Contents.

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All the participants who took part in the project and attended the focus groups.

Abstract:

The following paper reports the findings from a study pertaining to the introduction of a shared training programme for junior Drs, nurses and other professionals.
The project was supported by the NorthWest deanery as part of the Blending Service with Training Initiative, and took place between October 2000 – September 2001.

The study aimed to identify the doctors and nurses perspectives of a shared training programme, and the impact such training had on their practice.

A single shared training programme, which addressed aspects of Clinical Governance, was developed by a working party. The programme was delivered to a sample of ten qualified, experienced nurses, and nine pre-registration house officers.

A qualitative methodology was employed to illicit the participants perspectives of shared training in terms of benefits, professional development issues and changes they would make.
Semi-structured focus group interviews were conducted and tape-recorded. The recordings were transcribed and thematic content analysis undertaken to identify common themes. Post-workshop questionnaires were also used to help support the findings of the focus groups.

The results highlight many positive aspects of shared training including improved collaborative working, mutual understanding of roles and improved communication. Clinical skills' training was not thought useful, and some of the sessions were not considered to be interactive.

This study proposes recommendations which include attention to content detail and the use of problem solving utilising patient scenarios and case loads to facilitate debate and foster the augmentation of knowledge. The involvement of specialist practitioners is also highlighted, thus promoting a more complete insight into roles and knowledge.

Following evaluation of the programme, it is hoped that future training programmes will be developed based on the recommendations suggested in this paper.

1.0 Background to the Project:

When the NHS Plan (2001) was introduced, a wave of anticipated change ensued. The past decade has witnessed major reorganisations in the NHS resulting in reduction of Junior Drs hours and the extended role of the qualified nurse (SCOPE,1992). We live in a culture in which there is great opportunity to make substantial health improvements where chances are waiting to be grasped (Watkinson,1998) Against this background, Clinical Governance offered NHS organisations a way forward which would put quality at the heart of NHS service and assist in the delivery of a more collaborative, prepared workforce which could meet the demands of today's society.

Amongst other changes proposed in the Plan, the suggestion that future training should be more collaborative was interpreted by some to be a great 'leap' for all professional education. Indeed, there has even been talk about an 'NHS University' in the future and the National Institute of Clinical Excellence now refers to 'health professionals' rather than singling out any one group (Davies,2000). Inter-professional working as a "substitution" is strongly advocated….. "to end the demarcation line". The Plan envisages that a major new role for education is to break down such barriers.

Some believe the NHS Plan to be a "daunting challenge", suggesting that the evidence base is only now being secured and that value and theoretical bases have yet to be put in place (Annonm,2001), however, no matter what the general opinion is regarding the Governments latest strategies to improve health care, the prospect of multi-disciplinary training has always played a part in professionals thinking. This was an area already recognised in the States following the publication of the Pew Report (1995) which stated that
"students in medicine, nursing, pharmacy & dentistry must learn to work together to provide efficient, high quality care, this may mean sharing some lessons".
A more contemporary initiative undertaken by the NHSE (1996) recommended that education commissioners should actively explore multi-disciplinary training, a concept which the UKCC (1992) had already begun to work on, supporting shared learning as a principle within the context of professional practice. The UKCC (1992) strongly believed that shared learning could increase the scope of collaboration and co-operation in care. More recently, the Chairman of the GMC's Educational Committee stated that they were currently revising the guidance provided to Universities which will augment and update recommendations made in Tomorrows Doctors (1993). The Committee maintains that they will "continue to encourage innovation in developing the curriculum".(Catto, 2001). It is not surprising then that any developments in multi-professional training have been actively encouraged and supported by both the medical and nursing profession.

The idea that multi-professionals should work closely together to improve patient care and quality of service was appealing to many. It is within this current climate of dedicated change and improved quality through Clinical Governance and the NHS Plan, that a project, specifically designed to introduce shared training into one Trust was developed with support from the North Western Deanery.

1.1 Multi-Professional Education – ambiguous definitions.

Fagin(1992) provides further evidence to support the introduction of shared training with the notion that individual hospital success will be linked to the ability of each institution to facilitate the nurse-physician relationship. Although the definition of multi-professional training is varied, Headrick (1998) offered a good analogy regarding the concept of shared training:
"the intent of inter-professional education is not to produce khaki-brown generic workers. Its goal is better described by the metaphor of a richly coloured tapestry within which many other colours create a picture that no one colour can produce". It seemed clear that the programme would create an ideal opportunity to develop collaborative working and shake off some of the old professional barriers and role misconceptions.
Despite the overwhelming evidence supporting the introduction of shared learning, and the promotion of collaborative working, there have been to date, very few rigorous evaluations of potential interventions which address the issue of collaboration (Zwarenstein,2000). With this in mind, the project was directed to not only developing a shared training programme, but also evaluating the programme through discourse and questionnaires.

2.0 Literature Review:

2.1 Historical Perspective:

By the end of the 19th Century, nursing had emerged beside medicine as the 3rd major department in the hospital and was putting forward a claim to be a serious profession (Helmstadter, 1997) and by the mid 1990's, the move of nurse education into Higher Education Institutions had led to new inter-professional possibilities (Leathard,2000). Some people have expressed concern about the reputation of nursing as an academic discipline (Brown, 2000), but as can now be witnessed, there has been a remarkable change in the nursing profession, since its Florence Nightingale days when many nurses were drunken, working class women, to today's array of nurses with educational ability which has fostered the 'professionalisation' of nursing.

In Britain, we seem to have neglected to fully develop multi-disciplinary education, reasons for which are buried in historical rivalries (Brooking,1991). Traditional and skeptical attitudes have led to the adoption of the 'handmaiden' perspective of nursings' power position in relation to medicine. Historically, the relationships between Drs and nurses have been unequal. Annadale (2000) discovered that some practitioners identified deep-rooted power inequalities between professionals. This is in part due to the status of nursing in its embryonic stages. For example the most famous nurse of the 19th Century, Florence Nightingale, demanded that nurses ask permission from Drs before they delivered any care episode (Carter,1994). It appears that this statement, simple though it might have been at the time, may have contributed to the way in which the two professions have perceived each other ever since.

Nursing and medical training are powerful socialization processes (Salvage,1999), and the case against shared training appears to derive from amongst others, historical rivalries (Jackson,2000) It is through shared training however, that the myth of the omnipotence of the independent practitioner is being challenged as we discover the gains in quality and cost savings when professionals work well together (Headrick,1997). The notion that improved collaboration between professionals could enhance quality of patient care and services are not new. Historical rivalries could be better placed in Madam Tousards where, dust and out-moded perceptions could sit comfortably amongst Florence Nightingales 'lamp' and other relics of that era. The move towards dismissing these rivalries can be best delivered through a collaborative approach, both in education and working practices. The quality of today's nurse-Dr relationship plays an important part in determining the quality of care in today's NHS (Fagin,1992) and also influences patient mortality (APACHE trials), so it is deemed wise that areas now highlighted in the NHS Plan (2001) should be driven forward with vehemence and the commitment to improve collaborative working and ultimately, patient care.

2.2 Improving Communication & Collaboration

The NHS Plan states that communication is an area which requires much work and devotion. All communication must be directed to the achievement of the same goal (Porter-O'Grady, 1995).Locally, a large majority of our complaints are thought to be caused by poor communication (Bury Health Care NHS Trust, Complaints Department 2001). The reduction in Drs hours caused a blurring of the traditional roles of nurses and Drs (Freeth,1998). Conflict between physicians and nurses is fostered by the very inter-dependence of their roles in patient care (Forte, 1997) and it is perhaps this lack of understanding of both groups about each others roles, that have been cited as major contributory factors to poor nurse-Dr relations (McKay, 1991). Hall (1991) in a letter to the BMJ suggested that "the extended role of the nurse and the 'IV certificate' have failed to solve this problem….The real issue is that medical and nursing staff fail to acknowledge it as a shared role". The distinction between Drs and nurses is increasingly artificial (Salvage, 1999). This is supported to some extent through research undertaken in which Drs and nurses who were interviewed revealed an agreement that medicine and nursing had overlapping rather than distinct domains (Weiss, 1992). .

It becomes evident that Drs and nurses view the management of their roles quite differently, whether an historical perspective plays a part in this is difficult to ascertain and is not addressed in this study. What is recognised is the need for nurses and Drs to develop a greater understanding of each other's roles and increased trust in each other's skills and competencies. This has fostered the idea that the introduction of a shared training programme could enhance this understanding (Jackson) and go some way to dissolving the 'doctor bashing' which has become popular orthodoxy in nursing (Brooking, 1991).

2.3 Role Format & Perceptions

Equally challenging are peoples attitude (Freeth 1998). When adults learn, they require their past experiences to reflect upon, however, a paradox exists, in these past experiences which may foster prejudices and differences which make inter-professional learning so difficult (Williams, 1980). As far back as the 70's, 'role format' was identified and referenced as "a set of normative idealisations which participants use to guide their actions within particular ceremonial acts". Carter (1994) reports that some Drs continue to assume that nurses should gain knowledge and experience through ward based activities whilst attending to the medical staff, i.e. in ward rounds. This is a realm, which has received much attention, perhaps most famously by Busby (1992) who discovered those Drs see nurses as their assistants rather than independent team members. It is this type of attitude which can be the most challenging. In Steins (1978) infamous 'Dr-Nurse Game', he identified that the 'game' is a transactional neurosis and that both professions would enhance themselves by taking steps to change the attitudes which breed the game.

Although Stein et al (1990) identified the changing nurse/ Dr relationship, they underestimated the patriarchal context that upholds the traditional status quo (Carter, 1994). Whilst this study is not concerned with gender issues, it must be recognised that this has played an important role in the development of practitioner perceptions and awareness of each other. Patriarchy has been described by Hartman (1976) as a "set of social relations which has a material base and in which there are hierarchical relations between men who may oppress women. Considering that the nursing profession consists manly of women, the patriarchal culture is potentially detrimental to the majority of its members (Carter,1994). It is argued that Dr-nurse interactions are more diverse and situation specific than traditional models of Dr-nurse relations, emphasizing professional dominance. (Snelgrove,2000) although little attention has been paid to the ways in which nursing as a separate and 'subordinate' profession may represent a special threat to the security of medical competence (Campbell-Heider,1987).

More importantly, there are significant differences between Drs and nurses in terms of territories and spatial occupancy that affect the nature of their contacts with patients (Snelgrove,2000).The presence of inter-group conflict between physicians and nurses versus the ability to create collaboration, significantly influences patient mortality (Forte, 1997). Many have looked towards shared training as a way in which many of these rivalries and misinterpretations could be resolved.

2.4 Possibilities of Shared Training:

Working together means acknowledging that all participants bring equally valid knowledge and expertise from both professional and personal experience (Davies, 2000) Dr and nurse collaboration implies that sharing care and work requires shared responsibility and that the complexity and uniqueness of care required by individual patients makes it hard to divide tasks between the professions (Zwarenstein,2000). Gill (2000) also suggests that Drs and nurses are different, working together is difficult

In previous research about shared training Freeth (1998) commented on one Dr who, when interviewed had stated that he understood "who does what more and how to approach practical patient problems". This is just one example of how shared training

could affect professional relations and collaborative working. Leathard (1994) & McGrath (1991) both suggest that shared training can improve communication and foster a more collaborative approach to work. It seems common sense that shared training could enhance communication and effective working. A more open dialogue generated through this type of training could allow for more honesty and freedom for professional initiatives" Stein (1978). This sharing of ideas and experience has been adequately demonstrated already to improve mutual respect between nurses and other health professionals,(Brown,2000) and may perhaps reduce events of patient mortality through improving communication and collaboration.

3.0 The Study:

The historical, professional and current political climate was considered when deciding upon the aims of this study. Initially a working party which consisted of Royal College Tutors, Post-grad management, Practice Educators, the Clinical Governance Director, Nursing Director and Medical Director and junior Dr representatives was set up. The aim of this group was to identify a training programme which could address the needs of the NHS Plan and result in improved patient care through sustained collaborative working. Following a 'generic' mapping exercise of existing training, a provisional programme was developed which was approved by the working party.

3.1 Programme Design:

Storrie (1992) discussed the design of shared training programmes, commenting that it was hard to track down opportunities for shared learning which could span disciplines….it is not straightforward and there are no 'directories' which exist to provide a guide to such programme. The GMC recommends that when Drs qualify they should be knowledgeable and be able to demonstrate the responsibilities and skills required to deal with common medical problems (Elizabeth,1986).

When deciding on the content and design of the programme, it was agreed that communications skills should be included alongside record keeping, Clinical Governance and some clinical skills and that the programme should build on the rapport generated between the Drs and nurses. The programme is similar to that of a short course, whereby the same participants complete a programme. It was anticipated that the more the group became familiar, the better the rapport, the greater the chance of debate between professions.

Currently, the Trust's education and training department offers a wide range of in depth clinical skills training for nurses; however, a 'refresher' or update course had never been delivered. It was generally believed that the nurses attending the programme would do so as a refresher and to experience shared training.

In total there were six sessions arranged which covered clinical skills such as venepuncture, IV drug reconstitution and urinary catheterisation. The team felt it

necessary to include venepuncture as a recent infection control audit (Bury Health Care NHS Trust) highlighted that junior Drs infection rates of Cannula sites were higher than nurses. Intravenous Drug reconstitution and medical devices was also included as practical sessions, as it is thought that "Drs receive inadequate training in many practical procedures" (Hardman,1991).

Multi-Disciplinary Training Programme

SEMINAR	DATE	VENUE
Communication- Multi-disciplinary & inter-professional communication. Developing inter-professional communication skills.	26th March 12 – 2pm Group A 2nd April 12-2pm Group B	Postgrad Centre BGH Members room BGH
Venepuncture & Cannulation – waste management	17th April 1 – 3 Group A 1st May, 12-2 Group B	A&E Dept BGH A&E Dept BGH
Intravenous Drug and Medical Devices – drug reconstitution	22nd May 1-3 Group A 29th May 1-3 Group B	A&E Dept BGH
Record Keeping – to include live audit	6th June 12-3pm Group A 4th July 12 –3pm Group B	A&E Dept BGH Seminar Room 2, Training & Development
Clinical Governance	6th July 12-2 (Both groups)	Post-Grad lecture Theatre
Catheterisation – male & female	10th July 12-2 Group A 17th July 12-2 Group B	Postgrad Centre BGH A&E

Headrick (1998) suggests that effective adult learning occurs when the topic is important… and when learning combines reflection with experience. Drs are also generally dissatisfied with the quality of their work, especially practical procedures (Walker, 1991). In a study of practical procedures undertaken by Carter (1990) it was discovered that there was an "appreciable ignorance of the practical and theoretical aspects of catheterisation". The group believed that urinary catheterisation was a skill often overlooked or not deemed as important and warranted inclusion within the programme and something which the participants could reflect upon experiences so far.

The clinical skills sessions were designed to be very practical whereas the communication, clinical governance and record keeping, were more interactive on a discursive level. A self-assessment tool was developed on a competency framework to

help the participants identify whether their skills had improved through discussion with their educational supervisors and mentors. Where-ever possible, the participants were encouraged to discuss problems or ideas with their colleagues from other professions.

3.2 The Participants:

A letter about the programme was distributed to all managers in all departments within the Trust. A copy of the programme was included in the information. Managers were asked to identify staff who would find the programme useful and who would like to refresh their skills. A mix of experienced nurses was identified ranging from E grades to senior G grades. Because of the small number of PRHO's it was felt that all of them should be included in the study.

3.3 Programme Introduction Day

An introduction day was arranged to explain the programme and research to the participants, and allow them time to get to know one another and discuss what the training included, why the project was being undertaken and the benefits for the participants.

The introduction was built into the Drs protected study time, and attendance was good. Unfortunately, a lot of the nurses were unable to attend and the researcher had to speak to participants individually. Consent was obtained before the start of the programme, once the research had been fully explained.

3.4 Statement of Intent:

This study aimed to identify the practitioners' perspective of the shared training programme and the impact, shared training has had on individual practice. The value of this training programme for practice can be determined through the practitioners lived experiences and reflection on their clinical practice.

3.3 Aims of the Study

Following the programme design, the aims of the study were developed:

- Identify perceived strengths and weaknesses of the multi-disciplinary shared training programme.
- Evaluate the impact of the multi-disciplinary shared training on the practitioners' practice.
- Ascertain practitioners' perceptions of the value of shared training to practice.

3.4 Methodology:

In order to investigate the value of a shared training programme, a qualitative methodology was employed which could best elicit the views of the participants. Qualitative research by its very nature furnishes the researcher with the possibilities of understanding phenomena in their natural environment. Because the researcher helped in the development of the programme, it was understood that this would be an advantage in terms of the researcher becoming part of the research process and therefore having particular insight into the participants' perceptions of the programme. It was anticipated that this would reveal a true account of shared training whilst improving relations and communication through the demystification of professional roles.

3.5 Data Collection & Analysis:

3.5a Data Collection:

Post-workshop questionnaires and tape-recorded focus groups were the main methods of data collection. Although qualitative research doesn't attempt to validate in a positivist sense, it was felt that the post-workshop questionnaires could provide extra data to support the findings from the focus groups because the participants were familiar with the researcher and therefore perhaps more inclined to provide answers which they thought the researcher would like to hear.

3.5b Data Analysis:

A thematic content analysis of the tape-recorded semi-structured focus group interviews was used to elicit themes from the data coupled with observationary data through the researcher. A practice educator and a Public Health Consultant undertook a co-analysis.

3.6 Ethical Approval:

Before the introduction of Research Governance (DoH,2001), research involving staff normally did not require ethical approval. With the introduction of Research Governance and due to the researchers position within the Trust, the project was submitted for ethical approval. All the participants were informed of the right to withdraw and confidentiality was assured. Once transcribed by the researcher, the tape-recordings were destroyed. Ethical approval was granted with no amendments to the protocol being requested.

4.0 Study Limitations

There were a few limitations which need to be addressed. The findings have been derived from a subjective thematic content analysis, and although a co-analysis was undertaken, the researchers background is nursing and this might be considered a strong bias. The time limit on the research also hindered the resultant findings to some extent, it would have been useful to 'follow-up' some of the participants before presenting this report to identify if there relationships with Drs & nurses had improved.

Many qualitative researchers accept the interpretive nature of this paradigm and consider reliability an alien concept (Robson,1993). What is reported has been done so contextually and every effort was made to return transcripts to the participants for confirmation of detail and accurate transcription. Some of the tape recordings picked up a hiss and made some parts of the conversation difficult to hear and transcribe, but the resultant transcriptions are a true and accurate account of the participants' viewpoints regarding shared training.

5.0 Results:

In total, five themes were identified through the thematic analysis. Many of the themes have already been identified in previous literature. The programme itself was well attended with 10 nurses of various grades and 9 junior Drs. An audiologist and Medical Technical Officer also attended the non-clinical skills sessions. The themes identified reflect the participants' views regarding their experiences of the shared training programme and what, if any, changes they would make to future programmes.

The findings from the focus groups were supported by the questionnaire data, although data from the questionnaire does not reveal the individuals profession.

There were quite distinct differences between the Drs perceptions of shared training and the nurses, although there were also some similarities especially with regards to the positive aspects of the programme.

The post-workshop questionnaire focussed on the content, usefulness and value of shared training and the focus groups provided an opportunity for the participants to expand on their experiences.

5.1 Identified Themes.

Semi-structured questions about the content; value and how they perceived the importance of shared training to professional development were asked in the focus groups. Widening Perceptions, neutral forums and improved communication, role ambiguity and clarification, compromised development and training content and usefulness were identified.

5.1a Widening Perspectives:

This was a theme which was identified within the focus groups and also through questionnaire analysis. There was a general feeling that sharing knowledge was good and that perhaps shared learning could help to alleviate some shared problems. The questionnaire responses highlighted aspects pertaining to the understanding of others thoughts:

"I feel that it is important to understand how other professionals deal with record keeping and how they approach obvious difficulties"

"Different perspective on a shared procedure same problems experienced by both groups".

One respondent commented that

"The communication workshop allowed for more discussion, it's not the skills, it's the fact that you are being taught with the Drs and getting to know them".

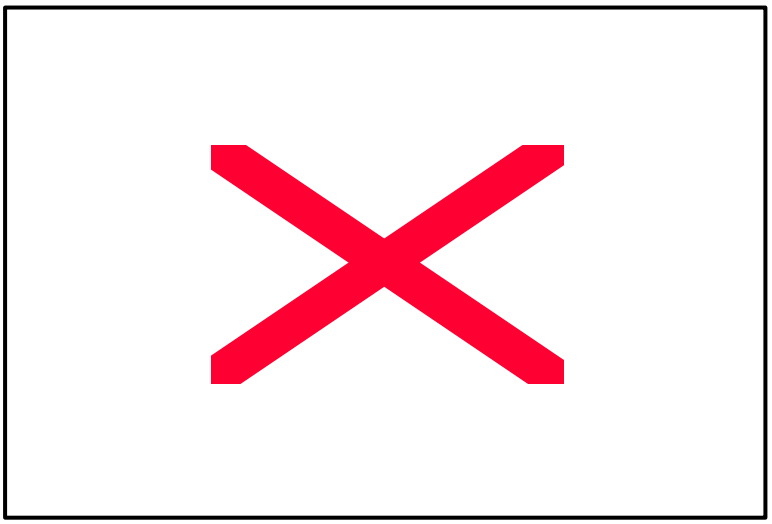
This is a communal view for example Reeves (1998) study on a shared training programme revealed that most students regarded the shared training as a useful opportunity to obtain another professionals perspectives on issues of health care.

Other participants suggested that they felt it was valuable to obtain various thoughts and opinions and

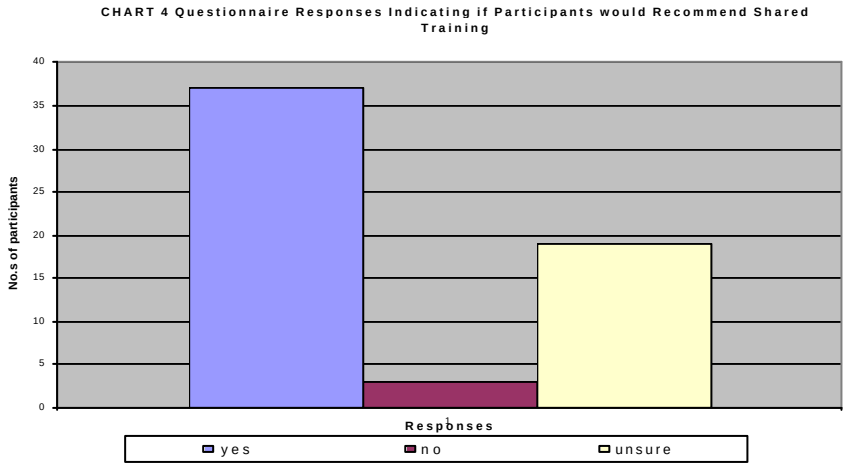
"hearing the medical opinion on some items".

The notion that exchanging ideas could improve understanding and that "shared learning sorts out shared problems" has been reported elsewhere, however, the participants believed that this was a great advantage to shared training.

The questionnaires identified that most (n=45) felt that the shared training had value, only a small number but some were unsure (n=19) which is reflected in the focus group discussions



One of the questionnaire questions asked the participant to decide whether they would recommend the programme to a friend and again, most said that they would recommend the programme to a friend (n=37) and only two who would not recommend shared training. Which gives the general impression that most of the participants enjoyed and valued the shared training, perhaps because of the opportunity to widen their perspectives.



5.1bi Role Ambiguity & Clarification:

The relationship between Drs and nurses has never been straightforward (Salvage,2000), the challenging nature of Dr-nurse relations (first looked at by Leonard Stein, 1978) is still pertinent today (Snelgrove,2000). Carter (1994) suggests that taking into consideration current and historical factors, nurses' ad Drs need to examine their interactions, essentially evoking understanding. The shared training programme has helped some practitioners to appreciate each other's roles through debate and interaction. One participant highlighted that shared training was

"A valuable tool in demonstrating our roles individually and as a team"

One Dr suggested that the training helped them to become aware of other people by getting to know nurses in different settings. In terms of role clarification, it was apparent that the Drs and nurses weren't fully aware of each other's roles. Even some experienced nurses were unfamiliar with the Drs knowledge base during their first year as House Officers. A common assumption was that junior Drs had far more intensive training in some clinical skills, whereas the actual reality suggested that Drs needed to know more. As one participant commented:

"you realise issues that are commonly encountered…a good opportunity to reflect".

One nurse commented that she felt some Drs were "petrified of some nurses", but as a Dr discusses, the training helped them to perceive the nurses role which was supported when a nurse thought that the shared training "lets them (Drs) realise that they might need help". This notion of medical omnipotence and see one, do one, teach one, has been referred to elsewhere – the idea that experience is not a substitution for training ..scuppering the shibboleth 'see one, do one, teach one, (Snelgrove,2000). Previous studies have highlighted tat 62% of Drs had learnt a lot from nurses (Snelgrove, 2000).

The acknowledgement of roles and overlap was apparent within the groups. Both the questionnaires and the focus groups highlighted that nurses and Drs had distinct ideas about their roles. The Drs felt that they were only doing tasks like venepuncture as this was their first year. The suggestion was that once they climb the career ladder, they would no longer perform these tasks to the current extent. They also believed that they didn't require venepuncture sessions because they were already doing it, it was part of their job and believed it was a waste of time and frustrating to have to do venepuncture and cannulation sessions.

"I don't think Drs need to have venepuncture sessions because its part of our job"

Nurses also had clear distinctions between roles, suggesting that medical devices were not really the role of the Dr however, they appreciated that they did have pre-conceived ideas about a Drs role. One nurse following the communication and venepuncture session commented that she "would help them more now", encouraging the thought that previously, she believed that the Drs would not require her help.

5.1c Training Content and Usefulness:

An interesting area of discovery was around the Drs perceptions of venepuncture and cannulation. As mentioned previously, a recent audit highlighted that infection rates for cannulation were unacceptable, and the Drs had the highest level of infection rates. None of the participants were aware of this, however, the general view regarding venepuncture and cannulation was negative. One Dr commented that

"the topic of the session (venepuncture) should be more appropriate, having teaching sessions for the sake of them is not a constructive use of time."

The issue around see one do one teach one seemed to prevail here. Participants did not seem to relate competence with quality. Venepuncture and cannulation therefore were low priorities with Drs stating that they wanted more training in skills such as Central Venous Line insertion and chest drains.

Generally, most of the participants found the content of the programme useful and especially enjoyed the first session (communication) as it allowed the participants to discuss their roles.

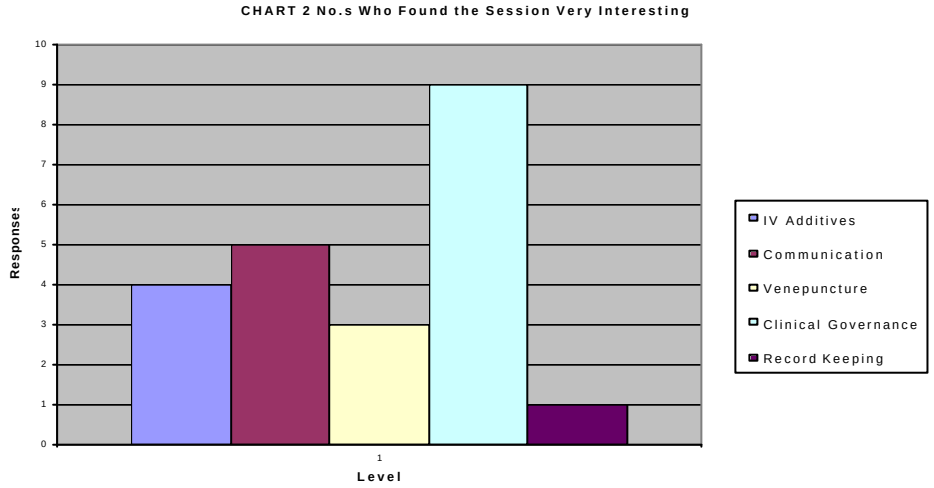


Chart 2
Demonstrates the general values the participants placed on the content and its interest level. The chart is based on a score of 5

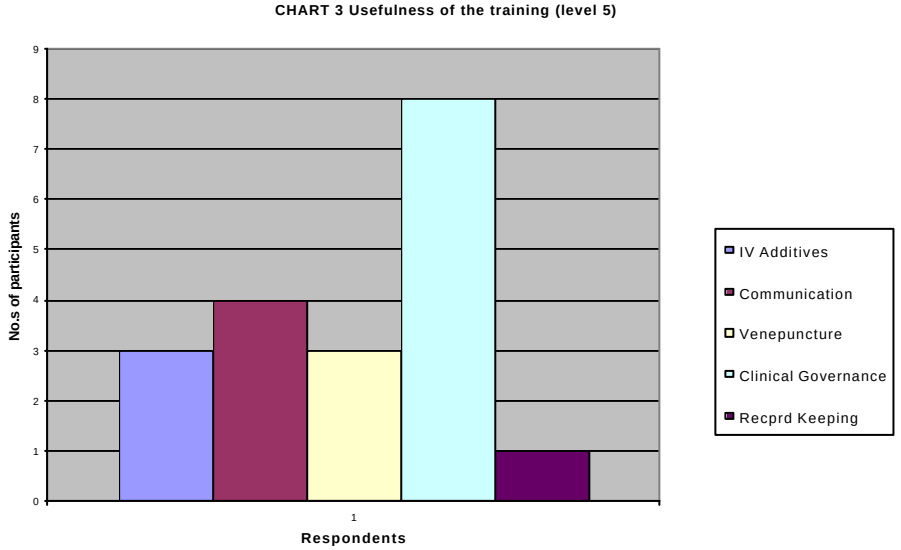


Chart 3
Demonstrates how useful the workshops were for the participants. Clinical Governance has so far been shown to be the most useful and interesting session. The participants valued the communication workshop and this is reflected in the focus group analysis

In terms of what they would have include in the training, most agreed on the following areas:

- Diabetes – with the specialist nurse coming to talk to them
- More pharmacology
- One nurse suggested that ECG's could be useful, especially in an emergency situation. This idea has been discussed in Freeths (1998) research when she stated that "there is an overlap of educational needs in areas such as venepuncture, cannulation and ECG".
- Breaking bad news
- How to handle angry patients
- Ethics and moral dilemmas

Nearly all of the Drs stated that it would have been more useful to have the clinical skills in the first month – *"to help break the ice"* and most of the participants welcomed the opportunity in future training to attend seminars led by specialist nurses.

Another popular session was the Clinical Governance session. Although this wasn't interactive, it was very topical, well presented and cleared some ambiguity around what is meant by ''Clinical Governance'' for some of the practitioners. One Dr commented that information about clinical governance was needed at medical school.

Unfortunately, most of the Drs and some of the nurses suggested that urinary catheterisation was not a skill which they felt was useful in the training. Such was the dismissal of this training, that the session was cancelled. Carter (1990) also found similar attitudes in her study of practical procedures of urinary catheterisation; they reveled that "there was an appreciable ignorance of the practical and theoretical aspects of catheterisation". They expand this discussion further and identified that the Drs in their study were reluctant to seek advice, because of their impression that "catheters were not worthy of disturbing senior staff". It would have been useful to question staff further during a follow-up interview.

5.1d Compromised Development.

At post-registration stage, medical graduates feel instinctively more attracted to study within a recognised medical arena (leatard,1997). Educational levels and needs differ, which often makes it difficult for Drs to participate. This was highlighted as a concern for some of the Drs. They suggested that

"Shared training restricts your skill development, stops you from doing something like CVP's, you have to compromise"

The term 'compromise' was used by a number of Drs, one of which commented that *"You can't tailor the training to specifically the Dr or the nurse….you've got to reach a compromise".*

Whilst the Drs shared this opinion, the nurses didn't make any comment about the nature and level of the training. They felt that all the programme had been really useful because they were being taught the same things, which they felt encouraged a quality standard throughout the generic aspects of their roles.

Headrick (1998) lists some barriers to shared training as fears of diluted professional identity whereas Finch (2000) actually questions whether shared training is the most effective way of learning. Some of the Drs also had "reservations" about shared training and weren't convinced that there were many benefits. This is in total contrast to the nurses who clearly stated that they could identify no negative aspects of the programme. The only suggestion offered by the nurses was the recommendation that Drs leave their bleeps wit someone. Although the Drs protected study time was used, some were on call, and others couldn't attend due to busy ward demands. The timing of the sessions were fixed into the pre-set training sessions for the Drs. It was felt that he Drs were so few, that any other time would have meant the Drs being unable to attend. Some of the nurses though, found it difficult to get away from some shifts and often they would attend the training in their own time.

5.1e Neutral Forum and Improved Communication:

Perhaps the most positive aspect viewed by the participants was that of the improved communication during the training. Alongside role clarification, this was seen as a great advantage with the training providing a neutral forum away from the wards where professionals could actively debate issues and gets to know one another.

As well as proving an ideal way to develop relationships, Leathard (1997) suggests that shared learning has also proved an effective way to augment knowledge. This was also identified by the participants, one commented that

"I find it useful to listen to their views during training and it adds extra food for thought hopefully to increase my understanding outside of learning sessions."

Practitioners valued getting to know others and building a rapport, something which has been highlighted in previous research by Hugh Barr (1994) where he stated that practitioners value shared explorations of the implications for each profession".

The neutral forum concept was one which a few participants commented on. Most felt that through this neutral forum communication had been improved purely by listening to each other's problems, getting to know their point of view and expectations of colleagues.

6.0 Discussion & Conclusions.

Generally, most felt that, despite some concerns about the clinical skills, the interactive sessions helped them to forge new links and enhance their perceptions of others roles. This is reflected throughout the interviews and also in the literature. Most common were the perceived benefits pertained to team building, collaboration and role clarity, again, these are areas highlighted in current research.

6.1 Self-Assessment Documentation

One area not commented upon so far are the self-assessment documentation. None of the participants completed the documentation. Some of them couldn't remember where they were, and some of the Drs felt the assessment process slightly patronizing. Reasons for this lack of self-assessment were varied, ranging from difficulty in getting an educational supervisor to watch cannulation insertion, to inability to arrange meetings with mentors due to a heavy workload. It was hoped that the self-assessment would encourage participants to examine their own practice and identify any improvement in skills through the training.

6.2 Teamwork

The idea that 'Teamwork' and the importance of teamwork was commented on by many

"It makes everyone aware that we work as a team for the benefit of the patient"

It is suggested that separation & conflict have resulted in a depletion of skills and knowledge, which has ultimately affected patient care (Brooking, 1991) Hall argues that if we devote as much time to shared training as we do to quarreling over ownership of tasks, patient care would benefit. Some of the participants in the groups argued that

"many elements of patient care are now being shown again as shared problems & that we all aim for the same outcome.. the ultimate care of our patients.

Working towards a shared outcome has perhaps been recognised more as a priority which has been furnished through shared training. Many practitioners are too busy to step back and decipher what they are doing, how they are doing it and why and many may take good relations for granted. When professionals come together in a 'neutral forum,' a lot of the tensions are eased as new relationships and understandings are forged.

6.3 Improved Collaboration & Role Clarity

The concept that shared training was an ideal method for improved collaboration is echoed throughout both sets of participants. It was generally believed that we care for the same patient, therefore, shouldn't we have the same goal?

we are all working towards the same goal….whether we are a Dr or nurse or other professional….shouldn't we be taught the same thing?"

This is a view which may not shared by others as many authors express a belief that patient advocacy is integral to the role of the nurse and that the nursing role is more about caring, whereas the Drs role is concerned with curing (Brooking, 1991). Authors would attempt to identify professional perceptions as separate, but working towards meeting the patients needs.

Snelgrove (2000) found in their study that most agreed that the core activities associated with nursing centred on routine care, social and emotional care and the monitoring of treatments .This opinion has not changed much since the 1970s when Tucker (1974) suggested that the nurse is a submissive, handmaiden who has undergone a transition in the 20th Century…..a nurse is still obliged to follow orders…she works with the Dr". Neither profession has the prerogative on either care or treatment (Brooking, 1991). Busby (1992) suggested that Drs still perceive nurses as their assistants and not as autonomous practitioners, yet the participants in this study welcomed the opportunity to learn from each other.

The Drs recognised that nurses had many skills, which could be disseminated to Drs, for example breaking bad news and communication in general. This is also supported by Brooking (1991) who states that "there are important subjects such as communication and the psycho-social aspects of care where nurse educators should be able to offer expertise to medical education" .When asked what they would include in a future training programme, the Drs indicated that talks from the specialist nurses (i.e. pain or diabetes) would be very useful. This provides the reader with an impression that Drs have a great respect for nurses, despite seeing their role differently ,and despite arguing that the roles only overlapped during the first year post-reg.

6.4 Practicalities and Content

The difficulties of developing a shared training programme have long been recognised. Jackson (2000) identified several areas which were considered as barriers to developing shared training.

Difficulty of organisation

Different knowledge base (educational experience)

Training Content

These will be used to highlight some of the practical difficulties and content design problems.

6.4a Organisation

Relationships between the Post-grad department and the Post-grad tutor have always been excellent, so it was agreed through a working party that Drs bleep free time could be used developed to meet the needs of the time constraints.

Because the programme was designed to fit into the existing Drs bleep free time, meant that only two hours maximum could be provided for one session. Most of the sessions ran by Training & Education often covered a half-day or a whole day. Recognising that Drs couldn't be spared to attend a half or whole day, meant that sessions had to be re-designed

6.4b Different Educational Experiences

Perhaps the most serious obstacle to the development of joint training is the educational gulf between certain disciplines (Brooking,1991). This became apparent through the focus group discussions whereby both groups identified a difference in need and experience. The nurses felt secure and happy to study at "the same level as the Drs, however, the Drs felt that they were somewhat disadvantaged although they felt they had acquired some benefit in terms of identifying the knowledge base of nurses.

6.4c Training Content

Williams (1980) recommends that in order to promote successful shared learning one must consider the aims, meaning, motivation, and the use of case materials. The content on the whole reflected some of these aspects. Aims were clearly outlined, meaning was discussed at the introduction day but case materials were not used. Apart from using records to audit their record skills, the participants did not use any cases. The success of case study using a problem solving approach has been demonstrated elsewhere (Freeth,1998) and as the participants recommended more interactive sessions, this should be borne in mind in the future. Some participants felt that they were just sitting in on shared sessions, rather than learning together and believed that if clinical skills are to stay within the training then they should be more interactive.

7.0 Recommendations

Although the programme proved to be a positive experience for most involved, it did raise questions about the content and direction of future programmes. Alongside developing a programme which is relevant to most practitioners, the skill and knowledge level and previous experiences should be considered when designing a shared training programme.

Future Content

Shared training isn't just about the medical practitioners 'sitting in' with nurses or visa versa, its about mixed groups of students learning and working collaboratively on patient centred tasks (Gill, 2000). Working together rather than alongside can energize people and result in new ways of tackling old problems (Davies, 2000). Future content of training should be more problem based, focussing on patient care episodes, where professional can work in mixed groups to solve the patients problems. This would provide an ideal opportunity to discuss problems collaboratively, away from the work area in a neutral forum which facilitates and fosters an honest sharing of knowledge.

If possible, clinical skills should be taught earlier on in the programme, which may act as an icebreaker and be of more use to Drs who arrive from medical school.

Drs bleeps

Although bleep free study time was utilised, Drs still carried their bleeps (apart from one or two) therefore most sessions were interrupted by the bleeps going off and the Dr being called away. This is a concern which most of the nurses commented on. They felt that this greatly disadvantaged the Dr and indeed the session. Future programme should identify this need and develop a 'rotational' system or other means of removing the Drs bleeps during training.

Skill Level

Different skill levels are inevitable. A generic approach to training is required by teachers skilled in shared training techniques. The difference in skills level could be compensated through the use of problem based learning around a clinical scenario or caseload. This would facilitate discussion and the sharing of knowledge and ideas and positive reinforcement of roles and perceptions. A combination of specialist nurses, practitioners, Doctors and Practice Educators should be utilised to develop teaching and learning strategies and assist in the delivery.

Involvement of Specialist Practitioners

As suggested by the participants, the involvement of specialist practitioners such as the pain nurse or diabetes specialist could prove invaluable for maintaining the participants' motivation and interest level. This could also assist break some popular myths concerning the status, role and educational level of nurses and encourage knowledge acquisition pertaining to specialist areas of practice. Specialist practitioners should deliver at least two sessions in future shared training programmmes.

Extend Training Programme

The programme needs to be extended to include the additional sessions mentioned and be available for all PRHO's during their first six months hospital experience.This training is an invaluable introduction to other professionals removed from the constraints of a busy and demanding ward where the pleasantries of conversation are all too often neglected. The junior Dr no longer need fear the nurse, but have the knowledge and confidence to approach other professionals and ask for help when required.

Widening Participation

Although all professional groups were invited to attend, the response rate was quite poor. Only one audiologist and one MTO attended. This may be due to the fact that a shared training programme has never been delivered to this extent and many people may not have recognised the potential benefits.

Different professional should be include in future programmes. The audiologist and Medical Technical Officer who attended some of the session found them useful in terms of being able to understand others roes and gain greater insight into shared problems.

Forte (1997) once stated that "shared training may enhance our future as professionals and enable us to create important formative memories of a collaborative approach." The shared training programme in this DGH has already highlighted the path, with work and commitment, relationships, collaboration and ultimately patient care could improve dramatically.

References.

Annandale, SJ. McCann S. Nattrass H. Regan de Bere S. Williams S. Evans D. (2000) Achieving health improvements through inter-professional learning in Southwest England. Journal of Interprofessional Care. Vol 14. No. 2

Annonymous (2001) Mixed training plan is 'daunting'. Nursing Times. 97.11:8

Barr H. (2000) Working together to learn together: learning together to work together. Journal of Interprofessional Care. 14 (2)

Barr H. (1994) Perceptions on shared learning. London. CAIPE

Brooking J (1991) Doctors and nurses: a personal view. Nursing Standard. Vol 16, 12. 24 – 28

Brown SE. (2000) Does a multi-disciplinary health degree provide a satisfactory post-registration course for a nurse. A follow-up survey of health science studies. Nurse Education Today. 20 (8) 613-9

Busby A. Gilchrist B (1992) The role of the nurse in the medical ward round. Journal of Advanced Nursing. 17 339—346

Burmah, R. Bury Healthcare NHS Trust (2001) Infection Control Audit of Cannulation Sites.

Campbell-Heider N. Pollock D (1987) Barriers to physician-nurse collegiality: an anthropological perspective. Social Science Medicine. 25:5 421-25

Carter H (1994) Confronting patriarchal attitudes in the fight for professional recognition. Journal of Advanced Nursing. 19. 367-372

Carter R. Aitchinson M. Mufti GR. Scott R. (1990) Catheterisation: your urethra in their hands. BMJ. 301: 905

Catto G (2001) Education, education, education. BMJ. 322-52. 7301

Davies C (2000) Getting health professionals to work together. There's more to collaboration than simply working side by side. BMJ: 320. 1021-24

Department of Health (2000) The NHS Plan: A Plan for Investment, a Plan for London. DoH.

Elizabeth JE. Hughes S. (1986) An assessment of the pre-registration experience. BMJ: 293 1559.

Fagin CM (1992) Collaboration between nurses and physicians: No longer a choice. Academic Medicine. 67. 5

Finch J (2000) Interprofessional education and team-working: a view from the education providers. BMJ: 321. 1138-40

Forte PS (1997) The high cost of conflict. Nursing Economics. 15 (3)

Freeth D. Nicol M. (1998) Learning clinical skills: an interprofessional approach. Nurse Education Today. (18) 455-461

Gill E. (2000) Doctors and nurses need to collaborate. BMJ: 321

General Medical Committee. Team-working in Medicine. www

Good Medical Practice (1998) GMC. London

Hall T (1991) Junior doctors, nurses and drips. BMJ: 303.

Hartman H (1976) Capitalism, patriarchy and job segregation by sex. In Classes, Power and Conflict. Classical and Contemporary Debate. Giddens A. Held D (eds) MacMillan Education London.

Headrick LA. Wilcock PM. Batalden PB (1998) Continuing medical education. Interprofessional working and continuing medical education. BMJ: 316: 771-4

Helmstadter C (1997) Doctors and nurses in the London teaching hospitals. Class, gender, religion and professional expertise 1850-1890. Nursing History Review. 161-97

Jackson S. (1996) The case for shared training for Doctors and nurses. Nursing Times. 92 (26) 40-1

Leathard A. (1997) Interprofessional education and the medical profession: The changing context in Britain. Education for Health. Vol. 10 No. 3 359-370

Mackay R. Matsumo K Mulligan J. (1991) Communication problems between doctors and nurses. Quality Assurance in Health Care. Vol 3. No. 1 pp11-19

Making A Difference (1999) Department of Health. London

NHSE (1996) Education and Planning Guidance. EL. (96) 46

National Institute for Clinical Excellence (1993) A Guide to Our work. London. NICE: 3

Porter-O'Grady T (1995) Five rules of engagement for multi-disciplinary teams. Aspen's Advisor for Nurse Executives.

Reeves C. Pryce A. (1998) Emerging themes: an exploratory research project of an interprofessional education module for medical, dental and nursing students. Nurse Education Today. 18 534-541

Research Governance (2001) Department of health. HMSO. London.

Robson C (1993) Real World Research. A Resource for Social Scientists and Practitioner-Researchers. Blackwell. Oxford. UK.

Salvage J. (1999) Doctors and nurses: is teamwork enough? Nursing Times. 95 (39) pg 20

Salvage J. Smith R (2000) Doctors and nurses do it differently. BMJ: 320: 1019 – 20

Standing Committee On Postgraduate Medical and Dental Education (1997) Multi-professional working and learning: sharing the educational challenge- The Consultation Paper. London: SCOPME.

Snelgrove S. Hughes D. (2000) Interprofessional relations between doctors and nurses: perspectives from South Wales. Journal of Advanced Nursing. 31 (3) 661-667

Stein L (1978) The doctor-nurse game. In Dingwall R et al. Readings in the Sociology of Nursing. P107-117. Churchill Livingstone

Tomorrow Doctors (1993) GMC. London

Tucker WM (1974) The nurses' role through the physicians eyes. A historical review. Virginia Medical Monthly. Vol 101. 449-451

Walker A (1991) Teaching junior doctors practical procedures. "see one, do one, teach one" will no longer do BMJ: 303. 1157

Williams T (1980) Adult education and interprofessional teaching. Journal of the Royal College of General Practitioners. Occasional Paper. 14. Pp10-11

Wilson J. Mires C (2000) A comparison of performance by medical and midwifery students in multi-professional teaching. Medical Education. 34: 744-6

Witz A (1990) Patriarchy and professions: the gendered politics of occupational closure. Sociology 22(4) 675-690

Wright S. Bawkett J. Bray K (1996) The communication gap in the ICU – a possible solution. Nursing in Critical Care. 1 (5) 241-245

Zwarenstein M, Reeves S. (2000) What's so great about collaboration. We need more evidence and less rhetoric. BMJ: 320: 1022-1023

Zwarenstein M. Bryant W (2000) Interventions to promote collaboration between doctors and nurses. Cochrane Library. Issue 4

Bibliography.

Allmark, P (1992) Developing roles. Nursing Times. 88 (38) pg 47

Bain PG. The WL. Rowe TJ. (1990) Workload of PRHOS. BMJ. 300: 1463

Berwick D 91996) A primer on the improvement of systems BMJ 312: 619-22

Brink TL (1984) Multi-disciplinary team success: the role of mutual respect. Clinical Gerontologist. Vol.3 73-4

Bulger J. (2000) Commentry on Achieving health improvements through interprofessional learning in southwest England. Journal of Interprofessional Care. Vol.14 No.2

Chandler J (1991) Nurse Education Tomorrow Conference 1990- Reforming Nurse Education 1- The reorganisation of Nursing Knowledge. Nurse Education Today. 11 82-88.

Cheater EM. (2000) Intelligence is not in the eye of the beholder. BMJ: 321

Cooley C. (2000) Communication skills in palliative care. Professional Nurse. 15 (9) 603-605

Doyal L Cameron A (2000) Reshaping the NHS workforce. Necessary changes are constrained by professional structures from the past. BMJ: 320. 1023-1024

Dyer C (1991) Doctors convicted of manslaughter. BMJ: 303. 1157

EMAP Healthcare Open learning (2000) Overcoming difficulties in communication with other professionals. Nursing Times. 93 (28)

Girot EA. (1993) Assessment of competence in clinical practice- a review of the literature. Nurse Education Today. 13: 83-90

Hardern R. Sutcliffe J. Catto A. Pope R. (1994) Doctors and nurses and training in the administration of intravenous drugs. British Journal of Clinical Practice. 48 (5) 246-7

Iliffe S (2000) Nursing and the future of primary care. Handmaiden or agents for managed care BMJ: 320. 1020-1021

Kelly C (1993) Junior doctors hours. Health Service Journal. 100 5372, 25-26

Making A Difference (1999) Department of Health. London

NHSE (1996) Education and Planning Guidance. EL. (96) 46

Pirrie A. Wilson V. Stead J. (1997) Evaluating multi-disciplinary education: work in progress Journal of Interprofessional Care. 11,2 228-229

Watkinson G. (1998) The educational advances that nursing has made over the past 10 years. Nursing Times. 94 (33):51

Wilcock PM. Headrick LA. (2000) Interprofessional learning for the improvement of health care: why bother? Journal of Interprofessional Care. Vol 14. No.2

Witz A (1990) Patriarchy and professions: the gendered politics of occupational closure. Sociology 22(4) 675-690