

Implementing interprofessional bedside rounding at the prequalification stage

Daniel R Tuite¹
David Healy¹
Thomas S MacKinnon²

¹Faculty of Medicine, Brighton and Sussex Medical School, Brighton,

²School of Medicine, Imperial College London, London, UK

Dear editor

We read with great interest the paper by Henkin et al,¹ demonstrating that the use of interprofessional bedside rounding (IBR) significantly improved nurse–physician teamwork, particularly from the nurses’ point of view. This finding is relevant when one takes into account the importance of interdisciplinary teamwork; a review conducted by Epstein concluded that effective interprofessional teamwork both maximizes patient safety and increases job satisfaction and efficiency.² We, as medical students, believe that inadequate emphasis is placed on interprofessional collaboration at the prequalification phase, and therefore, we suggest that implementing IBR at the university level could represent a method to improve teamwork between the nurses and doctors of the future.

The lack of a significant improvement in Safety Attitudes Questionnaire (SAQ) scores of doctors following IBR implementation in Henkin et al’s study suggested that physicians’ teamwork benefited less from the exercise than that of nurses. While the reasons for this may be multifactorial, it is possible that this attitudinal disparity relates to hierarchical differences.³ We additionally suggest that these discrepancies in baseline attitude may, in part, be due to an “us and them” mindset already ingrained in both parties at the point of qualification.

Leipzig et al demonstrated that senior doctors within a multidisciplinary team were less positively inclined toward interdisciplinary teamwork;⁴ however, there is evidence to suggest that this perception is, in fact, deeply embedded at an earlier stage, with a study indicating that negative perceptions of nurses can exist among medical students as early as their first year of study.⁵ Interestingly, Carpenter has shown that programs which promote early teamwork between different health care professions are successful in diminishing stereotypes.⁶ Therefore, in order to pursue an improvement in interprofessional practice, we believe that it may be preferable to implement interventions such as IBR before qualification. Furthermore, it could be an effective method of encouraging a culture of inclusivity and respect in health care students and, as a result, could optimize the efficacy of the multidisciplinary team.

We acknowledge that integrated teaching does already exist at many UK medical and nursing schools. Yet, from our experience as student doctors, although our “shared learning” sessions were useful in introducing us to nursing students in a classroom context, these were limited at promoting a sense of integration and teamwork within a clinical setting. This is consistent with a report by Horsburgh et al stating that “shared

Correspondence: Daniel Tuite
Audrey Emerton Building, Brighton and Sussex Medical School, Eastern Road, Brighton, BN2 0AE, UK
Email D.Tuite1@uni.bsms.ac.uk

learning” may be ineffective, suggesting instead that “inter-professional clinical learning” such as IBR allows students to acquire clinical knowledge and understand the complexities of a multiprofessional environment.⁷

Although in the UK it is a General Medical Council requirement for medical schools to provide opportunities “to work and learn with other health and social care professionals and students to support interprofessional multidisciplinary working”,⁸ there is currently no universal framework in place indicating how these opportunities for interprofessional engagement should be delivered. However, Bridges et al identify “didactic, community and clinical teaching” as the core components of medical education,⁹ with IBR representing a clinical method of bringing together nursing and medical students, while providing a true-to-life example of interprofessional practice.

Indeed, there would be challenges to the implementation of student IBR. The educational needs of nursing and medical students differ, and as such, tailoring a teaching ward round to suit both would require consideration. This also poses questions as to which professional would lead the teaching. Furthermore, grouping of students may lead to overcrowding, which may be uncomfortable for patients and inefficient for the progression of the round. A possible solution could involve the creation of supplementary ward rounds for educational purposes.

A pilot study commencing with a small cohort of nursing and medical students would be useful in establishing the feasibility of student IBR. Methodology akin to that of Henkin et al’s trial, combined with the use of Parsell and Bligh’s Readiness for Interprofessional Learning Survey,^{1,10} could enable measurement of changes in interprofessional teamwork. Also, a survey of patients present would be important to assess their perspective.

In summary, we feel that IBR, at a student level, could represent a beneficial and clinically applicable method to cultivate interdisciplinary collaboration at an early stage. By nurturing and sharing a more cooperative mentality in their early training years, future doctors and nurses are more likely to work “together” rather than “alongside” each other, ultimately resulting in better patient care.

Disclosure

The authors report no conflicts of interest in this communication.

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