Consumer-oriented groups: a new approach to interdisciplinary teaching

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SUMMARY. Difficulties in the development of primary health care teams have been demonstrated by a number of authors. The important place of interdisciplinary teaching in this development has been stressed. This paper describes an experimental series in which emphasis has been placed on the patient's view of the input of different team members. The value of this approach is discussed.

Introduction

IN the last 20 years there has been substantial development in the team approach to primary health care with reports of success in individual practices,[1,2] its extension to a wide range of professions[3-6] and encouragement from such bodies as the World Health Organization,[7] the Royal College of General Practitioners[8] and the Royal College of Nursing.[9] However, there have also been a number of hindrances to true interdisciplinary working. Managerial policy may have hindered the extension of the role of the district nurse thereby contributing to the increased employment of practice nurses and a fragmentation of community nursing provision.[10] Although the orientation of the nurses and their employment needs may also have contributed to this,[11] Hockey has recently expressed a widespread concern about the increased employment of practice nurses.[12] On the other hand, Bowling has shown that a significant minority of general practitioners and nurses are reluctant to delegate even minor clinical tasks.[13] Health visitors have expressed concern at being diverted from preventive care to crisis intervention and also at the loss of responsibility in a geographical area. Dingwall has described some of the conflicts that may occur between doctors, health visitors and social workers, and considers that practical aspects, such as the independent contractor status of the general practitioner compared with the salaried and geographical basis of other professions, are a major source of conflict but he also focusses attention on the professions' different perceptions of their roles.[14] Huntington has examined whether the different cultural backgrounds of social workers and doctors affect their ability to cooperate[15] and Matthews in a review of the problems of communication in a clinical setting has suggested that communication between doctors and nurses and of both with patients is affected as much by differences in ideology as by status.[16] The varying attitudes of the professions led England to predict that organizational change would have a limited effect in removing obstacles to cooperative care.[17] He also emphasized the importance of education and particularly interprofessional teaching in producing better understanding between the professions and a preparedness to work together with a positive regard for each other.

Interdisciplinary sessions with the aim of understanding the concept of the primary health care team, the roles of other disciplines and the dangers of professional self-interest[18] have an important part to play. However, the issues of status and power, influenced by aspects such as age, sex, length of training and different intellectual approaches to problem management,[15] may have a divisive effect and put the newer professions at a disadvantage when the interdisciplinary teaching is largely professional. Salkind and Norell[19] found that increasing the emphasis on the relationship between the professional and the patient produced a critical change in their seminars and Ludden[20] reported that discussion focussed on particular situations that cause discomfort to team members was beneficial. A development of this emphasis on the needs of the patient rather than on the professional role is to make use of the patients' perceptions of the part different professionals play in their care. Such input may help to overcome professional self-interest and enable participants in interdisciplinary sessions to reappraise the value of different facets of cooperative care.

We report the results of a series of interdisciplinary workshops whose purpose was to explore the effects on primary care 'consumers' of the way we work as individuals and as a team. Consumer-orientation was provided by simulated patients. The emphasis was on what could be learnt from the perceptions of the client rather than on the participants' views of each other; it was realized that the latter could not be completely excluded.

Method

In 1983 the Burford Nursing Development Unit secured funds for the development of its use of simulated patients in nursing education.[21] This unit is attached to a community hospital which is considered to be part of the primary health care facilities in the area. The primary nurses — state registered nurses with overall nursing responsibility for patients admitted to the hospital — are seen as members of the primary health care team and they were invited to participate in the scheme together with groups of general practitioners, district nurses and health visitors from nearby districts. Existing primary care teams did not attend although some participants had previous experience of working in a team. In all there were four groups, with four members each.

The teaching was based on small group discussion of a series of simulated interviews performed in a separate room and watched on closed-circuit television. The group members took their usual professional role while the patients were portrayed by members of a group of actors (North West Spanner) who have not only had considerable experience in simulation but have also learnt to continue playing the role during the discussion that follows the interview when the 'patient' and professional have rejoined the group. This development, which has been fully described elsewhere,[22] enables the client's perceptions to be elicited and kept central to the discussion. The director of the group of actors was also able to encourage reflection on the lay input.

Each participant was invited to attend three group sessions, each lasting a whole afternoon, and a final plenary discussion. Overall there were 11 sessions.

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The first four sessions were for single disciplines, to enable participants to familiarize themselves with a new teaching method and at the same time to help them reappraise their own roles and attitudes in a consumer-oriented situation. As well as the director of the group of actors a professional of the appropriate discipline experienced in the method attended as a resource. This form of learning can be threatening because the skills and attitudes of an individual are exposed in the interview and explored in the ensuing discussion. These preliminary sessions thus enabled participants to feel more at ease when groups included potential rivals and not only their peers.

The roles chosen in these preliminary sessions were intended to highlight the possible divergence of the perceptions and needs of patients from professional expectations. Thus the ground was prepared for an acceptance of the importance of the patient's viewpoint in assessing the appropriateness of care suggested by various team members. In the doctors' group, for example, a discussion of professional concerns about whether and what to tell the patient was diverted by a patient with an inoperable cancer towards the question of the rights of that patient in accepting and managing the information.

The second set of four sessions were interdisciplinary, each group containing one member of each profession. This enabled participants to see colleagues at work and thereby gain an appreciation of their skills. The presentation of situations that were on the borderline of responsibility between the different professions resulted in discussion on respective roles, while the presence of the patient enabled conflicts between the professions to be resolved, not by an exertion of power and status but with a view to the appropriateness of the care suggested.

These sessions were followed by a pair of sessions with larger interdisciplinary groups consisting of two members from each discipline. In these two sessions situations that required cooperation were presented, such as a hospital admission (doctor and primary nurse), a surgery attendance following a health visitor referral (doctor and health visitor) or a hospital discharge (primary and district nurses). It was anticipated that at this stage participants would feel less threatened and thus be able to expose their own feelings. They would also have gained a greater understanding of the roles of their colleagues and the rights of patients, and thus should be able to discuss potential conflicts in cooperative care and the patient's contribution in the resolution of such conflicts.

Following the three teaching sessions the participants were asked to complete a short questionnaire about the experience and to join in a final plenary session. In view of the intense emotional demands on the participants this final session was important.

Results

This was a pilot exercise with a limited group and although it was stressed to all participants that their presence at each of their sessions was essential, there were still a few absentees. Despite the limitations it was clear from the feedback that a number of the objectives had been achieved.

In the single-discipline sessions there was an element of personal reappraisal. Primary and district nurses commented on their roles while one (male) doctor faced with the greater emotional involvement with patients of a (female) colleague was led to reflect on the appropriateness of his own distancing.

The health visitors were found to be more diffident. They showed interest in the way other health visitors approached problems, but there was less evidence of positive personal reflection and reappraisal. Indeed, some health visitors considered that the preliminary session had undermined their self-confidence so that they felt less secure in their role and professionally more vulnerable. Further sessions as a single discipline may have been necessary to rebuild their confidence.

The vulnerability felt by the health visitors may partly explain their failure to project their role in the interdisciplinary sessions which followed. This was commented on by participants of all disciplines. One health visitor felt that some members of the primary health care team did not appear to understand the role of the health visitor and considered this role irrelevant in primary health care. After the interdisciplinary sessions two doctors said that they still did not understand the role of the health visitor and a district nurse commented on the doctors' lack of awareness of the health visitor's role. Many of the situations presented in the sessions centred round problems needing intervention rather than educative and preventive care and it may be that this gave inadequate opportunity for health visitors to project themselves.

In the interdisciplinary sessions conflict between roles was apparent. In one group a primary nurse commented that some doctors considered themselves to be the head of the team and that they saw others as subordinate and an extension of their excellence. In another group there was marked resentment when a doctor encroached on the territory of nurses while counselling a patient. The obstacle that medical status and power presents to true cooperative care is emphasized by the fact that it should still be a barrier when the doctor is outnumbered three to one and is concerned enough about cooperation to participate in the scheme. However, the doctors admitted that other team members seemed able to provide aspects of care that they could not, although their desire to avoid too close an emotional involvement may have played a part in this. A primary nurse noted that patients appeared to find nurses more approachable than doctors although this was linked with the realization that each profession sometimes failed to respond to an expressed need, not in terms of technical skill but in terms of communication, sympathy and involvement.

In view of the aims of the scheme it was important to determine the extent to which awareness of patients' needs had increased. Some participants clearly felt that they had achieved a greater personal understanding of these needs. One primary nurse commented that professionals do not always listen or rather comprehend what patients are saying; professionals should learn to be better listeners and not to pigeon-hole patients. A health visitor went further, stating that she had become aware of the patient's apprehension and the fact that a patient could misinterpret a situation and she now realized the importance of ensuring a complete understanding at the appropriate level. She then emphasized the need to talk with patients as equals in order to make a mutual decision possible.

Discussion

Most participants felt that the sessions were successful and that they had increased their awareness of the diverse needs and perceptions of the consumer. For most of the participants the objective of diverting their attention away from their own role and possible role conflicts and towards an exploration of patients' needs was achieved. Thus, a primary nurse realized that nurses were still handicapped by their role identity and that orientation towards patients was the answer. One doctor felt that the great advantage of the team was its ability to respond to the varied expectations of patients.

The doctors, primary nurses and district nurses probably felt secure within their roles — the primary nurses, in particular, work in a nurse-oriented environment where there has been considerable development of professional status. On the other hand the health visitors still seemed trapped by problems of role identity — the workshops appeared to highlight the individualistic approach of some health visitors and the differences between

their roles in primary health care teams depending on the practice. This may be one reason why the health visitors felt that the session could have achived more if existing complete teams had been involved. It was a health visitor who stressed the importance of previous knowledge of the family which is difficult to reproduce in simulation, and this, together with the lack of emphasis on their educative role and the fear of being manipulated into crisis intervention, may have contributed to the unease of the health visitors. Similar training has helped health visitors to cope with the crises that they do meet, such as violence in the family, but the situations used in that training may have been less appropriate to establishing their role within the primary health care team.

As primary care becomes increasingly concerned with preventive and educative work where help is not requested, the response of patients and their perception of the role of different team members may have an important influence on the effectiveness of primary care. Teaching involving simulated patients gives professionals the opportunity to explore the response of patients in an area where feedback may be hard to obtain, and the problems that this exercise has raised show the need to extend the range of situations which interdisciplinary training covers.

Conclusion

Overall, the problems of the dominance of a single profession were overcome; the value of feedback from patients was clearly seen in dealing with caring situations where intervention had been requested and doctors as well as different branches of nursing came to understand the value that patients place on the help of other professions. Further experimental work is now required to enable participants to have greater knowledge of each other and the range of situations and of participating disciplines needs to be widened. This training has considerable potential for improving interdisciplinary training so that all the members of the primary health care team can play their part in responding to the needs of the community.

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Respiratory distress syndrome

Respiratory distress syndrome of the new-born, prematurity, and familial airway hyperreactivity may contribute to long-term pulmonary sequelae. The authors assessed the role of each by testing pulmonary function and airway reactivity in 11 prematurely born children who survived the respiratory distress syndrome and in 11 prematurely born children who had no neonatal respiratory disease, each of whom was paired with a sibling born at term. The subjects were between seven and 12 years of age when studied. Airway reactivity was also assessed in their mothers. The group who had had the respiratory distress syndrome had higher ratios of residual volume to total lung capacity and lower values for forced expiratory volume in one second than did their siblings or normal controls ($P<0.01$). Expiratory flow was decreased in both groups born prematurely ($P<0.02$) and was related to neonatal exposure to oxygen ($r = 0.71$, $P<0.02$). The incidence of airway hyperreactivity was elevated in all groups, including the mothers. These data suggest that long-term pulmonary sequelae of the respiratory distress syndrome of the newborn are related to the disease, its treatment, or both, and to airway hyperreactivity. In prematurely born children without neonatal lung disease, the sequelae are related to airway hyperreactivity. The possibility of a relation between familial airway hyperreactivity and premature birth is suggested.

Source: Bertrand JM, Riley SP, Popkin J, Coates AL. The long-term pulmonary sequelae of prematurity: the role of the familial airway hyperreactivity and the respiratory distress syndrome. *N Engl J Med* 1985; **312:** 742-745.