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'I beg your pardon?' Nurses' experiences in facilitating doctors' learning process – An interview study

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ABSTRACT

Objective: Working alongside specialized palliative care nurses brings about learning opportunities for general practitioners. The views of these nurses toward their role as facilitator of learning is unknown. The aim of this study is to clarify the views and preferences of these nurses toward their role as facilitator of physicians' learning.
Methods: Qualitative study based on semi-structured interviews. We interviewed 21 palliative care nurses in Belgium who were trained in the role of learning facilitator. Data were analyzed using Grounded Theory principles.
Results: First all interviewees shared the conviction that patient care is their core business. Secondly two core themes were defined: nurses' preferences toward sharing knowledge and their balancing between patient care and team care. Combining these themes yielded a typology of nurses' behavioral style: the clinical expert-style, the buddy-style, the coach-style and the mediator-style.
Conclusions: Palliative care nurses' interpretation of the role as facilitator of general practitioners' learning diverges according to personal characteristics and preferences.
Practice implications: Asking clinical expert nurses to become a facilitator of other professional's learning requires personal mentoring during this transition. Nurses' preferences toward practice behavior should be taken into account.

1. Introduction

Most palliative patients prefer to be cared for at home by their general practitioner (GP) until death [1]. To tackle this complex task, GPs need a set of palliative care competences [2,3]. A recent review of palliative care education in Europe shows that not all medical schools have a mandatory undergraduate palliative education: in only 47% of the countries palliative care is taught as a subject (mandatory or optional) [4]. Furthermore in Belgium, where our study was done, the offer of continuing medical education (accounting for the lifelong learning of physicians) shows to be insufficient to train GPs in palliatieve care [5]. Therefore GPs have difficulties maintaining palliative care competences. In many countries GPs can appeal to specialized nurses from palliative home care teams (PHCTs) to support them when care becomes too complex or exceeds their own competences [4]. Besides being supported in the delivery of patient care, GPs state to learn through this collaboration [6]. They mention to gain new knowledge by asking on-the-spot advice. Furthermore they state to acquire practical skills by performing technical tasks (e.g. handling a syringe driver) together and under the supervision of the PHCT nurses. This 'learning by doing' is also called workplace learning (WPL). Literature on WPL describes characteristics of the learner (who is learning?), the learning context (the practice environment where the working and learning takes place), the learning process (which learning activities are used?), and the learning facilitator (from whom has been learned or who is helping the learning process?) [7–12]. To have an effective learning process, ideally the learner needs the willingness to learn, has to be aware of his own learning needs and needs to seize learning opportunities actively [10,13–15]. Since most of the WPL occurs during daily work activities, the practice

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organization should ideally offer a wide range of challenging activities and opportunities to learn, while providing time and space for reflection [8,10,11,16,17]. The learning process is often unscheduled, informal and implicit or encompasses the use of tacit knowledge, therefore it can be hypothesized that not all learning opportunities are seized [9]. It might be hypothesized that making the implicit learning more explicit (by introducing the role of a learning facilitator) could make it more efficient. The learning facilitator can be any colleague on the work floor. He can help the learner with his needs assessment, solve problems jointly, share materials and resources and give feedback [8,14,18,19]. Essential for facilitators is the need to be skilled (both as an expert in the job and as a facilitator) and motivated to act as a facilitator. PHCT nurses are trained and experienced palliative care experts. They are however not trained for the role of learning facilitator for physicians. Since GPs indicate the collaboration with PHCT nurses to be a learning moment, it is worthwhile to explore the views of the nurses toward their role as facilitator of GPs' learning. Introducing this new role in their daily task must be done with respect to their views.

The aim of this study was to

- Describe the views and preferences of PHCT nurses toward sharing their knowledge and expertise with GPs.
- Describe the views and preferences of PHCT nurses toward the balance between care for the patient and care for the team.
- Describe how these views and preferences influence the uptake of a role as facilitator of GPs' learning.

2. Methods

2.1. Setting and sample

This interview study is part of a larger study (the ELICIT-study) on primary palliative care in Belgium. The ELICIT-study explores the learning impact of inter-professional collaboration and has been designed as a randomized controlled trial. The entire Dutch speaking part of Belgium is covered by 15 PHCTs. Nurses from these teams advise and support GPs in their caring for palliative patients. Final responsibility remains with the GPs. A large part of them is still working in single handed practices and PHCT support is welcomed. All PHCTs were invited to participate, 12 of them agreed. After randomization, the six PHCTs from the intervention group received a training program (35 nurses). The focus of the program was to train the PHCT nurses to be facilitators of GPs' learning by teaching them how to improve the learning effect of the workplace interaction, as GPs point at these nurses, during focus group research, as a resource for learning [6]. Part of the training comprised reflecting on the nurses' roles and responsibilities. As a result they were able to explicitly articulate personal views on their professional identity and behavior. Therefore these nurses (from the six PHCTs of the intervention group) were selected to participate in this interview study.

After the initial training day, nurses had 2 months of practice experience, whereafter all nurses were invited for semi-structured interviews during the period of February–March 2013. Informed consent was obtained before the interviews were conducted.

2.1.1. Ethical approval

The Ethics Committee of Ghent University Hospital approved the study. (B67020123863).

2.2. Data collection

Qualitative research through semi-structured interviews was chosen to elicit personal views and experiences of the nurses [20].

Table 1
Topic guide used for semi-structured interviews with PHCT nurses.

Topics	Probing questions and relationships to the research questions (RQ)
Implementation of the trained skills	What has been easy to put into practice? (RQ1) How and when did you try it? Why do you think this was easy? What was difficult to put into practice? (RQ1) How and when did you try it? Why do you think this was difficult?
Effect on collaboration with other professionals	Did this change the way in which you collaborate with others? (RQ2) Did this change the way in which you care for the patient? (RQ2)
Permanence of the implementation	What helped you to continue putting it into practice? (RQ3) What made it difficult to continue putting it into practice? (RQ3)
Effect on nurses personal feelings	How did you feel adopting this new behavior? (RQ3) Did you notice others reacting to your new behavior? (RQ3) How did that make you feel?

An interview guide was developed based on literature on teamwork (essential elements for effective teamwork), interprofessional relationships (the importance of relationships regarding quality of patient care) and implementation of change (how to change practice through training) [21–24]. To validate the content, this interview guide has been discussed with the program's trainers and with external experts (a coordinator and a psychologist of a PHCT not involved in the training). The resulting interview guide comprised four topics: the implementation of the trained skills, the permanence of the implementation, the effect of the new role on nurses' personal feelings and the effect on collaboration with other professionals (see Table 1 for details). All interviews were held by the first author (GP, palliative care physician and trained interviewer), audiotaped and transcribed verbatim.

2.3. Analysis

The interviews were analyzed following a Grounded Theory approach with different coding phases. The first five interviews were open-coded (free coding without pre-existing codes) by two researchers (PP an MF) separately. Differences in coding were resolved by discussion. The next 16 interviews were coded independently (8 each). On a regular basis, the two researchers engaged in discussions on the codes. This second phase, the axial coding phase, resulted in the codes being allocated to categories and concepts. Intermediate discussions on these concepts were held with a third researcher (DM). Interviews were conducted and coded until data saturation was reached. During the last phase, the selective coding phase, core categories were defined. These core categories served as framework for the final description of the results [20]. Analysis was done using NVivo 10 software.

3. Results

Twenty-one nurses participated (age: M 46.0 (SD 7.7); years in PHCT practice: M 6.8 (SD 5.3); gender: Male 3). Fourteen nurses did not participate in the interviews due to change of job ($n = 1$), long term sick leave ($n = 2$) and workload too high ($n = 11$). All interviews took 30–60 min with a mean of 41 min. Details on the participants are shown in Table 2.

The following results are presented with illustrative quotes from participants. Each quote is identified by gender, age and years of experience.