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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.

Table 2
Characteristics of participants.

Case number	PHCT number	Age (years)	Gender	Experience in PHCT (years)
1	1	40	F	2.5
2	1	51	F	1.5
3	1	34	F	5
4	1	45	F	9
5	2	56	F	15
6	2	35	F	2.5
7	1	41	F	5
8	2	52	F	10
9	1	35	F	1
10	2	57	F	14
11	3	40	M	0.5
12	4	54	F	7
13	4	42	F	1.5
14	3	45	F	12
15	4	49	F	12
16	5	50	M	2
17	5	45	F	6
18	4	38	F	4
19	5	59	F	17
20	1	44	M	2
21	2	55	F	14

All interviewees agreed that patient care is their core business. They unanimously declared the quality of patient care to be their main concern. In the midst of their complex set of tasks comprising patient care, family care, team coordination and an advisory role toward other professionals, quality of the patient care comes first. When asked if they tried to take up the role of facilitator of GPs' learning a nurse answered:

> 'The focus should remain with the patient. We have to stimulate GPs, true, it's okay to be attentive to that but the patient, the focus has to be on the patient!'

(P 7: Female; 41 years, 5 years in practice

Research question 1: Describe the views and preferences of PHCT nurses toward sharing their knowledge and expertise with GPs.

Some nurses prefer to share their knowledge when GPs are looking for expert advice, i.e. on demand. Giving advice is, as they explain, what they have been doing all the time and what they feel they do best. In answer to the question if it was possible to reflect on a GP's question instead of answering immediately (one of the aims of the training) one nurse stated:

> 'I try to but it's difficult, you know. I'm a person who's giving the solutions in a conversation. And just answer straightforward. I find it difficult to ask that open question. Sometimes after a conversation I realize . . .., I am, yes, too straightforward, I think. Yes, I'm offering the solution instead of asking 'what do you think?"

(P 4: Female; 45 years, 9 years in practice)

Contrarily, some nurses like to share their knowledge in order to improve the competence of others. These nurses actively and persistently tried to share their knowledge with others arguing that the whole care team should be competent in order to provide good care.

> 'Today I've met such a GP, I've known him for ten years now and he has never understood it. He still doesn't. And then I try to explain it again 'doctor, now this and now that.' But some GPs still hold on to injections for pain control and I have repeatedly explained that we try to avoid that in palliative care . . . and then I explain it again. I never give up!'

(P 19: Female; 54 years; 17 years in practice)

Teaching GPs to reflect on palliative care is a satisfying and reciprocal way to facilitate others' learning to some nurses.

> 'Reflecting on it together with the GP is nice because they might have another line of thought that I haven't come up with.

(P 13: 42 years; 1.5 years in practice).

These positions are the extremes of a continuum with a whole range of positions in between. Nurses express their preferences but they can also navigate along the continuum during practice, depending on the patient's context and the GPs' attitude.

Research question 2: Describe the views and preferences of PHCT nurses toward the balance between care for the patient and care for the team.

A second continuum can be defined with regard to nurses' main focus during their daily work. Patient care is the core business for all PHCT nurses but some explicitly position themselves as the patient's advocate, thereby opposing other professionals if necessary. In the next case, the nurse had noticed that a patient wanted to talk to the GP. The GP did not intend to have that conversation as he was not convinced that it would benefit the patient. The nurse then called the GP:

> 'I had to push it a bit, I had to pull rank, yes, yes! I really had to put emphasis on it: that patient needs a talk with you, you really have to go, it's a patient's right to get a conversation. I told him he cannot ignore this request.'

(P 11: Male; 40 years, 0.5 years in practice)

Others were more inclined to attend to the well-being of all people involved and took care not to harm the interprofessional relationships. Good working relationships are a guarantee for good future collaboration and future patients may benefit from this. One nurse contacted a GP again in the evening, after having had a conflict with him during a telephone call in the afternoon.

> 'I felt that he was under pressure (by my question in the afternoon) and so I called him in the evening and again I sensed his defense. But then, I named the problem: 'doctor I think that you were under pressure.' And yes, that made him feel acknowledged: 'yes, I was . . .'. And then I got him on board. We started talking about the problem and we reached an agreement on how to handle it, what does the patient need? And then we also agreed on the best moments to call each other.

(P 7: Female; 41 years, 5 years in practice)

Research question 3: Describe how these views and preferences influence the uptake of a role as facilitator of GPs' learning.

These two continuums (sharing of knowledge and care focus) were subsequently used to define four styles of behavior: the clinical expert-, the buddy-, the coaching- and the mediator-style. This is shown in Fig. 1. Each of these styles represent a combination of behaviors as typical features of the combination of two of the endings of the described continuums. Each style however can be represented by nurses in different ways, depending on selected features being more prominent than others.

- The clinical expert-style

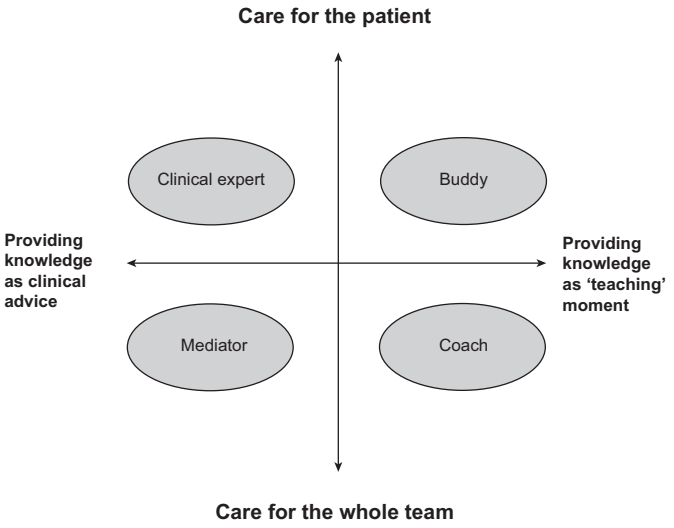

Fig. 1. Typology of PHCT nurses' practice behavioral style.

Nurses with the clinical expert-style feel most comfortable when there is 'something to do'. With their efficient and practical approach of problems, they readily take action.

> 'I think that's just it. We are very practice-oriented. We like to see immediate results when we arrive somewhere. Especially in the medical domain. For the social and psychological aspect we can... but we do have to intervene in the medical field hum!'
>
> (P 5: Female; 56 years; 15 years in practice)

They are eager to be seen as the expert and as such they fear negative comments on any of their actions losing the argument during a discussion. Being the advocate of the patient, they zealously deliberate and discuss patient care matters with other professionals. They value a good working relationship with the GP but do not hesitate to confront when quality of care is at stake. In their view every team member takes responsibilities according to their expertise. They will advise others when asked to but have no intention of taking up the 'teacher role'.

> I: 'Did you go through the guidelines together with the GP?'
>
> N: 'No, I had him on the phone and I just referred him to the website of the guidelines'
>
> (P 14: Female; 45 years; 12 years in practice)

- The buddy-style

A nurse with the buddy-style is perceived as a gentle person. His preferred way of caring for the patient is to work 'hand in hand' with other team members, joining knowledge and skills.

> 'I try to engage community nurses actively! When I'm discussing something with ... (name of the community nurse) then he says: 'Will you call the GP or should I?' And then I let him handle the call because he knows the situation best and afterwards it's so nice to talk things over and exchange things.'
>
> (P 13: Female; 42 years, 1,5 years in practice)

As such he will easily advise others whenever needed or asked for. Contesting the GP's treatment plans makes him feel uncomfortable. Therefore he looks for guidelines to support his opinion or to substantiate it by mentioning the team's expertise. Acting as a teacher is done rather implicitly by 'thinking aloud' during decision making, thereby evoking joint reflection with the GP. A typical think-aloud question is: 'Are we doing well?'.

> 'There was this doctor, who was really involved and we were with one of his patients and he said to me 'I really don't know what I should do right now.' And then together, yes, 'what do we have?' and 'what is the social context?' and 'what's the position of the son?' and finally we decide to install a syringe driver. We didn't put much into it but ... then there really was peace.'
>
> (P 15: Female; 49 years; 12 years in practice)

- The coach-style

The nurse with a coach-style behavior is characterized by a cautious and respectful attitude toward others. One of his main interests is the continuous growth and well-being of all team members. He stimulates and encourages all caregivers involved to take up their responsibility and practice their expertise. He accepts and explores others' knowledge gaps.

> 'Then you feel that he's (the GP) open to take a step into the unknown. Concerning the rise of the morphine dose, I observe that GPs are somewhat hesitant, or some GPs very hesitant. it surprises me sometimes. Then I think 'hey, you have all the signs here, let's adjust the pain medication.'
>
> (P 2: Female; 51 years; 1.5 years in practice)

Even 'teaching' is done cautiously by giving hints and cues rather than explaining or correcting the problem. Gaining knowledge and new expertise from other team members is considered a voluntary process: no one is forced, achievements are applauded. Coach-nurses do not like to contradict others.

> 'I'm mostly afraid of getting a wrong answer from them, or that they have a completely different idea of morphine for instance and that I'll have to say 'no it's wrong, it's not like that.''
>
> (P 3: Female; 34 years, 5 years in practice)

- The mediator-style

A nurse with a mediator-style has a down-to-earth and analytic way of looking at patient care. Team meetings as well as occasional contacts with other professionals are well-prepared. Taking care of team members is regarded as part of the job. This also involves being the liaison between GPs and other professionals during practice coordination as well as taking initiatives to handle team conflicts.

> 'Well I think, well yes, I just think it's important, and it has to, the collaboration of the community nurse, our team and the GP, it should run like clockwork. We really should work as a team. So it's important that nurses report to us, that we could be the mediator with the GP if that's the heavy part.'
>
> (P 14: Female; 45 years; 12 years in practice)

Mediator-nurses restrict themselves in giving advice, out of respect of others' expertise and actions taking up teaching opportunities is done when there are no risks of harming interprofessional relationships and if there is a reasonable chance to succeed.

'I think, coaching GPs, well, if at least they would accept it, but you know, they're hardly open to advice', let alone being coached!'

(P 16: Male; 50 years; 2 years in practice)

Contextual variables influencing nurses' behavior. Next to nurses' personal preferences, some contextual variables (e.g. the patient's actual needs and the GPs' attitude toward collaboration) also affected nurses' professional practice behavior. As a result, nurses were able to deviate from their personal preferred behavior and act differently if circumstances required it.

'With those GPs it's different, yes it is. They delimit themselves. You can feel that, they clearly show you 'ho, hum, you're trespassing', then you know that you can't go any further, then you, yes, you look for other ways (of communicating).'

(P3: Female; 34 years, 5 years in practice)

4. Discussion and conclusion

4.1. Discussion

The strong focus on quality of patient care, identifiable among all participants, is a well-known aspect of the nurses' profession. Graduating nurses, early career nurses and experienced nurses have been shown to share this focus as their core business [25–27]. Our study shows that even highly specialized nurses with a specific task (supporting and advising other health care professionals) keep valuing this objective.

In answer to the first research question, analysis reveals how the preferences toward sharing knowledge and expertise diverged among the participants. Some regarded their knowledge and expertise as a professional tool in the execution of their job and made little efforts to disseminate it through 'teaching' or 'educating' GPs. Some nurses saw it as part of their job to 'teach others' and to facilitate others' learning by sharing their expertise. Weidman described the 'desire to teach' as a necessary characteristic for turning a clinical nurse into a nurse educator, although their study was situated in faculty development and not in the workplace [28]. Literature on workplace learning indicates that sharing and dissemination of knowledge and expertise during practice facilitates learning [29,30]. This could mean that nurses who were 'willing to share knowledge' were more prone to adopt the facilitator's role than others.

In answer to the second research question we found a range of preferences, stretching from caring mostly for the patient on one end to caring mostly for the whole team on the other end. Nurses who are almost completely focused on the patient do not hesitate to challenge the GP when views on patient care diverge. Others invest more in the relationship with the GP, reasoning that in the long run a good professional relationship may benefit future patients. Literature clearly states that interprofessional relationships are important for effective teamwork to deliver high quality patient care [5,23,24]. In teams with good interprofessional relationships, views on patient care and shared care goals can be discussed and are a basis for shared learning [25].

In answer to the third research question, we found that nurses' preferences toward both themes described above affect their professional behavior. The broad spectrum of professional behavior and attitudes could be grouped into four general behavioral styles. This typology of practice behavioral styles, emerging from our data, is a new way of looking at the nurse–physician interaction. Each group has its preferences toward the two main themes and displays a specific conduct toward the facilitation of GPs' workplace learning. Nurses can adapt their professional behavior, and steer along the main axes, according to contextual demands. Despite their natural tendencies toward a certain position on both continuums, nurses navigate along the lines according to situational demands (e.g. other professionals' behavior, patient needs) in order to deliver the best possible patient care since this remains their core business and point of interest. Adopting a new task or role, like we asked our participants to do during the training may require a change of style away from their natural tendencies. Care is needed when the new role is far removed from their actual professional identity. This role transition may therefore be too difficult for some nurses [29,31,32]. This may explain the accounts of some nurses (e.g. the 'clinical experts' types) of having difficulties adopting the role of a facilitator of GP's learning.

The four styles account for differences in the nurses' behavior toward the teaching/learning aspect of collaboration. Some prefer not to take the teacher's stance (e.g. the 'clinical expert-style') but to restrict to giving advice. The 'buddy-style' shows an implicit intention to teach, namely through reflection, together with the GP. The 'coach-style' on the other hand explicitly displays the willingness to teach. Teaching is not a natural byproduct of clinical expertise but requires a skill set of its own [31,33].

A nurse may be excellent as a clinical expert but a novice in teaching and education [34]. It is a pitfall to think that experts in one domain (e.g. clinical experts) automatically have expertise in another domain (e.g. teaching). Giving a new role/responsibility to a professional demands careful mentoring of the process from novice to expert [29,31,32,35]. Our study adds to this a typology of styles showing different ways of coping with the challenge of the new role as an educator. This may instruct mentors on personalizing the process.

Strengths and limitations: literature describes the role and the characteristics of preceptorship/mentorship in nursing and in medical education but always between mentor and mentee of the same profession [36,37]. The strength of our study is to add insights on views and preferences toward interdisciplinary mentoring. A limitation of our study is that we do not know the effect of different styles on GPs' learning. Therefore we can only ask for care and respect toward the nurses during their role transition but we cannot promote one style or the other. Although our results are sustained by literature, they might not be generalizable to countries with a different organization of palliative care.

4.2. Conclusion

Training PHCT nurses as facilitator of GPs' workplace learning is feasible. Preferences toward sharing knowledge and toward the focus of care (just the patient or the whole team) leads to different behavioral styles. Nurses have personal preferences toward one of the styles but shift between them according to the circumstances (e.g. actual patient care needs and GP's attitude).

4.3. Practice implications

Nurses have different behavioral styles during interprofessional collaboration. Asking clinical nurses to become a facilitator of other professionals' learning might include a change of style. A change of style requires personal mentoring during this transition.

Further research is needed to evaluate the best way to mentor nurses in their role transition and to study the effect of the different behavioral styles on GPs' learning.

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Conflicts of interest

No conflicts reported.

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