

A discussion on research and appraisal within comparative perioperative professions: the potential contribution to ODP professional development

Nick Rowe argues the case for developing research and an evidence base for the ODP profession

Nicholas Rowe

The author is a lecturer at Bournemouth University and an ODP with longstanding experience in clinical lead, management and educational perspectives, with involvement in pre- and post-registration delivery of perioperative care education for nursing and ODP programmes.

Abstract

Despite recent steps towards formal regulation of ODPs as professionals, there remains a disputed boundary in perioperative care with nursing. A literature review showed each profession expressing unfounded and critical views of the other. Much of the criticism of ODP practice assumed that nursing was the caring profession, while ODPs were more technical.

Nursing has a significantly more developed framework of research and evidence-based practice that has helped to shape the way nursing is perceived. However, comparatively little has been generated by ODP profession. Given that the governing bodies of both professions advocate continued professional development, evidence-based practice and the sharing of knowledge, research and appraisal has a vital role to play in the development of perioperative practice.

This article proposes that active utilisation of research, and the development of demonstrable evidence-based practice, would serve to benefit all perioperative practitioners and improve clinical effectiveness across a wide spectrum.

Key words

Profession, ODP, nursing, research, evidence, CPD

Reference

Rowe N (2007) A discussion on research and appraisal within comparative perioperative professions: the potential contribution to ODP professional development. *Technic* 3(11): 16-19.

Introduction

This article seeks to establish the context within which research-based evidence may guide and inform the development of operating department practice, and either support or dispel the preconceptions that we hold in regard to ourselves, our 'rival' professions and our daily practice. While professional registration for operating department practitioners (ODPs) was formally established in 2004 (AODP, 2006), nursing became a registered profession in 1919. This has led to a significantly more developed framework of nursing research and evidence-based practice, which has helped to shape the way nursing is perceived as a profession, from both within and without. However, the relationship between the two professions still holds contentions and this is evident through both the experiential observations of the author, directly reported workplace observations of Dip HE ODP students (2005-07) and in a review of published articles. (A linked-text 10-year review of BNI, CINAHL full text and Medline, with the simple directive of: *Operating Department Practitioner OR ODP – TX All Text* (in order to access ODP centred literature), highlighted a mere 54 articles. Only one of these (Timmons and Tanner, 2004) analysed the comparative roles of ODPs and perioperative nurses, and forms an acknowledged limited basis for comparative review, in support of the experiential position of the author.) However, with the adoption of a grounded approach to conducting and reviewing research, all perioperative practitioners can develop themselves and their professions, perhaps dispelling unfounded judgements, by providing reviewable data that supports their practice.

Evidence-based practice

In 1996, while seeking to promote clinical effectiveness, the NHS Executive highlight-

ed an inherent need to underpin practice with solid supporting evidence (NHSE, 1996). The resulting methodology has come to be referred to as evidence-based practice (EBP). Findings by Colyer (1999) assert that the literature concerning EBP within health care is mainly centred upon the specialities of medicine and nursing, with little representation from other healthcare professions. This may be contributory to the perception of the division between nurses and ODPs, in that while both are 'caring' professions with overlapping roles within perioperative practice, there is comparatively little self-generated evidence compiled that openly supports the ODP as having evidence-based practice (Timmons and Tanner, 2004). In that article, which examined the nursing-ODP division, responses by both groups at interview appeared to be strongly opinionated, despite lacking substantiated fact on either side. This is in-line with the experience of the author and consulted colleagues.

A direct parallel demonstrated by Percy (1995 cited Fletcher 1997), may be drawn to entrenched practices within the workplace that remain unchallenged and lacking in supporting evidence. Individual work methodology, especially that of more experienced, senior practitioners, is often supported solely by the rationale of 'This is how I was shown' or 'This is what we have always done', without any further evidence. While the efficacy of this practice may not be in question, and can contribute a degree of experiential evidence, it does not reflect the published views of both the ODP and nursing governing bodies, which promote a responsibility to 'deliver care based on current evidence, best practice and, where applicable, validated research when it is available' (NMC, 2004).

The fact that patients both survive and benefit from these practices is in itself, a

form of evidence, and is used to satisfy the moral and professional conscience of the practitioner. However, this does not lend to the theme of transparency, in which colleagues, patients and the broader community may clearly see and balance information in order to develop shared best practice. Available perioperative-related literature is growing, and while the NHS seeks to maximise patient care and streamline service provision and costing, the related study and research is not always reflected in the care received by patients [Haynes et al (1995 cited Parahoo 2000)]. As such, an appropriate system of critical research, structure and appraisal is needed so as to focus and validate the multiple sources of 'evidence' available. Indeed, much of the substance of perioperative practice is effectively established, with results being seen in the effective day-to-day treatment of the surgical patient in the UK healthcare system. However, in order to promote clinical effectiveness, a formal acknowledgement of this validating material and its subsequent publishing will allow practitioners to evaluate their own practice, and that of others, in a process of continual professional development (CPD). This will also ensure open access to core information, and so improve the development and implementation of care.

Question and challenge

William Beaumont (US Physician 1785 – 1853) wrote in his notebook: 'Of all the lessons which a young man entering upon the profession of medicine needs to learn, this is perhaps the first – that he should resist the fascination of doctrines and hypothesis till he has won the privilege of such studies by honest labour and faithful pursuit of real and useful knowledge.' Indeed, while this may seem a dated viewpoint, it still holds considerable relevance today. Students are engaged in the 'faithful pursuit of real and useful knowledge', but all too often, this is unsubstantiated, other than the blind faith, placed in the practitioners, in whose care they are placed. The systematic and organised knowledge of healthcare leads to its consideration as a science (COED, 2003), and as such, requires that its principles be grounded in fact. This should be clearly evident and may be produced either as quantifiable data, or more often, as valid qualitative

proposals. All healthcare practitioners should be encouraged to follow current research (if not in pursuit, then in review), both as trainees and educators, concurrent with their fields of practice. Burnard and Morrison (1994) describe research as '... a means of understanding, assessing and evaluating what we do (as nurses) [preface ix]', and this is of equal application to all healthcare professionals, at all levels. In assessing the theory and practice of both ourselves and others, we encourage professional development and legitimise our position as providers of care. A study by Parahoo (2000) showed that of a survey of 1363 nurses in Northern Ireland, 75.4% expressed the opinion that they did not feel they had enough authority to change patient care procedures. If EBP is to be truly effective, then the manner and rationale by which we undertake research and its subsequent appraisal may serve to empower healthcare professionals to challenge traditionally entrenched practices within their professions, by the adoption of clearly reasoned and balanced argument. This challenge should initially look to validate current practices, before considering the requirement for change. Many professional bodies advocate the pursuit of CPD, so as to maintain and develop registrants' skills and knowledge, in order to practice safely, legally and effectively (HPC – CPD, 2006). Either applied or adopted research and appraisal, will allow healthcare workers to evaluate their field of study, and ensure that the information gained is tested against the principles of reliability and validity, prior to its implementation in formulating policy and procedure. This may improve the limited implementation within the workplace observed by Colyer (1999), with traditional practices remaining unchanged or running parallel to alternative approaches, so giving inconsistent methods of working.

Research as CPD

In the same way that core texts provide a knowledge base for topics of study at an initial level, the use of research serves to initiate the empowerment identified as lacking in the development of EBP (Parahoo, 2000). This process is required to be progressive, so as to avoid the substitution of one set of entrenched beliefs, for another. Thus, practitioners

need to undertake research and appraisal, so as to continue to develop on both professional and personal levels, and also to give reflective evaluation of their practice in relation to the requirements and opinions of the broader society they seek to serve. Within both practice and standard texts, there remain constants to which we adhere. However, the requirements that are made of these 'truisms' are dependent upon inconsistent spheres of application and continuous change. No two operating departments are the same, and the scope of practice within employment roles differs within each establishment. Therefore, the influencing factors which determine our rationale for both thought and practice, continue to be identified by means of freely accessible emerging research. Guidelines published on topics such as emergency medicine are often an individual representation, evolved from collated research from a variety of expert sources. Opinions are justified on the relation of their content to an underpinning science, which has been agreed by representative organisations (Resuscitation Council UK, 2000). This forms their demonstrable 'evidence-base'. In order to do this, a direct research question needs to be established and an appropriate methodology devised to obtain the data. The criteria we set regarding the aims of practice and the operational management processes are often a reflection of things we hold to be important – values (Ajeneeye, 2006). From this position, experience serves to direct our subsequent related activities and thought patterns and may influence the way in which we conceptualise a topic, and so have a bearing on any analysis undertaken. The manner in which we interpret, may deviate from the original intent. This is recognised as a flaw of communication, and as such, taken into account.

Valuing knowledge and experience

In a study examining the context of 'expert knowledge', Smith et al (2003) found that learning to read and reconcile (critically analyse) different types of knowledge was a key area of practice development. The opinion was expressed, that in order to reach the level viewed as being expert within any given area, it was important to balance EBP with informal



guiding experience, gained from exposure to alternate learning environments. The ODP is acknowledged as having the guiding experience, but would benefit greatly by validating this against an evidence base, by means of research. Again, the clinical qualifications and senior positions held by ODPs within the healthcare setting bear witness to the abilities they hold. Demonstrable evidence of independent analysis and practice serves to support the change from the founding base of assistant or technician status, to that of the professional practitioner. Rodgers (1994 cited Parahoo 2000) observed that research utilisation 'should not be decontextualised or fractionated in order to lead to an understanding, but must address multiple factors simultaneously'.

Referring to the contentious issues highlighted in the study by Timmons and Tanner (2004), a basis for the perceived differences between ODPs and theatre nurses may lie in the possible imbalance in the appreciation of the value of experiential knowledge recounted by ODPs within their EBP. This 'data' is still relatively unexplored by the ODP profession (as may be determined by a literature review of 'operating department practitioner') yet, due to the abundance of available 'nursing' literature, there might be a perceived inference that it is in fact non-existent in a formal context, and from that, the ODP profession is not research or evidence-based.

The existential slant of this argument is not prevalent within nursing research, but an interesting parallel is that both the UK pre-registration ODP and nursing programmes of the last 15 years have been structured with an approximate 50:50 ratio of theory to clinical practice. Current nursing courses offered at universities (50:50 over three years) can have a higher amount of credits awarded for the theory allocation, than that of its equal-length practice equivalent, and this may reflect implied values. Many observed contentions between nurses and ODPs centre upon the perception that there is greater recognition of 'patient care' on the part of theatre nurses, while the ODP has a more practical application (Timmons and Tanner, 2004), yet there is an absence of published literature available. If, however, both primary and continuing education undertook critical analysis of

research, concerning the wider clinical and non-clinical aspects of perioperative practice, then it would be observed that within the multi-disciplinary setting, both groups undertake similar roles (Goodwin et al, 2005). The care of the surgical patient has many practical and technical requirements, with recent 'role-development' pushing the professional boundaries of the perioperative practitioner (PCC, 2003). Hence, research and analysis will need to be applied if the acceptance of any new responsibilities is to be gained from both service users and peers alike. If there is a difference between theatre nursing, and operating department practice, where does one stop, and the other begin? The Oxford English Dictionary (COED, 2003) defines the term nurse as 'a person trained to care for the sick or infirm' or 'to give medical and other attention to' – underlying tenets of both professions. Participation in the research process may help to illustrate this fact, and thus dispel some of the unfounded pre-conceptions still adherent to the profession.

Qualitative and quantitative research

The conditions of research application, along with the underlying concepts of each research form, need to be understood by all learners and practitioners before evidence can be gathered or reviewed (HPC 2006). It is therefore important that these topics be covered in any field of professional study, at an appropriate level.

Commonly available healthcare information may be found as quantifiable data, often within a qualitative format. Statistics is a science in itself, and there is a depth of knowledge required by the user in order to either read or employ these techniques. In the study by Parahoo (2000), secondary to the question of restricted empowerment posing a barrier to the implementation of research in EBP, the comprehension of the statistical analysis, often present in quantitative research, was also cited as posing a significant barrier. Motulsky (1995) is of the opinion that for many professionals who are establishing a grounding in research, the mathematical notation present in many papers is both confusing and threatening.

The concept of this threat is influential

when approaching the undertaking or analysis of research with pre-registration students, post-registration practitioners or educators themselves, as it is cited as a contributory factor in preventing research being implemented within EBP, and may also have a negative effect upon the individuals belief in their own abilities. Perioperative care practitioners gather information, analyse effects and re-evaluate situations as an on-going part of their daily clinical work. The process of 'formalising' this into recognised research skills is therefore a development of existing abilities to fit a prescribed framework of analysis and questioning that can be understood and adopted by the broader healthcare community. This may be illustrated by noting that many of the 'unspoken' daily aspects of professional practice (as outlined above), are in fact recognised steps within the action research process (Heron and Reason, cited Bradbury and Reason 2002).

Facts are only facts, once we have measured them against known concepts and variables, which as previously discussed, are individual in nature, and can ascribe belief to what we find. If the practitioner is positivist in their outlook, that is, prefers 'evidence' to be in the form of objective data that can be refined to an observable or measurable conclusion, then they may have difficulty giving credence to more general information that could improve their practice or suggest scope for development or change. In an ethnographic study by Smith et al (2003), concerning the acquisition and use of knowledge, it was felt appropriate to include an explanatory passage that outlined the focus of qualitative study, and its difference to the quantitative work, more commonly observed and employed to study anaesthesia. Its objective was not to enumerate findings, but to outline the context of observations, and seek to ascribe meanings and interpretation to the experiences found during the study. Nursing literature often takes this form of approach, especially when looking at practice. The reason for this is that the work tends to observe people and phenomena within a given setting and take into account the experiences of those involved and the circumstantial evidence available (phenomenological approach). By using small sample

studies, the information gathered is often both resultant and subject to individual perception, so allowing the researcher to induce hypotheses from a broader combination of findings. This is in opposition to the deduction of more positivist theories from qualitative data (Holloway 1997).


To offer a clinical comparison, the concept of patient pain is not always identified by quantifiable data such as heart rate, blood pressure, a pain score system and so on. The qualitative acceptance of how someone actually 'feels' must be taken into account, along with a full range of individual physiological, psychological and external influences, before a decision on treatment can be taken. Processing this information is again, a routine skill of the perioperative practitioner and as such, may demonstrate an ability to apply this type of rationalisation to other aspects of their work. If the resultant findings are both reliable and valid enough to formulate patient care techniques, then the underlying rationales should stand scrutiny when put forward as best practice, by means of influencing policy and procedures at a local level, or publishing on a broader level for the benefit of others. Feedback should be sought as an opportunity to review current thinking and practice, in line with standards laid down by the respective governing bodies of both nursing and operating department practice. There is also an obligation to obtain and share information effectively within the care group. The undertaking and analysis of research can play a key role in fulfilling these requirements, and also lend to the 'professionalism' that the individual or group is seen to demonstrate.

Conclusion

Many guidance publications, both medical and para-medical, cite a diverse range of literature and authorities, from which their final conclusions have been drawn. It might therefore follow that it is reasonable to expect a similar example to be followed by healthcare professionals – of all disciplines – when examining their rationales for practice and when following courses of study, whether personal, professional or academic, so as to show that they are neither thinking, nor operating in isolation from the wider healthcare community. At a time when roles within healthcare are becoming less

clearly delineated, with 'advanced' roles at many levels, research, and its subsequent analysis can serve to both inform and develop an increasingly multi-disciplinary service.

Combinations of practitioner expertise, experience and 'the best available evidence', guided by a balanced patient perspective (Hek, 2000), will contribute to the increased use of EBP, in order to develop practice and improve patient care. Despite the many pieces of 'research' available to verify a given topic, careful analysis will reveal that not only may the 'truth' of an assertion be questionable, but that those caring professions that are viewed to be paragons of trust and honesty, may be placed on this pedestal by unsubstantiated means at an individual level. Critical analysis may serve to let us look at ourselves first, by way of contextualising information, so as to ensure we lead by example – not through a position of assumed authority. The analysis of sources cited in this work highlights multiple ways that purported 'facts' may be attributed to any given area, simply to provide substance to a claim or argument. It is, however, only by subjective analysis of the information available, that we may ensure that changes to practice and thinking are both valid and appropriate.

A new employer will ask for credentials that will give a base on which to place their initial trust. The willingness to let them see our attributes and thought processes in order to merit this trust, shows however, a transparency that is diminished when dealing with colleagues and peers. Analysis of available information allows us to form a judgement on others. The contribution of information to a broader audience however, allows others to judge us, so enabling a process of continuous review and development. To revert back to the Oxford English Dictionary (COED, 2003), professional is described as 'a person having impressive competence in a particular activity'. If, as a profession, we wish others to view us as competent, then we must provide them with evidence to support such a judgement. A wider contribution to published material, and the adoption of transparent, evidence-based practice, may help to enable this, so promoting both the profession and the practitioner alike. 

References

- Ajeneye F (2006) How to validate diagnostic research. *The Biomedical Scientist*, **50(6)**: 535-7.
- AODP (2006) The establishment of the AODP and beyond. Available from: http://www.aodp.org/about_the_aodp/The_establishment_of_the_AODP_and_beyond (Accessed 01 June 2006).
- Burnard P, Morrison P (1994) *Nursing research in Action*. 2nd ed. Basingstoke: Palgrave Macmillan.
- Colyer H (1999) Evidence-based practice. A philosophical and political analysis: some matters for consideration by professional practitioners. *Journal of Advanced Nursing* **29(1)**: 188-93.
- COED (2003) *Compact Oxford English Dictionary*. Oxford: Oxford University Press.
- Fletcher K (1997) Do nurses really care? Some unwelcome findings from recent research and inquiry. *Journal of Nursing Management* **5**: 43-50.
- Goodwin D, Pope C, Mort M, Smith A (2005) Access, boundaries and their effect: legitimate participation in anaesthesia. *Sociology of Health & Illness*. **27(6)**: 855-71.
- Grindley D (2005) HLR Newsletter: News & notes. The Health Libraries Group. Available from: www.blackwellpublishing.com/~cgilib/hlr.asp?month=June&year=2005&page=news (Accessed 09 June 2006).
- Health Professions Council (2006) *Standards of Education and Training guidance for education providers Consultation*. London: HPC.
- Health Professions Council – CPD (2006) *Continuing Professional Development and Your Registration*. London: HPC.
- Hek G (2000) Evidence based practice: finding the evidence. *Journal of Community Nursing*. **14(11)**:
- Holloway I (1997) *Basic Concepts for Qualitative Research*. Oxford: Blackwell Science
- NHS Executive (1996) *Promoting Clinical Effectiveness: A framework for action in and through the NHS*. London: NHSE.
- Motulsky H (1995) *Intuitive Biostatistics*. Oxford: Oxford University Press.
- Nursing and Midwifery Council (2004) *The NMC code of professional conduct: standards for conduct, performance and ethics* (Standards. 07.04). London: NMC.
- Parahoo K (2000) Barriers to, and facilitators of, research utilization among nurses in Northern Ireland. *Journal of Advanced Nursing* **31(1)**: 89-98.
- Perioperative Care Collaborative (2003) *The provision of the non-medical perioperative care practitioner working as first assistant to the surgeon*. Available from: http://www.codp.org/professional_standards_and_guidance (Accessed 22 March 2007).
- Reason P, Bradbury H (2002) *Handbook of Action Research*. London: Sage.
- Resuscitation Council UK (2000) *Advanced life Support Course Provider manual*. 4th ed. London: Resuscitation Council (UK) & ERC.
- Smith A, Goodwin D, Pope C (2003) Expertise in practice: an ethnological study exploring acquisition and use of knowledge in anaesthesia. *British Journal of Anaesthesia* **91(3)**: 319-28.
- Timmons S, Tanner J (2004) A disputed occupational boundary: operating theatre nurses and Operating Department Practitioners. *Sociology of Health & Illness* **26(5)**: 645-66.