An interprofessional education programme for medical learners during a one-month palliative care rotation

Kalli Stilos, Patricia Daines, Jennifer Moore

Abstract
Interprofessional education in health care and in palliative care has been the focus of increasing attention in recent years. For health professionals to provide and deliver high-quality palliative care, collaboration and teamwork is required. Palliative care is the ideal service to introduce interprofessional teamwork to medical learners early on in their training. During a 1-month palliative care rotation in Ontario, Canada, medical learners completed a questionnaire seeking their feedback on the interprofessional team model. This article will highlight the results of the questionnaire, how the team promotes a culture of interprofessional collaborative practice, and the supportive structures that foster collaboration among professionals.

Key words: Interprofessional learning, Medical trainees, Advance practice nurse, Palliative care consultative service, Clinical rotation

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Interprofessional care is now considered a priority in Ontario’s overall health human resources strategy, and a provincial interprofessional care project was set up in 2006 to develop concrete approaches to implement interprofessional care at a systemic level. In July 2007, the Interprofessional Care Steering Committee of the Ministry of Health and Long-Term Care created a blueprint to provide guidance to government, educators, health-care workers, organisational leaders, regulators and patients about interprofessional care strategies. The definition of interprofessional care is:

‘The provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality of care within and across settings’ (Health Force Ontario, 2010).

The literature indicates that there are many benefits of interprofessional care. These include: improvements to patient and family care, health-care processes and outcomes (Way et al, 2000; Zwarenstein et al, 2009); increased job satisfaction (Liedtka and Whitten, 1998); improved knowledge and role understanding early in the process of professional socialisation; enhanced learning experience for trainees; emphasis on the importance of communication and teamwork (Koffman and Higginson, 2005) and more creative problem solving (Drinka, 1996).

Interprofessional education (IPE) in health care and specifically in palliative care has been the focus of increasing attention by medical educators during the past decade (Koffman and Higginson, 2005; Price et al, 2009). It has been suggested that medical education inadequately prepares students for interdisciplinary collaboration, which is an essential component of palliative care (Fineberg et al, 2004). Essential skills that are required to engage in effective interprofessional practice include:

● Cooperation
● Assertiveness
● Responsibility
● Communication
● Autonomy
● Coordination (Norsen et al, 1995).

Nadolksi et al (2006:4) explored physician-nurse collaboration; they surveyed 268 university medical students and 175 nurses who worked in the hospital’s clinical training site. The medical students had completed their third-year clinical rotation. The findings proposed:

‘That interactions between third-year medical students and practising nurses are suboptimal and do not provide sufficient opportunities to establish high levels of mutual understanding and collaboration.’

This raises a question concerning whether medical students are getting the kinds of educational experiences that encourage optimal physician-nurse collaboration.

While most universities in Canada have incorporated IPE into their curriculum, embracing the practice in the clinical arena can

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pose a challenge for medical trainees. Wee et al (2001) describe palliative care as the ideal service to introduce interprofessional teamwork in early professional education. Hermsen and Have (2005) support interprofessional collaboration as the model of care ideal at the end of life, where a team approach is assumed essential for the provision of good palliative care.

To provide patient-centred care, collaboration by an interprofessional team is fundamental to meet the frequently complex needs of patients receiving palliative care and their families. With almost 70% of Canadian deaths occurring in a hospital (Statistics Canada, 2015), it is imperative that health professionals have an opportunity to develop the attitudes and skills needed to deliver collaborative, comprehensive end-of-life care. Therefore, rotations on palliative care teams may serve as ideal experiences for exposing trainees to interprofessional collaboration and teamwork.

In this paper, a palliative care consult team (PCCT) explores structures that foster interprofessional collaboration and promote learning and skill development for medical trainees completing a compulsory palliative care rotation.

Table 1. Components and activities of interprofessional education programme

<table>
<thead>
<tr>
<th>Formal learning opportunities</th>
<th>Informal learning opportunities</th>
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<tr>
<td><strong>Education modules</strong></td>
<td><strong>Learning pearl</strong></td>
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<tr>
<td>Trainees take part in case-based education modules that are facilitated by physicians or advance practice nurses (APNs). Topics include pain, anorexia/cachexia, nausea/vomiting/constipation, congestive heart failure/dyspnoea/code status, end of life, delirium and reflective practice</td>
<td>Trainees identify topics not covered in the standard education modules that they would like to learn more about and all team members contribute after morning rounds</td>
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<tr>
<td><strong>Bedside rounds</strong></td>
<td><strong>PCCT members providing examples of interprofessional care (i.e. being a role model)</strong></td>
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<td>Direct observation of learner by the physician/APN visiting patients at the bedside and providing patient/family support. Opportunities to liaise with allied health care professionals on patient care units as needed</td>
<td>Introducing the trainees to allied health professionals on the various units (e.g. social worker, pharmacist, occupational therapist, physiotherapist, discharge coordinator. Opportunity for learners to observe PCCT members seeking input from allied health care professionals</td>
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<td><strong>End-of-life cases</strong></td>
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<td>Trainees paired with APNs for end-of-life patient encounters</td>
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<td><strong>Morning rounds</strong></td>
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<td>Daily morning team rounds to review on-call issues, so that all team members are made aware of any changes made in their patients’ care plan. All new patients from the previous day and current ones on the roster are reviewed, providing an opportunity to discuss any questions, concerns, challenging patient/family situations</td>
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<td><strong>Mid-rotation evaluation</strong></td>
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<td>Learners meet with their supervisor for feedback on performance and to identify strengths and weaknesses moving forward</td>
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<td><strong>Health professional rounds</strong></td>
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<td>Home care palliative care rounds once a month</td>
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<td>Psychosocial oncology rounds once a month</td>
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<tr>
<td>Palliative care consult team (PCCT) education rounds once a month</td>
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<td>Monthly oncology grand rounds</td>
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Background

In the setting of a large tertiary-care university-affiliated hospital in Toronto, Canada, the inpatient PCCT comprised advance practice nurses (APNs) and physicians, research personnel and administrative staff. Each month, there are 2–4 medical trainees primarily from the University of Toronto Department of Family and Community Medicine and Psychiatry residency programmes rotating on the service. The model of the PCCT service is consultative in nature. The APN and physician roles complement each other in their ability to model educational leadership to both the referring services and the medical trainees. The inpatient team receives an average of 30–40 new patient consultations per week from a variety of programmes and units. Referrals received are for pain, symptom management (such as shortness of breath, nausea, delirium), psychosocial concerns and end-of-life care. This clinical rotation is an ideal one for exposing medical trainees to interprofessional practice and allowing for the opportunity to develop teamwork skill, as well as knowledge and appreciation of each professional’s scope of practice (Wee et al, 2001; Pettifer et al, 2007). It is an expectation that by

“I hope to work in a similar team-based situation in the future.”
the end of their 1-month rotation the medical trainees will have achieved the following three components of interprofessional practice:

- Participate in the development of interprofessional management plan for symptoms including pain, fatigue, anorexia, and cachexia, constipation, dyspnoea, nausea, and vomiting, delirium, anxiety and depression
- Effectively communicate within interprofessional team as well as with community providers regarding end-of-life care issues for patient and family
- Effectively arrange and coordinate the care of dying patients in the context of an interprofessional team, including the multiple modalities of care available in the hospital and the community.

Learning components

The components of the palliative education programme are shown in Table 1. The rotation includes formal and informal learning opportunities, and structures that support communication and socialisation among team members and trainees. Formal clinical learning opportunities are based on the pairing of trainees and staff (physician or APN) for patient encounters (shadowing and reviewing of consultations). Other formal activities include various palliative care or hospital-wide rounds along with mandatory case-based education modules led by PCCT staff. Informal educational opportunities are also key elements of the programme, which occur ‘just in time’ when reviewing the patient roster in morning rounds or when reviewing a clinical case on a medical unit. These opportunities allow trainees to discuss cases with unit-based allied health professionals, thus allowing for the sharing of expertise across disciplines and facilitating teamwork and collaboration. Supporting structures include the information technology system and the leadership of the department. The medical trainees are made aware that they can always access the administrative support staff for any operational issues or technological support. In addition, the department aims to ensure that there is a supportive environment, with an ‘open door’ philosophy so that all trainees feel welcomed at anytime.

Method

Informed consent was obtained from all medical trainees before completing the questionnaire. The questionnaire was developed collaboratively and reviewed by the three researchers to ensure questions were presented in an unbiased manner.

Appendix A

Evaluation of interprofessional model for palliative care

Over the past year our team has been working on improving the model of interprofessional practice and education. Interprofessional practice is characterised by a team approach to problem solving, defining goals of care and joint assumption of responsibility for actions/interventions.

1. What is your level of training?
   - Undergraduate
   - Postgraduate
   - Fellow

2. What is your gender?
   - Female
   - Male

3. What is your age?
   - 18–25
   - 25–33
   - 35 and older

4. Which programme do you belong to?
   - Psychiatry
   - Family medicine
   - Other

5a. Have you ever worked on an interprofessional team composed of nurses and physicians? (Check the appropriate response)
   - Yes (If so, please describe the setting)
   - No

5b. Have you ever worked with an advance practice nurse in this capacity where you share responsibility around patient care?
   - Yes
   - No

5c. What was the experience like for you?

6a. From your experience during this rotation how has the nurse/physician complement impacted your education and clinical practice?

6b. What do you see as the benefits in this model?

5c. How could our team improve the current model we have in place to enhance your education and practice needs?
Both structured and unstructured questions were included in an effort to collect comprehensive, descriptive data. The goal of the questionnaire was to elicit trainees feedback on the interprofessional model and evaluate whether it helped in achieving their interprofessional learning objectives (Appendix A). During the data collection period (January 2009–June 2009), 24 medical residents, PGY1 (postgraduate year 1) completed a 4-week rotation with the PCCT. On the last day of the learner’s rotation they were given the questionnaire to complete. Participation was voluntary and participants were anonymous. Completed forms were kept confidential from the research team as they were submitted to the PCCT's administrative inbox, who stored them until recruitment was completed.

**Student feedback**

Some 12 questionnaires were completed over the 6-month period, achieving a 50% response rate. All trainees surveyed had worked with an interprofessional team composed of nurses and physicians during prior clinical rotations. Examples of previous clinical rotations included:

- A family practice clinic
- Acute care geriatrics unit
- An acute pain service
- Various psychiatry units.

More than half had not worked with an APN in the capacity of shared responsibilities around patient care.

The trainees were asked about their experience of working within the shared care model with the APNs; 19 of 25 (76%) medical learners responded positively. What was echoed by trainees was the value of having more than one team member’s input and perspective on patient care and enhanced collaboration. Comments from four of the participants are as follows:

‘We had several meetings about the patient’s care in which everyone’s input and perspective is appreciated.’

‘It’s always great to get new insight and new methods of communicating and broader spectrum of care awareness and practice.’

‘Having an extra person with experience was very helpful.’

‘Different viewpoints to broaden differentials and management plan and time effective as you can divide duties.’

Contrasting views were expressed by two medical students related to sharing responsibilities around patient care with the APNs. One student commented:

‘It caused some confusion as to distribution of responsibility.’

While another stated:

‘Sometimes I felt like I wasn’t given enough independence to make decisions.’

Question 6a related to the learners’ experiences on how the nurse/physician complement impacted their educational and clinical experience. Once again, responses were mainly about role clarity and relationships. Three of the trainees commented that they were able to begin to understand the different dimensions of the APN role:

‘This rotation has made me more aware of the role of advanced practice nurses.’

‘Their roles were similar on the team, so my experience with both was similar as they had similar approaches.’

‘I learned equally from the APNs and the MDs.’

A comment was made about rolemodelling:

‘Great interactions between Dr X and APN X always showed respect towards each other’s opinions.’

Another learner referred to these positive interactions, with the following comment:

‘Improved patient care through nurse/physician discussions and allowed for more time to be spending with patients.’

Question 6b asked medical trainees their perceived benefits of this interprofessional model. One stated:

‘[This model] addresses all aspects of the patients’ health-physical and psychosocial.’

Two trainees responded favourably to working within an interprofessional model and expressed the desire to work in a similar model in the future:

‘The interprofessional model of care is my ideal for practice in the future.’
‘I hope to work in a similar team-based situation in the future.’

‘Team work.’

Subsequently, another two respondents commented on the impact the APNs had on direct patient care:

‘[APNs] had a particular strength in communicating with patients, which will influence my future approach—especially with end-of-life care issues.’

‘[The APN] was able to provide advice around what supports patients can access.’

The final question asked trainees to comment on how the model could be improved to enhance their educational and/or clinical experience. Six medical trainees commented on the need to clarify the APNs role:

‘Especially for those who haven’t worked with APN’s before.’

One suggestion was made to have:

‘An educational session at the beginning of the rotation on the role of advanced practice nurses.’

Finally, four medical trainees suggested improvements needed to be made to the process for review of consultations.

Discussion

IPE contributes to the development of health-care providers with the skills and knowledge needed to enter the workplace as a member of the collaborative team (Barr et al, 2005; Breiddal, 2012). Introducing interprofessional collaboration early in medical education breaks down professional silos, improves role understanding in the process of professional socialisation (Fineberg et al 2004; Brienza et al, 2014) and leads to development of a sense of belonging to an interprofessional team. To circumvent this problem, Fallsberg and Hammar (2000) describes this challenge as related to role boundaries, inherent in teams where each member of the team is trying to deliver care, resulting in overlap in expertise and knowledge.

In these circumstances, trainees can be particularly challenged in determining their own unique contribution to the team. To circumvent this problem, Fallsberg and Hammar (2000) suggest team roles are clarified upfront.

Medical trainees, like other professionals, typically review their work with someone from their own discipline and may be less secure and uncomfortable being supervised by members of other professions. On the PCCT, medical trainees...
may review their patient consults with a physician or APN. The majority of the learners expressed appreciation with the interprofessional model of reviewing patients; it promoted:

‘Different viewpoints to broaden differentials and the management plan, along with efficiency as duties could be divided.’

A couple of trainees expressed dissatisfaction with the interprofessional model. They found practising within the model ‘more work’ and ‘an ineffective use of time.’ This was more likely to happen in situations where the learner and APN reviewed a new patient, and certain clinical elements were beyond the APN’s scope of practice, requiring further input from a PCCT physician. Trainees may have seen this as unnecessary duplication of work for themselves. Grace and Morgan (2015) refer to similar circumstances, where learners perceived their opportunities to build skill and competency were compromised due to a supervisor’s lack of necessary expertise. This contributed to a perception that the interprofessional placement was a less than optimal learning environment.

This challenge with reviewing patients was also alluded to in Price et al (2009) but was perceived as an opportunity for trainees to seek out other staff members on the team. McNeil et al’s (2012) study also speaks to the notion that supervision by disciplines other than their own provides trainees an opportunity to practice core competencies such as:

○ Communication skills with patients and other health professionals
○ Teamwork
○ Critical self-reflection.

Grace and Morgan (2015:4) suggested that interprofessional learning environments where trainees are supervised by other disciplines should not be seen as ‘inferior substitutes’ but for learners to embrace those moments of learning to further understand the ‘shared characteristics of the caring professions’.

Lessons learned

Overall, the questionnaire results have emphasised to the authors the importance of fostering the relationship between APNs and medical trainees early in the clinical rotation. As part of the orientation session they already receive, the authors plan to add a piece on the APN role within palliative care; highlighting their knowledge and skills, and outlining expectations of sharing patients. In addition, the authors plan to continue to monitor the effectiveness of the interprofessional teaching experience of the 1-month rotation and make adjustments as needed.

Conclusion

The goal of this paper was to showcase how the PCCT’s structures foster educational opportunities in interprofessional collaboration. The feedback received from our trainees has allowed us to better understand the trainees’ experience over their 1-month rotation. Overall, the survey results were quite positive with respect to the impact on learning and the utility to medical trainees from psychiatry and family medicine. Interprofessional collaborative practice needs to be nurtured at all levels as it may not be intuitive. Initially, trainees may not adapt to working in teams spontaneously, so educators must assist them in developing those skills. The authors’ expectation is that this 1-month rotation working interprofessionally will continue to serve as a foundation upon which medical trainees may gain future confidence and proficiency in teamwork. In addition, university-based evaluative measures must encompass interprofessional practice components to capture the true value of the interprofessional experience for trainees. 

Declaration of interests

The author has no conflict of interest to declare


Six medical learners expressed some role confusion and ambiguity around the advance nurse practitioner role.
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I hope to work in a similar team-based situation in the future.*