Interprofessional Rhetoric and Operational Realities: An Ethnographic Study of Rounds in Four Intensive Care Units

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Introduction: Interprofessionalism – the idea that patient care is best delivered through collaboration among the professions – has gained prominence over the past few decades as evidence of its positive impact on care outcomes has grown. Interprofessional rounds (IPRs) are now a key strategy to improve collaboration in healthcare, and often serve as the main locus of interprofessional education in graduate medical education. In the four intensive care units (ICUs) we studied, IPRs aimed to improve patient outcomes by inviting heterogeneous groups of clinical professionals to discuss care plans in different units, yet they were peppered with conflict.

Methods: Our comparative ethnographic study of interprofessional collaboration and patient and family involvement in four intensive care units (see Paradis et al. 2014) sought to explain this conflict. Data were collected over one year in four tertiary academic hospitals in two American cities. The study included 576 hours of observation of team interactions, 47 shadowing sessions and 40 clinician interviews. In line with best practices in ethnographic research, data collection and analysis were done iteratively using the constant comparative method. Member check was conducted regularly throughout the project.

Results: IPRs were implemented on all units with the explicit goals of improving team-based and patient-centered care. Operational conditions on the units, despite interdisciplinary commitment and engagement, appeared to thwart ICU teams from achieving these goals. Specifically, time constraints, struggles over space, and conflicts between IPRs’ educational and care-plan-development functions all prevented teams from achieving collaboration and patient-involvement. Moreover, physicians’ de facto control of rounds often meant that they resembled medical rounds (their historical predecessors), and sidelined other providers’ contributions.

Discussion: Our study of morning interprofessional rounds adds to previous evidence of interprofessional conflict during rounds (Lingard et al., 2004). The IPRs model we have described isn’t well suited to the provision of team-based and patient-centered care for three main reasons. First, it required clinicians to accomplish more tasks with more players in less time and in the same physical space. Second, the organizational, teaching, professional and legal responsibilities of physicians allowed them to be the final arbiters of the form and content of IPRs, thereby reducing interprofessional collaboration. Third, IPRs did not appear to encourage patient involvement during rounds, and rarely included physical exams or care conversations with awake and alert patients.

Conclusion: The IPRs we observed were often indistinguishable from medical rounds: adding providers from the other professions had not transformed medical rounds into spaces that foster team-based, patient-centered care. New and empirically-tested models for rounds are urgently needed if we are to deliver on the promise of interprofessionalism while also optimizing clinicians’ time, the quality of medical education, and the care delivered to patients. In order to translate the principles of interprofessionalism into practice, we need to consider how healthcare providers enact it in situ.


Longitudinal qualitative study of medical students’ experience, motivation and attitudes towards participating in interdisciplinary teams providing hospitalized elders with preventive intervention and care

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Introduction: 45 undergraduate students participated in three years volunteer-based programme of preventive care for patients hospitalized at geriatric ward of university hospital. Giving care to elder patients within interdisciplinary teams (medical, nursing and psychology students) was accompanied with comprehensive practical and theoretical training, as well as regular supervision and psychological support. Longitudinal qualitative study was conducted to investigate students’ experience, motivation and attitudes towards their future medical profession, volunteer-based work, activity in interdisciplinary
teams, care-giving to elder patients, emotional burden and doctor-patient relationship. Change that happened in their experience, motivation and attitudes throughout the period (in most cases one or two semesters for a person) of participation in the programme was of our special interest.

**Methods:** Each participant was subjected to semi-structured interview twice – before and after the period of participation. First interview concerned motivation to participate in volunteer-based prevention programme at geriatric ward and more general motivation for future medical profession, attitudes and previous experience with voluntary service as well as relationships and giving care to older people. They were also asked about their expectations and concerns about the beginning of participation in the programme. During the second interview they were again asked about their motivation and attitudes towards the volunteer-based work and their experiences of giving care to older people at the hospital ward. They were also interviewed about their activity in interdisciplinary teams and doctor-patient relationships. Other topics appearing in the process of interview, e.g. frequent theme of own identity as medical professional, were also very welcomed. Interviews were audiotaped and fully transcribed. Obtained data were qualitatively analysed in Interpretative Phenomenological Approach with the assistance of Atlas.ti software. Informed consent was given by each participant.

**Results:** As a result we obtained rich idiographic descriptions of complex and subjective individual experiences and attitudes towards different aspects of participation in interdisciplinary teams providing hospitalized elders with preventive intervention and care. We also had an opportunity to observe personal change that happened in most subjects throughout the period of participation in the programme, especially in the area of subjective motivation and attitudes towards their future medical profession, e.g. their future specialisation. Secondary, nomothetic analyses allowed to observe variety of motivations underlying the participation in the project and, more generally, the choice of medical profession. We were also able to notice some interrelations between the type of motivation and the way of coping with difficulties present during the work on geriatric ward.

**Discussion:** Significant change in attitudes toward other medical professions (e.g. reformulation of mutual stereotypes) happened in the process of work in interdisciplinarian teams. Participants reported positive effects of regular training, supervision and psychological support on emotional burden connected with giving care to patients hospitalized at geriatric ward.

**Conclusion:** Practical training of care-giving and doctor-patient relationship on geriatric ward accompanied with supervision, psychological support and possibility to freely and deeply discuss own values and professional identity are key factors to prevent excessive emotional burden for future medical professionals.

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**#8E3 (126722)**

**Interdisciplinarity: Reality or fantasy? The experience of social scientists and humanities scholars working in Canadian faculties of medicine**

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**Introduction:** The academic background of the workforce of faculties of medicine has changed in the past decades: an increasing number of faculty members from medical education and other areas come from the social sciences and humanities (SSH). In Canada, interdisciplinary policies seem to have hastened this change. We sought to investigate how SSH faculty are integrated in their academic medical research environment. Three questions guided our investigation: How do SSH scholars adapt to the medical research environment? How do they navigate their career within a culture that may be inconsistent with their own? What strategies do they use to gain legitimacy?

**Methods:** Twenty-nine semi-structured interviews were conducted with SSH scholars working in 11 Faculties of Medicine across Canada. Participants were selected through purposeful and snowball sampling. Participants’ resumes and publications were reviewed prior to interviews. Interviews were audio-recorded and lasted between 60 and 90 minutes. Follow-up interviews were conducted as needed. The interview script addressed several aspects of the definition of legitimate research, the evaluation criteria used in faculties of medicine and participants’ career satisfaction. The data were analyzed by thematic content analysis.

**Results:** For most of our participants, moving into medicine has been a challenging experience, as their research practices and views of academic excellence collided with those of medicine. In order to achieve academic legitimacy, more than half of our participants altered their research practices. This resulted in a dissonance between their internalized appreciation of academic excellence and their new, altered, research practices. Only six participants experienced no form of challenge or dissonance after moving into medicine. Three others decided to break with their social science and humanities past and make the medical research community their new home.

**Discussion:** The results of our study show that the promise of inclusiveness at the heart of interdisciplinary research policies has yet to materialize for many social science and humanities scholars working in faculties of medicine in Canada. We argue that this challenging situation results, at least in part, from the decoupling between research policies favouring interdisciplinarity—which disrupt the stability of the medical research field—, and the enduring epistemic habits of biomedical scientists—the inertia of which impedes SSH scholars’ successful integration in medicine.
**Conclusion:** Most participants had to modify their research practices to gain recognition from their biomedical colleagues, which indicates the low value assigned to their research practices. In order for SSH scholars to fully participate in the health knowledge production enterprise, including medical education, faculties of medicine in Canada should develop a better awareness that various criteria are needed to fairly assess works from various disciplines. Leaving it to SSH scholars to alter their practice to meet the medical doxa contradicts the principles behind interdisciplinarity: that experts from different disciplines collaborate to create better solutions to enduring problems.

#8E4 (127577)

“*It’s making contacts*”: Notions of social capital and their implications for medical selection and education

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**Introduction:** Low economic and/or social position relative to others is typically the underlying issue for groups targeted for increased representation within medicine. In the UK widening access (WA) to medicine reflects under-representation from lower socio-economic groups despite numerous initiatives linked to a political rhetoric of inclusive education. This is compounded by a discourse that portrays WA applicants and students as lacking the essential skills or attributes to be successful in medical education. Whether or not this is the case is currently poorly understood as much of the research to date has been weak. However, it is critical to know how WA applicants and students negotiate medical admissions and education as only by understanding this can we inform change.

**Methods:** In an effort to address this gap, and working from an interpretivist perspective, that there are multiple realities because meaning is grounded in experience and reality is context-dependent, we drew on data collected using qualitative approaches. We combined data from three qualitative studies of student experiences of WA to medicine (48 participants in total). Using this amalgamated, larger dataset we inductively analysed the findings using social capital as a theoretical lens to better understand student journeys in medical education.

**Results:** We inductively created, and clustered, codes into categories informed by the concepts of “weak ties” (Granovetter, 1973) and “bridging and linking capital” (e.g., Putnam, 2000). We identified three main themes: on lacking the necessary contacts or resources; on social capital, widening access initiatives and other sources of information; and on knowing what is important. Our data illustrates that WA medical school applicants recognise and mobilise weak ties to create linking capital but, once in medical school, students seem less aware of the need for, or how to create, capital effectively.

**Discussion:** Our data provides evidence of significant disadvantage for some students from lower socio-economic groups either within their applications and/or during their undergraduate studies. Raising awareness of this is important as medical schools with their inherent preference for meritocracy may not recognise such inequality. Applying a social capital lens to our secondary analysis of a larger amalgamated dataset has enabled us to think in a more nuanced way about the types of social capital and how possessing social capital facilitates access to valuable information and resources for both medical applicants and students.

**Conclusion:** WA efforts could be well-served by activities that support increasing the social capital of under-represented students, and future selection policy needs to take into account the varying social capital of students, so as to not overtly disadvantage some social groups.