evidence produced all of one sort. Researchers adopt different roles depending on the design of research used. In positivist research the role of the researcher is typically described as dispassionate and they proceed to gather information from outside the experience of others (it is described as 'etic'). In naturalistic and critical theory research the researcher often approaches their subject much more closely, intimately, for example observing and interviewing as a participant in the situation explored (it is described as 'emic') (Brotchie et al, 2010). To gather authentic data the researcher permits themselves to become involved in proceedings, to use their own experience as part of the process of interpreting what has been witnessed. These distinctions are important if the nurse is not to use research evidence inappropriately, as something that was never intended by the researcher, making claims that are unsupported. The evaluating nurse needs to understand the research design as well as the research evidence on offer.

Evidence and practice fit

It is tempting to argue that one sort of evidence (positivist) is superior to all others and that it is upon that which nursing should be based. This is attractive where nurses wish to highlight nursing as a science and where precision is a key consideration in care. It is extremely attractive where the nurse has to manage risk and defend actions, especially if litigation is a consideration. Nursing though draws upon many different sorts of evidence and this is in large part because the nurse works with others to make sense of health and illness (Aveyard and Sharp, 2009). If the nurse helps the patient to decide what chronic illness means to them, and to devise coping strategies that seem manageable, they are working to help others manage uncertainty. There can be no single gold standard solution, because patients' circumstances and needs are different and very individual. It follows then that research which attends to this process, of making sense of what has happened and what might help now is also valuable. Such research is more speculative in nature, more tentative as regards what can be proven or claimed. Nursing then may require both 'hard' and 'soft' evidence, the first concerned with what works, what is safe and beneficial and the second associated with process, how it feels or what it means to recover or rehabilitate for example.

Proctor and Rosen (2004) describe a stepwise process for finding and evaluating research that might contribute to evidence-based practice (see Table 1). Importantly, the purpose of the evaluation needs to be understood first. What outcomes is the nurse most interested in? It is

necessary to review that research which fits clearly with the identified nursing need, and for Proctor and Rosen (2004) this is largely about demonstrating tangible improvements in care (outcomes). In Step 2 the nurse selects from the evidence reviewed the best fitting intervention, that which achieves the desirable outcome. In Step 3 the nurse supplements or modifies the intervention, drawing upon their experience and knowledge. This third step can seem contentious, but it is important where research was conducted in different contexts to the practice considered, or where the research evidence available is incomplete or perhaps contradictory. In Step 4 the nurse monitors and evaluates the changed practice, to make sure that the desirable outcome is sustained.

Table 1: Developing evidence-based practice guidelines and a nursing illustration (adapted from Proctor and Rosen, 2004)

Step	Illustration
Step 1: Locate evidence-based interventions relevant to the outcomes of interest.	The nurse is interested in helping patients to manage their asthma better. Three interventions are located within the research literature, one associated with group teaching, another with the use of video training and a third linked to coaching.
Step 2: Select the best fitting intervention in view of client problems, situation and outcomes.	The nurse selects the intervention that produces the required outcome (patient independence) and which also is affordable and realisable given the time and expertise available. In this example it might be group teaching.
Step 3: Supplement/modify the best intervention, using nurse experience and knowledge so that it fits with practice context.	Group teaching is cost effective but demanding on the skills of the nurse, so to make this work more easily, a teacher guidance pack is produced, one that will lead to consistent and well organised teaching sessions.
Step 4: Monitor and evaluate the effectiveness of the outcome.	Over the next year the nurse monitors patients' levels of self care and the incidence of readmissions to hospital for asthma crises. Expressed confidence and lower incidence of hospital readmission are seen as indicators of better coping.

In Table 1 it is possible to imagine positivist research being used in association with Step 2 (the sort of research that focuses upon cause and effect relationships), whilst naturalistic and possibly critical theory research might have a part to play in Step 3. For instance, there would be a case to consider research relating to patient experience (of asthma education) alongside that which suggested the best way to proceed if independent living was the goal. The role of experiential evidence is much less clear in the Proctor and Rosen (2004) approach and for some colleagues it might be seen to not have a role at all. Nevertheless, experience of particular patients, their needs and level of confidence, the skills of staff (in this instance as patient educators) could and perhaps should factor in determining which intervention is used. Coaching for example requires considerable skills and long term commitment, something that might seem less feasible here.

Judging evidence

As different evidence is found, there is a need for the nurse to judge its merits (Aveyard and Sharp, 2009). Just how the evidence is judged is associated with the design of the research, or in the case of experience, the process by which it was gathered, collated and discussed. In positivist research judgement focuses upon the authority of the design and this is judged using three questions. First, was the research ethical—can we reasonably draw upon this evidence? Second, whether the research was reliable—if the study was done again, would we be likely to obtain the same or very similar results? Third, whether the research was valid—did it ask the right questions, attend to the correct study population and secure a viable sample? In short, did the research methods help the researcher secure enough of the relevant information to meet the aims of the study, to answer the questions or permit the review of hypotheses stated? Where information of this kind is missing from the research report, or the design arrangements seem ambiguous, doubts are raised about the validity and/or the reliability of findings.

Different judgement criteria are used with regard to naturalistic research and these are usually associated with the authenticity of data obtained (Brotchie et al, 2010). The reviewer searches to see if the researcher has left an audit trail of how the results were arrived at and how field work or data analysis decisions were made. The research is meant to tell a story about the reasoning of the researcher, so that the nurse can estimate whether (in their experience) the results reported are likely to be representative of what research subjects might report. Judgement in this research involves a greater amount of what I term 'free style' reasoning. The nurse asks, do these results seem likely, important and central given what has been written and what I know within my own nursing work?

Judging critical theory research seems rather more difficult. It entails establishing whether the researcher has honestly and fully stated their premises about the subject concerned, the assumptions that they start with as they conduct research (Brotchie et al, 2010). It involves evaluating whether the researcher has been clear about the critical filter, the premises that have been used to select data for collection and its interpretation afterwards.

Judging experiential evidence is difficult. Whilst reflective frameworks focus on the analysis of experience, most of these operate to other purposes, typically the development of the nurses' thinking skills (Johns and Freshwater, 2005). They are not yet used to improve the quality of healthcare experience reporting, as a softer form of evidence. Questions that might be used to distinguish more convincing experiential evidence though include:

- Have questions been used to focus the reflections undertaken?
- Have the reflections been recorded soon after the experience is complete?
- Have the reflections been discussed by a group of practitioners working in the same area (e.g. a practice review group?)
- Have efforts been made to refine or improve the reflective activity, so that information is better understood?

Conducting reflection in these ways, as a collective and critical activity adds discipline to the process and enables the reviewer to weigh the points being made as a result of the reflections undertaken.

Evaluation problems

What brings the above things together, an understanding of the different types of evidence, a process for relating evidence to a chosen practice and the judging of the quality of evidence; is systematic evaluation. Proctor and Rosen (2004) demonstrate such a systematic approach, although in this essay I suggest that the evaluation might consider more than the authors originally intended. I propose that it could be used to describe how research and experiential evidence could be combined. The nurse ascertains what works and then considers the process of working towards a new practice—that which is realisable.

What is buried here are the difficult decisions when evidence is patchy and contradictory. Not only might there not be enough research evidence, but the evidence from experience might be inconclusive as well. The nurse is left with a partial picture of nursing care, what might help patients, how patients experience that care and what would enable the nurse to proceed differently. Under these conditions it may be impossible to evaluate the evidence, at least beyond noting that it is incomplete, contradictory or incoherent. Then the nurse has to proceed with new investigations, either more research or reflection, so that the volume and quality of evidence increase. In the meantime, nursing care continues based upon tradition or what might be considered 'common sense' solutions (i.e. those that the nurse believes will help but for which there is no proof of success).

Conclusions

This essay has described the different components of work as a nurse evaluates evidence. It suggests that the nurse has to have a good appreciation of the different types of evidence and what is offered there. Failing to appreciate that could lead to the nurse distorting the evidence, using it to purpose it cannot support. Clarity is needed too though as regards what purpose the evidence review has to serve. What do we really want to do or know here? Before the nurse can conclude what the evidence offers, he or she must evaluate the merit of individual evidence— something easier to do with regard to research where there are longer established criteria by which to measure the quality of work. In some instances the nurse must honestly concede that there is insufficient clear or coherent evidence to recommend a particular way forward.

The case stated at the start of this paper does however seem supported. Considering each of the above things, the nurse evaluates evidence in a more methodical way and using relevant questions to judge what has been found. It is possible for groups of nurses to work together to evaluate to clearer purpose, instead of the ad hoc way that individual nurses might have done in the past. Without an understanding of each of the above, nurses would not have identified consistent ways to engage in evidence evaluation—something that is important if nursing is to develop a reputation for evidence-based practice.

References

- Aveyard, H and Sharp, P (2009) *A beginner's guide to evidence based practice in health and social care*, Milton Keynes, Open University Press/McGraw Hill
- Barker, J (2009) *Evidence-based practice for nurses*, London, Sage
- Beam, R., O'Brien, R and Neal, M (2010) Reflective practice enhances public health nurse implementation of nurse-family partnership, *Public Health Nursing*, 27(2), 131-139.
- Brotchie, J, Clark, L., Draper, J., Price, B and Smith, P (2010) *Designing healthcare research (K824 Study Guide)* Milton Keynes, The Open University
- Finlay, I (2009) Developing a template to plan palliative care services: the Welsh experience, *Journal of Pain and Symptom Management*, 38(1), 81-6.
- Green, J and Thorogood, N (2009) *Qualitative methods for health research*, 2nd ed, London, Sage
- Grix, J (2004) *The foundations of research*, Basingstoke, Palgrave MacMillan
- Johns, C and Freshwater, D (eds) (2005) *Transforming nursing through reflective practice*, 2nd ed. Oxford, Blackwell
- Jolley, J (2009) *Introducing research evidence-based practice for nurses*, Harlow, Pearson Educational.
- Leach, M (2007) Revisiting the evaluation of clinical practice, *International Journal of Nursing Practice*, 13(2), 70-74
- Proctor, E and Rosen, A (2004) 'Concise standards for developing evidence-based practice guidelines' in Roberts, A and Yeager, K (eds) *Evidence-based practice manual: research and outcome measures for health and human science*, Oxford, Oxford University Press 193-199.
- Silverman, D (2004) *Qualitative research; theory, method and practice*, 2nd ed. London Sage.
- Stewart, D (2010) Diagnosis and management of an adult patient with an atrial septal defect, *Nurse Practitioner*, 35(2), 8-11.
- Swartz, O (1997) *Conducting socially responsible research: critical theory, neo pragmatism and rhetorical enquiry*, Thousand Oaks California, Sage.

Our notes

You might be struck upon first reading just how polished this essay is and wonder whether you could produce something quite so convincing. Before you judge such things, remember that a) Stewart has received particular teaching on evidence-based practice and b) that he is writing at the end of his course. His work, as he would concede, was not always so well developed! See beyond the polish then and consider the structure of this essay. Look beyond whether you agree with his points, for example about what does or doesn't constitute evidence, to determine how he brought information together to create the final impression of this work.

The introduction

The introduction consists of two paragraphs, the first of which is designed to capture the reader's interest and establish what he is writing about, and the second of which is used to signpost how the rest of the paper is set out and the case that he is making. Stewart captures our interest by linking his paper to the importance placed on evidence-based practice in nursing today. This is not a whimsical or passing interest—nurses need to know about it! In the second paragraph he sets out his case briefly and clearly. In analytical essays, especially as in this instance when they evaluate what is involved in particular nursing work, stating the case is very helpful indeed. It indicates to the reader that the author knows where he is going, what he is trying to demonstrate in the paper. It is almost as though we are challenged by the case. Do I agree with this? Do I think that these things would lead to better evaluation of evidence? As a result we read the paper more attentively.

This is quite a sophisticated subject so there are a number of terms that Stewart needs to use. He needed to decide which he would assume that the reader understood and which would need to be defined. In this example he defines evidence as he uses it in this context. You could consider that it might strengthen a paper if you used a published definition of a term such as this. In this instance though, as he is making his own point about what constitutes evidence, something more than some others might include, he sets out his own definition. Whilst it is right to draw the readers' attention to reference sources, and to build these together in support of your own case, it is still necessary for you to have adopted a position of your own. Simply reporting everyone else's case, their arguments, will not usually be enough to secure the best possible marks. This is a key point in learning to think critically.

Types of evidence

The crafting of the paragraphs in this section took Stewart some time. Each had to summarise a type of evidence clearly and succinctly and in such a way that the reader understood what he believed. There is a great deal of compression of information here, he summarises a great deal and there is a real risk that he could oversimplify or misrepresent points if he includes too much. He goes straight into an argument that experience, when observed and reflected upon adequately, can constitute a type of evidence. This is perhaps contentious, but by making this argument first, he ensures that he sets out a robust position. 'I am writing about this first, because this is what I believe. If I wrote about it last in this section, it might seem like an afterthought'. Notice how he uses examples from practice to reinforce his claim regarding the credentials of experiential evidence. Audit, risk analysis work, reviews of cases that have gone wrong, all highlight the importance of experience to practice.

Later, Stewart will argue that to improve the credentials of such evidence, reflection will need to be more systematic and collective.

Paragraph discipline is important when you try to convey a great deal of information in a small volume of words. Make sure that each paragraph is about a clear subject (in this case, the different types of evidence) and that within those paragraphs you avoid excessively long sentences. Try reading aloud the sentence—if you find yourself pausing for breath, it may already be too long.

The last paragraph in this section is especially important. Here Stewart shows his reasoning as the essay proceeds. He makes some judgements about research evidence as a form and notes that it is very varied. It really would be too simple to describe it as one thing, something to be contrasted against experiential evidence. It is many things, and the nurse needs to understand each if the evidence is to be reviewed well.

Evidence and practice fit

First, we make two stylistic points. Notice how Stewart is using sub-headings to help the reader navigate his essay. Historically, sub-headings were not used widely within academic essays, but we suggest that they are valuable. If you were writing for nursing journals, you would also use sub-headings to guide the reader. Second, notice the use of the table. Stewart uses this to convey information quickly and clearly and combines that provided by some other authors (left column) with points of his own (right column). The source of information is attributed and Stewart begins here an illustration (asthma) that will help him to explain important points. Stewart should add references to the three approaches to asthma education, as they would normally come from published work. Here Stewart is using ideas as an illustration, it is an example only of what might be found. By and large, assessors will prefer that students draw upon actual examples from the literature, demonstrating the student's work within the library. Imaginative and pertinent though Stewart's work is, it only shows what *might* be possible, the stronger case draws on that already argued or demonstrated elsewhere.

If the last section was made of paragraph arguments about what counted as evidence, this section sets out to argue that a process can help explain how evidence and practice requirements can be matched. He uses Proctor and Rosen's (2004) framework to show this work in action. At this point it would be easy to write extensively about the framework, where it came from, who designed it, but to do so would be a distraction. Frameworks of this kind are heuristic, that is, they serve a purpose, and right now this is to show how different types of evidence could serve a stated purpose. Our own view of this is that Stewart manages this rather well, with the possible exception of his last points about drawing experiential evidence into the process. Stewart is bold here, he suggests that experiential evidence has a role to play, but perhaps this is not a point fully substantiated until later, when he describes what is required to make the evidence more robust.

Judging evidence

This is another section where information has been compressed. Whole textbooks have been written on how to evaluate research! Nonetheless, if Stewart is to support the case that this work is but a part of evidence evaluation, he needs to convey the essential information quickly and clearly. Larger debates and explanations, for instance about the different sorts of validity, cannot find space

here and we would support his selection of points. Validity, reliability, authenticity and audit trail are important considerations in judging research. Had we wished to ask for further elaboration on any of them, it would be important to also suggest what else he might have omitted in this essay to make room for this.

Notice how each group of judgements is assigned its own paragraph—this adds to the overall impression of a disciplined essay. At the end, in the final paragraph he uses bullet points to introduce his own recommended criteria for judging experiential evidence. This is another bold step, one that demonstrates that Stewart is reasoning confidently. Irrespective of whether readers agree his stance here, we think that these are indeed things which would make reflection more systematic—more disciplined in ways that we might expect if evidence was to result.

Evaluation problems

It was at this juncture that Stewart realised something was missing. His original essay plan had not included this section! When he was planning the essay, he thought that if the above three components of evidence evaluation were argued that he would have a convincing account of what evidence evaluation entailed. The problem is that evidence is rarely that complete, coherent or neat. So the addition of this section nicely highlights then the need to stop and pause sometimes and to consider whether what you have written is adequate. Stewart needed to add something more, and had some word space to do this. That 'something' was about what happened if the component parts of the evaluation were not enough, if they did not suggest a best way forward.

This is quite a short section, and perhaps you feel that Stewart did not quite clinch the point? It is not merely the case that sometimes that evidence does not come together well, or that it is incomplete or contradictory, it is that the working with untidy, incomplete and sometimes confusing evidence is frequently a challenge for the nurse. The successful evaluator of evidence confronts this confidently and is prepared to argue 'we don't have enough evidence here to proceed'. Decision making at this point possibly distinguishes the more from the less successful evidence evaluators! It perhaps requires great integrity to make this decision, when the pressure builds to change practice in some way.

Conclusions

Conclusions have two roles. The first is to summarise what has already gone before—something that Stewart does in the first paragraph. The second is to demonstrate the author's deductions about what has gone before. In this instance that is that the case he set out at the start of the essay is supported. Stewart argues that successful evaluation is founded upon a mixture of things and the more systematically these are conducted, the better. His essay would be even stronger if he had argued that the process was transparent to others who listened to the case for change made afterwards.

EXAMPLE REFLECTIVE ESSAY

*This example of a reflective essay is presented in association with **Price, B and Harrington, A (2010) Critical Thinking and Writing for Nursing Students, Exeter, Learning Matters**. Readers are introduced to the process of critical and reflective thinking and the translation of these into coursework that will help them to achieve better grades in nursing courses. Stewart, Raymet, Fatima and Gina are four students who share their learning journey throughout the chapters of the book. In this essay on the assessment of pain, **Raymet** demonstrates her reflective writing skills near the end of her course. Raymet had by this stage written several reflective practice essays and gained good marks. This time though she was encouraged to deepen her reflections, speculating selectively on how the account of pain experienced by a patient (Mrs Drew) might help her to work more creatively with patient perceptions and reported needs.*

N.B. Remember, copying essays such as this, submitting them as a whole or in part for assessment purposes, without attributing the source of the material, may leave you open to the charge of plagiarism. Significant sanctions may follow for nurses who do this, including referral to the Nursing and Midwifery Council.

Assessing Mrs Drew's Pain

Mc Caffery and Pasero (1999) state that pain is what the patient says it is. If we accept that point, then nurses need to explore the patient's perceptions of pain, as well as their report of experiences. The two are not quite the same. Patients may report their pain in a variety of ways, dependent on the nature and the intensity of pain and the context in which it is felt (e.g. whether they are ever distracted from the pain). Their perception of pain is a little more though and it includes the meaning that the pain has for them. It includes explanation of why the pain is there in the first place, what it indicates about their body and what it could suggest might happen in the future (getting better, getting worse). The nurse assesses the account of pain shared by the patient, and this may be given in the form of a story. This is how it began, this is how it felt, this is what that meant to me and this is what I did about it (Mishler et al. 2006)

In this essay I explore the assessment of pain as conducted with one 60 year old patient whom I will call Mrs Drew. Whilst the essay describes an assessment of pain with a single patient, I try to share too some ideas and questions that this provokes within me about pain assessment more generally. Mrs Drew made me think about other patients, future assessments and what I had to do as a nurse to help patients. To help structure this essay I use the framework described by Gibbs (1988). Whilst the episode concerned relates a stage in Mrs Drew's illness when she challenged her treatment protocol, it also includes some of the memories and thoughts that this patient refers to regarding her earlier illness and past ways of coping with pain. In particular, it prompted me to question to what extent I as a nurse should recommend analgesia, drawing on what I had been taught about the effective control of pain. I had learned that it was better to control rather than to chase pain (e.g. Mann and Carr, 2006; Forbes, 2007).

Mrs Drew was diagnosed with lung cancer a year earlier and had initially had her illness treated by chemotherapy. This had helped her to achieve a remission that lasted for nearly ten months (Hunt et al, 2009 describe the prognosis of this disease). The cancer had returned though and spread to her

spine and it was here that she experienced most of her pain. It was at this stage that the doctors explained that her care would now be directed towards her comfort rather than a cure—to which she had replied, 'you mean palliative care'. Mrs Drew was supported at home by her husband Neil and visited on a regular basis by community based nurses to whom I was attached as part of my student nurse training. She was prescribed oral morphine and could decide within stated limits how many tablets she could take in any one 24 hour period.

The situation

I had visited Mrs Drew on several occasions over the period of a month when the community nurse and I were confronted by a tearful patient who announced that she did not wish to take the oral opiates quite as often as we were recommending. As she spoke she held her husband's hand tightly, looking across to him as she described her experiences and feelings about the matter. Yes, there had been some bad nights when the pain had woken her and she had to sit up and watch television to try and distract herself. Yes, sometimes the pain made her feel nauseous, but she was alarmed at how frequently she was taking the 'pain tablets' and how this made her feel about herself. However well meant the medication was, it didn't feel dignified to be so reliant on drugs, or quite so sleepy and unresponsive for such a high percentage of the day. Whilst the analgesia was working well when she took the tablets, the quality of life wasn't what she wanted.

The community nurse listened patiently to Mrs Drew and then explained that it was normal to have panic moments about such medication. Morphine had a reputation, one that people associated with misuse of drugs, rather than their therapeutic use. Used on a regular basis, the drug wouldn't cause addiction and it would provide a great deal of reassurance to Mr Drew as well. The community nurse stated that she was quite sure that he respected his wife's need to sleep when she wished and to build the rhythm of the day around her needs.

At this point Mrs Drew shook her husband's hand, and said, 'tell her...tell her what we've talked about!' Mr Drew then explained that his wife was used to dealing with pain, she had suffered recurrent pain in her neck and shoulder after a road traffic accident some years before. The pain had sometimes been severe, but he had massaged her shoulders and used heat packs that she found soothing. They had decided that they wished to use this technique now, keeping the morphine for absolute emergencies, when she was losing sleep and couldn't eat as a result of the discomfort.

The community nurse assured them that they were in charge of the analgesia and would be allowed to make their own decisions. She started to make notes though, and announced that she was making a referral to the cancer pain clinic, something that would help them to take stock of the situation. There was very good reason to suppose that this might be a problem associated with choosing the right dosage of the morphine, rather than using supplemental pain relief measures. Mrs Drew responded sharply, 'You're not listening to me though Jane (the community nurse's name—a pseudonym is used here), I want to use heat packs instead of morphine, at least during the day. I want to be more alive with my husband.' The community nurse assured Mrs Drew that she had heard what she had said and respected her point of view. There would though be nothing lost by using the clinic to gain a further check on this matter. With that she excused us, explaining that we had a further appointment that morning and we left, having checked that Mrs Drew had a sufficient supply of her different medicines.

As we walked to the car the community nurse empathised with Mrs Drew's plight, saying that if she had lung cancer she would probably grasp at straws too. She would reach out for things that seemed more normal, and then observed, 'but this isn't normal is it, the pain she has isn't normal. It's not just a whip lash injury and old age.'

Feelings

I remember that during this episode feeling a mixture of confusion, surprise, anger and impotence. Mrs Drew had surprised me by the way she had spoken, using what seemed to be a planned announcement. They had waited for and perhaps rehearsed this moment. Nothing in my experience to date had prepared me for such an encounter, at least in such circumstances, where we as nurses were so obviously working to support the patient. It was only later that I called the episode a confrontation. Mr and Mrs Drew had confronted the community nurse and I had been the largely silent witness to the event. As the discussion proceeded I remember making supportive noises, remarking how useful heat packs sometimes were and glancing across at Jane, who seemed to be signalling with her expression that I should leave this debate to her. I was trying to read her reactions to the Drew's points and concluded that if I couldn't support her arguments to the patient, then I should remain silent. There were issues here that I perhaps hadn't enough experience to deal with, at least, whilst 'thinking on my feet'.

My initial anger (with Mrs Drew for not acknowledging all that we were trying to do) quickly became displaced towards my colleague Jane. During the event I couldn't explain why that was, but afterwards, when I made notes, I realised that it was because she seemed to have set the agenda in her own mind and to be requiring the patient to comply with concerns of her own. Put rather crudely, Jane seemed to be saying, listen I know about these things, this is a phase, an anxiety; you can work through all this. I believed at this point that she had missed the significance of the event, the way in which the Drew's had arranged the conversation. For them, this was not a phase at all, but a considered and very important decision, one that they wanted the nurses to accept (Freshwater, 2002 and Edwards and Elwyn, 2009 emphasize the importance of negotiated care planning).

My feelings of impotence were associated strongly with my lack of clinical experience. I have met this before. No matter how many placements I do, no matter how good the mentoring I receive, I keep meeting situations where I am unsure about how to respond next. I feel younger, less knowledgeable than I should be at this stage in my training. I want to reassure patients, to support colleagues and to give good advice, but there is not enough confidence to do that. If I felt unsettled and uncertain about Jane's response to the Drew's, right then I couldn't easily explain that. I couldn't offer a second opinion, couldn't suggest an idea that might help support the patient. To my annoyance I couldn't manage that either as we left the house. Jane had made some fair points, she clearly seemed concerned about the patient's needs, but perhaps she hadn't spotted the right need—for Mrs Drew to determine in greater part how she dealt with her illness.

Experience evaluated

Afterwards, this short episode prompted doubts and debates about several important aspects of nursing for me. Setting aside the etiquette of learning in clinical practice, not challenging a qualified nurse in front of a patient, there were problems here associated with supporting patient dignity,

with my assumptions relating to analgesia and pain control strategies, and I realised, with my assumptions about types of pain and who had the expertise to define these.

Dignity is more than simply using the appropriate terms of address, protecting the privacy of patients and attending to their expressed concerns (Price, 2004). It is about clarifying the ways in which they live and accommodate illness or treatment. It is about finding out what benchmarks they use to say that 'yes, I am doing well here, this makes me feel good about myself'. Upon reflection, I sense that we on this occasion had not worked hard enough to discover how Mr and Mrs Drew define quality of life, or being in charge of their situation. We were more concerned with providing resources, sharing research or theory about medication and questioning the familiar misconceptions associated with morphine. To put it simply, we were 'missing a trick', reading the encounter as something that had happened many times before—the report of problems or anxieties, a request for help, rather than a decision that the patient and her carer had already come to. Reading situations well seemed, with the benefit of hindsight, to be the first basis for dignified care. 'What is happening here, what will help the patient most?' were questions that we perhaps assumed that we already knew the answer to.

I realised that in my training I had already accepted the argument that patients would wish to remain pain free come what may and that the tackling of fears about prospective pain, was something that nurses engaged in. I assumed that because cancer pain represented such a major threat, because it was greater and more all encompassing, that there was little or no doubt that it should be removed. What was so unsettling, and took so much time to examine, was that Mrs Drew acknowledged the possible severity of metastatic cancer pain, but that she still preferred to respond to it using measures that had worked for her whiplash neck injury. Mrs Drew was willing to trade off a pain free state for something that gave her a greater sense of control and which perhaps enabled her husband to express his support for her in a very tangible way (preparing heat packs, massaging her back, rather than simply giving her the tablets). Mr and Mrs Drew questioned all my assumptions about best analgesia practice, and seemed to write a large question mark on the textbooks I had read about chasing rather than controlling pain in palliative care situations (Mann and Carr, 2006).

Reflections (learning opportunities)

The episode with Mrs Drew left me uncomfortable because my past approach to pain management was theoretical. I (and I believe Jane too) regularly made use of science to decide what could be done as regards pain relief and to assume that patients would wish to achieve all of those benefits. This wasn't about local applications of heat versus morphine, Mrs Drew could use both, it was about choice and how patients made choices—why they reached the decisions that they did. It was for me, about accepting very personally, that providing that patients are given all the relevant facts, alerted to the options, that they really are able to make choices that work for them. The very fact that Mrs Drew's illness was now incurable, that she and her husband usually tackled pain together, meant that her solution to the challenge was different to those that many other patients arrived at. Having dealt with this pain for some time, knowing that it could and probably would get worse, meant that she was better equipped than other less experienced patients to make a decision here.

This took nothing away from the benefits of sharing further discussion with pain clinic experts. I thought, Mrs Drew will stand her ground, she will insist on doing things her way if her husband is

strong too. What it did highlight though was the importance of listening to patients, hearing how they perceive pain, how they narrate not only the pain but what they did about it. In this instance the narration was all about dignity, and coping, and finding ways to help one another and how this enables us to feel in the face of such a terrible illness. So, in telling us about her pain, what she did about it, using morphine when it was 'absolutely required', Mrs Drew was not reporting her ignorance of what could be achieved if the medication was used differently, but what she preferred to do as it enabled her to achieve different goals. Mrs Drew's goals were about liveliness, alertness and stoicism, showing that she could bear at least a measure of pain.

I wondered why I hadn't listened carefully enough to such a story? Was it because of time pressure, or perhaps complacency, that Jane and I felt that we already knew what account would be shared? Did we think that the patient would ask for help, more help, as the pain continued? If so, then our guesses had prompted us to behave as experts, and problem solvers, on the patient's behalf. Perhaps hearing a patient narrative is about discovering what sort of role they would like you to fulfil. If so, then it might be a difficult role. I thought hard about how hard this was for Jane. She was going to be asked to witness Mrs Drew's future pain, one that was now less perfectly controlled. She was going to be asked to reassure, to suggest measures that might help, without reminding the patient that she 'already knew that you couldn't manage pain *that way!*' When I think about it now, that is very stressful for a nurse. It is about caring and allowing patient's to make choices that we personally might not make.

Conclusions

I have drawn then three conclusions from the above reflection.

First, that being patient centred is never easy and requires real listening and interpretation skills. My criticism of what Jane chose to do, to try and dissuade Mrs Drew from a course of action, recommending further appraisal of the situation, is an easy one to make. Nurses confront situations such as this relatively unprepared and react as considerately as possible. It is easy in hindsight to recommend other responses, a further exploration of what motivated Mrs Drew's pain management preferences.

Second, that experience can be a valuable teacher, the equal of textbooks. If nurses are interested in care, then we should be concerned with the sense that patients make of their own illness, the treatment or support that they receive. We need to understand what patients have to teach us and have to acknowledge that this means that we won't always seem in control ourselves, expert and knowledgeable. Our expertise might be elsewhere, helping patients to reach their own decisions.

Third, that one way to understand patient perspectives on illness or treatment, on pain management in this example, is to hear how they talk about the situation. How do they describe the pain, how do they refer to what they did about it? The way in which the story is shared, how we coped, how this made us feel, is as important as the facts related. Sometimes a patient needs to feel stalwart, even heroic in the face of illness.

Future care

It would be foolish and unprofessional to recommend to other patients that they might not wish to remove pain, or that overcoming pain doesn't always mean we don't continue to experience it. For every Mrs Drew there may be many other patients who would welcome the complete removal of pain, so that they can die calmly, quietly, with their own version of dignity. But it does seem to me, that it will be worth thinking about the diversity of patients and how they prefer to cope when I assess pain and help manage this problem in the future. I won't be able to walk away from the responsibility of debating whether I have explained all that I could, detailed the strengths and limitations of different ways of coping. I will need to find reflection time to ponder what patients have said and if necessary to go back and say, 'I've been thinking some more about your words last week..' knowing that this doesn't make me any the less professional.

References

- Edwards, A and Elwyn, G (2009) *Shared decision-making in health care: achieving evidence-based patient choice*, 2nd ed. Oxford, Oxford University Press
- Forbes, K (2007) *Opioids in cancer pain*, Oxford, Oxford University Press
- Freshwater, D (2002) *Therapeutic nursing: improving patient care through self awareness*, London, Sage.
- Gibbs G (1988) *Learning by doing: a guide to teaching and learning methods*, Oxford, Oxford Polytechnic Further Education unit
- Hunt, I., Muers, M and Treasure, T (2009) *ABC of lung cancer*, Oxford, Wiley-Blackwell/BMJ Books
- Mann, E and Carr, E (2006) *Pain management*, Oxford, Blackwell
- McCaffery, M and Pasero, C (1999) *Pain: Clinical manual*, Mosby, Philadelphia
- Mishler, E., Rapport, F and Wainwright, P (2006) *The self in health and illness: patients, professionals and narrative identity*, Oxford, Radcliffe Publishing Ltd
- Price, B (2004) Demonstrating respect for patient dignity, *Nursing Standard*, 19(12), 45-51

Our Notes

The following notes offer points on the design of this essay but do not constitute a marking of the work. The notes are designed to help you identify key features of the work.

Characteristics of reflective essay writing

Raymet's work is characteristic of reflective writing in nursing, in particular:

- Appropriate use of the first person singular (I). These are reflections of the nurse herself. To write in the third person (the nurse) could become confusing and inauthentic.
- Use of a reflective framework (it is not beyond possibility to use a framework of your own design, but those tried and tested before have much to commend them. You are likely to cover material more evenly and to demonstrate a deeper analysis using these).
- Exploration of feelings, attitudes and values (these are used by nurses to interpret care requirements and to plan interventions).
- Description of a case study care episode (dispassionate and succinct).
- Limited reference to the literature (the focus here is upon experience and the meanings that might be arrived at through reflection upon the same. References to the literature are important by way of illustration or as part of a comparison of theory and practice, but the arguments within the essay are not justified by the literature. They are recommended to the reader in terms of experience described and what they suggest as regards the nurse's introspection).
- Patients/colleagues rendered anonymous (through pseudonyms).

Introduction

Whilst many reflective practice essays go straight into the description of the situation we recommend an introduction that sets up the purpose of the essay and which helps the reader to anticipate what will appear below. In reflective writing this usually refers to a journey, a process of enquiry. Here Raymet conveys this very clearly and acknowledges something of what she has already realised through the process of note making and essay drafting. In this case, that is that patient centred care and assessment of pain are about narratives, the ways in which accounts are shared by the patient as well as what is reported. Were this an essay about theory, Raymet might state a case at the beginning of her essay. Notice the signposting within this section, Raymet explains how she will use Gibbs (1988) reflective framework. This is important as otherwise we might expect to see the section 'conclusions' come last in the written work.

The situation

In reflective writing it is important to be clear when you are writing about facts and when you are referring to perspectives and experiences. In this section the focus is upon facts and so the writing is succinct and descriptive, reporting that which happened and which is pertinent to the rest of the paper. Raymet avoids surmising the meaning of what has happened, for instance the change in Mrs Drew's prognosis. We learn what the patient and her husband said, gain a summary of what the community nurse said and are left to ourselves reflect on what this signifies about Mrs Drew, about the pain assessment and about the care relationship in this context. Rather like a police officer, reporting information from a road traffic accident, the facts rather than interpretations and speculations are shared here.

To write this section it is necessary to decide what is pertinent and what is not. You might consider that we needed more detail about the medication used, how long Mrs Drew had been prescribed opiates, the dosage and the pattern of use. It could be valuable to learn something about past pain assessments and to learn whether the patient had kept a pain diary. Nonetheless, the section is well conceived as it focuses precisely upon the issues that are up for debate, that is, who should determine how best to judge pain and then how to manage it. It is this relationship between care philosophies, respect for the patient as partner in care decisions, and the nurse's eagerness to relieve suffering which is at issue here.

In a previous draft of such an essay Raymet might not have achieved such a clear focus. Drafting the reflective essay can itself improve reflection, prompting second and third thoughts. A judgement has to be made then between working and reworking essays to improve clarity and transforming them into theory, thereby losing some of the freshness of the first work. We think that Raymet has found a happy balance here.

Feelings

In this section Raymet writes about her feelings. She does not surmise what those of other people might be and were she to do so, it would have to be clear that she is speculating. A key part of reflective writing is to explore how our feelings might filter experience of care episodes and affect perceptions of what happened (as good, bad, indifferent). This can be a difficult element of writing because you might have to own up to some uncomfortable emotions. A balance has to be struck between self critique and compassion, recognising why such emotions can arise. Notice how Raymet identifies the key feelings in the first paragraph here and reviews each in turn using the following paragraphs. This is a clear and methodical way to proceed. We can see not only what emotions occurred but how the focus of these shifted. This demonstrates a careful consideration of emotions on her part. She does not assume that emotions are right, justified or self evident. There is no crusade here regarding how care should be.

Experience evaluated

It is possible for students to conflate the next two selections and to repeat themselves, but Raymet avoids that here, treating this section as a summary of what the episode means and the next section as an indication of what needs to be explored further, with regard to assessment and dialogue with patients. This section is very much reflection on action and about arriving at a measured judgement of how the episode can be characterized. For Raymet it is about a tension between philosophy (care that enables patients to feel dignified) and about mental set and theory (the ways in which nurses habitually approach care situations and use theory to anticipate how best to act). It is care that was less successful than it could be. She reviews the issues briefly, but conveys insights into why nurses behave as they do. It's worth considering here (and later) whether you think that Raymet shows a due regard for Jane the Community Nurse and her predicament. Do you think that she simply judges Jane, or whether she shows a due understanding of why her colleague might be operating in a more ritual or familiar way? Notice Raymet's observation that 'we were missing a trick'. This could seem rather colloquial writing, but it does convey crisply how Raymet saw this, as a lost opportunity.

Reflections (learning opportunities)

This is possibly the most powerful section of the essay, and one that is conveyed very lucidly. Raymet returns to the reflection some time later and begins to ask questions about why she and her colleague failed to read the care episode successfully. Such later stage thinking is important if reflective practice episodes are to help the nurse identify useful ways of thinking about healthcare, patterns of what it is important to consider when making care decisions. It is not simply that the nurses did not listen long enough, it was that they listened to the reported facts in the patient's account, but not how the account was arranged. Raymet here is using some teaching we shared about patient narratives and the propensity of us all to tell stories about events that give meaning to what happened. For example, we tell stories about a trip to the dentist. These report what was done (I had a filling) but may also indicate something about our bravery, the cost of treatment, guilt about eating too many sweets and much more! People use stories to convey the meanings of events to others and to elicit responses from us, the listeners. In this instance, Mrs Drew might have been looking for approval, support and consultation on her plan to manage pain differently. Instead, Jane treated it as a report of faltering confidence in pain management and suggested that reinforcement might help (the cancer pain clinic).

Conclusions

Raymet uses bullet points here and these can be effective, providing that they help you summarise information that has been either addressed elsewhere or which is incidental to the main arguments of the paper. Routine use of bullet points can make your essay look a little too notational, so use them sparingly!

The conclusions need to sum up the preceding reflections and your deliberations on the same. Raymet achieves that here, showing empathy towards her community nurse colleague (this work

isn't easy), insight into patient centred care and a possible way of thinking about what patients say (narratives) that might assist her to work differently in the future.

Future care

This is quite a short last section from Raymet and you should avoid running out of steam by planning your work so that an adequate proportion of words are allocated there. It can be difficult to decide what next, after you have reached conclusions in the previous section. Here it is necessary to avoid sounding trite ('I will listen to and hear all patients' narratives in the future and act accordingly') and to be clear about what could represent a next step. In this instance that could be things such as identifying one or more future case studies where you try to hear patient accounts more clearly, testing your interpretation with others. It might be to read more about patient narratives and their role, so that ideas can be evaluated further. Raymet's 'future care' is appropriately measured in tone, but it lacks a little detail as well.