Brief Report

Pilot Qualitative Study of Informal Teachers in Interprofessional Collaboration and Practice

Amy M. Westcott, MD, MHPE, Daniel R. Wolpaw, MD, and Janet M. Riddle, MD
Penn State College of Medicine (A.M.W., D.R.W.), Hershey, Pennsylvania; and University of Illinois - Chicago (J.M.R.), Chicago, Illinois, USA

Abstract

Context. Nonphysician members of the interprofessional palliative care team often participate in teaching physicians and others in the context of workplace learning due to the interprofessional collaborative nature of the specialty.

Objectives. This pilot study examines the beliefs of the nonphysician members of the interprofessional team about teaching physicians-in-training, the disciplinary training and expertise that informs their teaching, and approaches to teaching in the workplace.

Methods. Semistructured interviews were conducted. All interviews were audio recorded and transcribed verbatim. Initial open coding by two researchers identified the codes, and then the constant comparative method was used to find patterns by axial coding, categories, and themes within the data.

Results. Of the 10 health care professionals involved with palliative medical education at one academic medical center, six enrolled in the pilot. Those who participated included chaplains, nurses, a social worker, and a physician assistant. Three major themes were identified from the informal teachers: 1) using professional identity as a foundation for teaching, 2) teaching through experiential learning or debriefing, and 3) teaching to perceived gaps in physician training.

Conclusion. Nonphysician members of the interprofessional team interacted with physicians-in-training guided by their discipline-based skills and perspectives on patient care. They directed their informal teaching toward perceived educational gaps using reflection and debriefing. Future studies could explore the educational roles of health care professionals across diverse institutions and specialties. J Pain Symptom Manage 2019;57:108–111.

Key Words
Palliative medicine, medical education, teachers, hospice, interprofessional collaboration

Context

Medical educators have highlighted the importance of effectively preparing physicians-in-training (medical students and postgraduate trainees) to provide comprehensive end-of-life care.[1–5] Physicians-in-training often spend time with other health care professionals during palliative experiences.[2–4,6] Through workplace-based learning, physicians-in-training experience clinical care through the practice of an interprofessional team. Palliative health care professionals teach aspects of patient care that are not consistently taught in medical education, such as holistic patient care, communicating with patients/families facing life-limiting illness, and collaborating with other members of the team. Learning in these workplace settings tends to be more opportunistic and unstructured.[7] This pilot study examines the beliefs of nonphysician members of the interprofessional team about teaching physicians-in-training, the disciplinary training and expertise that informs teaching, and approaches to teaching in the workplace.

Address correspondence to: Amy M. Westcott, MD, MHPE, 500 University Drive, H106, Hershey, PA 17033, USA. E-mail: geripaldrmom@gmail.com

Accepted for publication: October 16, 2018.

0885-3924/$ - see front matter
https://doi.org/10.1016/j.jpainsymman.2018.10.499

Methods

Study participants included members of the Penn State Palliative Care Team (PSPCT) and Hospice of Central Pennsylvania (HCP)—collaborators in palliative clinical education for our academic medical center (AMC). The PSPCT is composed of an administrative coordinator, two chaplains, one nurse coordinator, one nurse practitioner, one pharmacist, four physicians, and one physician assistant. This team consults and contributes to the care for an average of 25 inpatients and 50 outpatients in our AMC and cancer institute. HCP has an average daily census of approximately 200 patients cared for at home or residential long-term care communities and a six-bed hospice residence based in the community.

Ten nonphysician members of the interprofessional team who regularly interact with physicians-in-training were recruited via e-mails in Fall 2014 to participate in face-to-face interviews. Six responded and participated in interviews. The Penn State Internal Review Board (IRB) and the University of Illinois-Chicago IRB approved the study.

The interview questions included the following:

1. Think about the best experience you have had in teaching or supervising physicians-in-training—when you felt that you were able to teach that learner something valuable and important about hospice and palliative medicine. Please describe that experience to me. What did you do that made that experience so effective for learning?
2. Based upon your experiences, what qualities and skills are important to being an effective teacher of physicians-in-training?
3. What do you view are the most important things associated with effective teaching hospice and palliative medicine?
4. What makes it easier in teaching the learners who are physicians-in-training?
5. To what extent, if at all, does the fact that you are a [profession] influence your teaching and supervision of physicians-in-training?
6. What are some of the challenges in teaching learners who are physicians-in-training?
7. Are there characteristics of the learner that make the educational experience more productive?
8. What types of information, activities, or staff development would you find helpful to make you feel more prepared to teach or precept learners who are physicians-in-training?

The transcribed interviews were analyzed using conventional content analysis in a series of systematic steps to provide structure to the approach.[8] This approach also allowed for flexibility due to the exploratory nature of qualitative research and maintaining transparency of the process.[9] First, each of the two of the authors (A. M. W. and J. M. R.) separately read all the transcript narratives and then compared codes and applications of codes to begin development of a code book to provide standardized names, definitions, and exemplar quotes. Using the constant comparative method associated with grounded theory, we identified patterns, categories, and themes within the data. These themes are defined as general propositions about a phenomenon that emerge from experiences of the participants providing repeated and merging ideas about the study aim.[10] Given the small sample size, all interviews were coded. Member-checking was conducted by asking all participants via email to review and provide feedback on the final list of themes. One participant responded to report that the themes were appropriate.

Results

Participants included two chaplains, two nurses, a social worker (hospice), and a physician assistant. All the participants practiced their primary discipline for many years (14–35); however, some were newer to palliative care. None of the participants viewed themselves as having a "formal" teaching role.

Three major themes were identified:

1. Using professional identity as a foundation for teaching

Strengths in training and discipline-based skills and expertise played a role in interactions with learners. For example, a chaplain, asked to help with a difficult situation by the medical team, reflected on the value of his experience and training in communication skills and storytelling—

> I (had) conversations with the patient and family, listened to some of (their) concerns. I shared a story that involved hope in the midst of scary times …

A nurse practitioner commented on sharing her areas of strength from her nursing training with learners in the context of a challenging patient care situation—

> … I like pain management … So just to be able to sit down with residents (physicians-in-training) and work out a complex regimen or do the (opioid) rotation, those are the little things that I think are the wins.

2. Teaching through experiential learning, debriefing, and role-modeling

Participants felt that they are best able to teach physicians-in-training using methods they experienced during their own professional training—learning by

doing, debriefing, and role-modeling. For example, chaplaincy training involves reflection and debriefing, hence their comfort with this type of teaching method. One participant observed,

> "… I think it was the time we took afterwards for him (physician-in-training) to debrief and to talk about what he experience(d) …" This chaplain commented on "… the action of reflection, allowing them (physicians-in-training) to attempt it and then having some immediate feedback in reflection …"

Debriefing allows learners to talk through their thoughts and emotions, which help them to solidify what they have learned.

3. Teaching to perceived gaps in physician training

While engaging in patient care with physicians-in-training, participants are able to identify gaps in learner's training. Participants perceived skill gaps in learners' interprofessional collaboration and communication skills. One participant reflected:

> … this is the first time he (physician-in-training) witnessed conversations between disciplines … he didn't realize what he was missing … he said that [it] was really neat to hear the perspective of the chaplain and to hear the perspective of the social worker who knew the family and how our physician was the patient's physician and didn't know some of that stuff … how he (physician attending) needed to be able to incorporate that in his care of the patient. That you need to understand the context in which people live …

This participant perceived that the learner did not realize how the members of the health care team work together. She hoped that the learner realized the important role the other members of team play and that the patient/family needed to be included in the plan of care for it to be successful.

Participants used their skills in role-modeling, among other skills, to teach to learners' gaps in training— *"Modeling the quiet and silence that we have to employ in our communication skills in our interactions with families and patients."*

Discussion

Nonphysician members of the interprofessional palliative care team do not always consider themselves to be formally recognized as teachers but rather members of a clinical team where physicians-in-training learn. They view their engagement in teaching as informal in the context of day-to-day workplace experiences through interprofessional collaboration and practice. We used Eraut's model of informal learning in the workplace to identify professional development topics based on our results.[11] In his model, learning in the workplace occurs as a result of interactions between the individual worker, the work itself, and relationships at work. In contrast to formal learning in a more structured setting, such as the classroom or simulation center, informal learning occurs within the social context of work and in the absence of a formally identified teacher and formal instruction. Eraut describes four main types of work activity that give rise to learning—participation in group activities, working alongside others, tackling challenging tasks, and working with clients.

Participation in Group Activities

Participants commented on the importance of the team and working toward patient-/family-centered outcomes. Focus on a common purpose provided physicians-in-training with a meaningful experience, even if they are not active participants in all the clinical situations. Nonphysician members of the interprofessional team have a common purpose to provide care for those with life-limiting illness; when learners joined family meetings and interdisciplinary team meetings, they were engaging in the common goal of helping a patient and/or family manage difficult health care challenges. Professional development activities should emphasize planning how to promote learning within family and interdisciplinary team meetings that address gaps in physician training.

Working Alongside Others

Learners observe and listen to how others think and participate in clinical activities. Role-modeling, particularly by individuals with different skill sets, can lead to learning new perspectives and clinical practices. Participants commented that role-modeling during patient care was a key teaching strategy. This aligns with the central role of experiential learning, debriefing, and role-modeling in the medical education literature.[12–15] Professional development activities should enhance existing skills to more effectively teach physicians-in-training.

Tackling Challenging Tasks

Challenging tasks faced by the nonphysician members of the interprofessional team may be outside the comfort zone of many physicians, including difficult conversations with patients/families, planning for a "good death," or creating a care plan for refractory pain and other symptoms faced by those suffering from life-limiting illnesses. These complex and often emotional patient situations represent "desirable difficulties" and critical learning opportunities for our physicians-in-training, especially when guided by experienced interdisciplinary staff. Professional

development activities should emphasize identifying appropriately challenging tasks for different levels of trainees—and scaffolding teaching to allow physicians-in-training to work with those tasks.

Working With Clients

Participants mentioned the importance of learning "special" information about the patients/families that allowed them to address the nonmedical issues. These informal teachers fill out the broader, biopsychosocial perspective of the patient and family, that is, sometimes missing from medical education. Learning a broader assessment of the patient care is a systems-thinking process and encourages a team-based approach to patient/family care, which are consistent with competency and milestone-based medical education.[16] The "nonmedical" pieces are often critical in successfully managing a patient's care, and the participants perceive themselves as teaching to these gaps in physician training. Professional development opportunities should help staff to connect their disciplinary skills and expertise to the curriculum within which physicians are trained.

This pilot study is limited by 1) the small group of participants at one AMC, potentially narrowing the scope of informal learning identified, 2) the possibility that participants biased their responses toward socially desirable or "acceptable" answers, 3) unidentified confounders in professional and institutional contexts that might limit the generalizability of results to all hospice and palliative settings, and 4) interviewer (A.M.W.) effect as a member of the team, potentially altering responses. To minimize some of these limitations, the instructions emphasized the anonymity of the project and encouraged open honest answers.

Conclusion

Our pilot qualitative study leads us to a concept of interprofessional informal learning that clarifies important opportunities to advance the training of physicians in palliative medicine. Based on these results, we would argue that all nonphysician members of the interprofessional team should be considered as faculty and be offered professional development to further enhance their teaching skills. Acknowledging this key educational role would also validate and support a meaningful interprofessional collaborative practice and learning environment. The direct observation, reflection and feedback provided to learners from these informal teachers deserves further attention. Future studies could explore the roles and perspectives of health care professionals in the education of physicians-in-training in other team care settings.

Disclosures and Acknowledgments

This work was supported through a Woodward Center for Excellence in Health Sciences Education Award. The authors would like to thank Carol Kamin and Sarah Kagan who assisted in the oversight of the development of the survey and design.

References

1. Horowitz R, Gramling R, Quill T. Palliative care education in U.S. medical schools. Med Educ 2014;48:59–66.

2. Shaw EA, Marshall D, Howard M, Taniguchi A, Winemaker S, Burns S. A systematic review of postgraduate palliative care curricula. J Palliat Med 2010;13:1091–1108.

3. Case AA, Orrange SM, Weissman DE. Palliative medicine physician education in the United States: a historical review. J Palliat Med 2013;16:230–236.

4. Schaefer KG, Chittenden EH, Sullivan AM, et al. Raising the bar for the care of seriously ill patients: results of a national survey to define essential palliative care competencies for medical students and residents. Acad Med 2014;89:1024–1031.

5. Corcoran AM, True G, Charles N, Margo KL. Geriatric palliative care: do medical students' narrative reflections after a hospice clinical experience link to geriatric competencies? Gerontol Geriatr Educ 2013;34:329–341.

6. Carmody S, Meier D, Billings JA, Weissman DE, Arnold RM. Training of palliative medicine fellows: a report from the field. J Palliat Med 2005;8:1005–1015.

7. Eraut M. A wider perspective on assessment. Med Educ 2004;38:803–804.

8. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. Qual Health Res 2005;15:1277–1288.

9. Miles M, Huberman A. Qualitative data analysis: An expanded sourcebook, 2nd ed. Thousand Oaks, California: Sage, 1994.

10. Bradley E, Curry L, Devers K. Qualitative data analysis for health services research: Developing taxonomy, themes, and theory. Health Serv Res 2007;42:1758–1772.

11. Eraut M. Informal learning in the workplace. Stud Cont Educ 2004;26:248–273.

12. Sutkin G, Wagner E, Harris I, Schiffer R. What makes a good clinical teacher in medicine? A review of the literature. Acad Med 2008;83:452–466.

13. Fromme HB, Bhansali P, Singhal G, Yudkowsky R, Humphrey H, Harris I. The qualities and skills of exemplary pediatric hospitalist educators: a qualitative study. Acad Med 2010;85:1905–1913.

14. Hatem CJ, Searle NS, Gunderman R, et al. The educational attributes and responsibilities of effective medical educators. Acad Med 2011;86:474–480.

15. Cruess SR, Cruess RL, Steinert Y. Role modelling–making the most of a powerful teaching strategy. BMJ 2008;336:718–721.

16. Holmboe E, Edgar L, Hamstra S. The Milestones Guidebook. American Council of Graduate Medical Education, 2016.