

Short Report—The MDT Speed Date

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Abstract

The importance of introducing both interprofessional education (IPE) and familiarity with the wider multidisciplinary team (MDT) roles cannot be underestimated in the undergraduate medical curriculum. This short report outlines an innovative method of teaching medical students about the role of the MDT in holistic patient management by way of a simulation “speed-date” and MDT meeting.

Keywords

Interprofessional Education, Multidisciplinary Team, Simulation

1. Introduction

Interprofessional Education (IPE) has been defined by the Centre for Advancement of Interprofessional Education (CAIPE) as occurring when “two or more professions learn with, from and about each other to improve collaboration and quality of care” (CAIPE, 2006). CAIPE’s vision of effective IPE is summarised in seven principles including focusing upon the needs of the service users and respecting the integrity and contribution of each profession.

According to Freeth (2011), suggested models of formal IPE (as opposed to informal IPE where members from different disciplines are learning alongside each other in the clinical environment) include simulation. Simulation has been proposed as a technique to bridge the educational gap between the classroom and the clinical environment (Okuda et al., 2009). It provides a safe learning environment that protects patients and learners, and has also been shown to be a reliable tool for teaching topics such as teamwork and communication (Freeth, 2011, Okuda et al., 2009).

Medical students experiencing Primary Care in the broader sense, with more multidisciplinary team (MDT) working, keeps in step with newer models of de-

livery of care and is direction of development in UK Primary Healthcare. Freeth (2011) states that “healthcare is delivered by multidisciplinary teams so inter-professional practice is inevitable”. By introducing IPE in their “middle years”, students have begun to build a relatively secure technical knowledge base relating to their own profession, but also have begun to appreciate the complexities of communication skills, teamwork, decision making and working in partnership with patients and carers (Freeth, 2011). Furthermore, studies of IPE at a pre-registration level have demonstrated a development of positive perceptions of members of other professions, and that rehearsing interprofessional teamwork is valued (Dienst & Byl, 1981; Cooke et al., 2003; Carpenter, 1995; Mires et al., 2001).

A reorganisation of the undergraduate primary care curriculum at our medical school raised the opportunity to develop central medical school teaching around MDT working, and our aim was to give students an increased awareness of the different roles that individual MDT members lead on in regards to patient care, and for students to have an immersive simulated experience in regards to an MDT meeting.

There was also the unique opportunity to work with a local specialist GP practice that only registered patients from the local area with five or more chronic conditions. This specialist practice had been developed as part of a Prime Minister’s Challenge Fund to improve access to General Practice and stimulate innovative ways of providing primary care services (NHSE, 2015), and as such, the practice directly employed a full MDT solely for its approximately 500 patients.

2. Methods

Third year medical students, all in their first year of full clinical study, took part in the activity as part of a half day pilot of teaching activities about MDT working. For this particular activity, a total of 16 participants were involved and divided into four equal sized groups. The pilot session began with MDT members from the practice, a community pharmacist, a social worker, an occupational therapist and a nurse-giving student a brief summary about their principal role in patient care. Following this, each student group were given a different printed patient summary that included information about a patient’s long-term conditions, their current medications and information about their three most recent contacts with the practice. Each group of students was also given the outline of the acute problem that their patient had presented to their GP with at that time.

Students were then advised that they would be given five minutes in turn with the four different members of the MDT, and at the end of the “speed date”, they would be asked to prepare and feed back to the MDT members a holistic care plan at an MDT “meeting” with the medical students in the role of the GP.

The patients used in the pilot were based upon four patients at the specialist practice described above, although all identifiable features of the patients had been either removed or anonymised, and patients clinical details had been

adapted. Permission to use anonymised patient information had been gained from the original patients prior to the pilot activity.

The MDT members who attended the pilot were all staff at the specialist practice described above and familiar with the original patients that were the basis for the patients used in the scenarios. Prior to the activity, MDT members had been advised not to discuss any identifiable features of the original patients in the discussions with the students.

Unbeknown to the students, two of the patients in the summaries were husband and wife, whose individual clinical problems were having a negative impact upon each other's health. Prior to the pilot activity, the MDT members were also advised not to divulge the information that two of the patients in the scenarios were connected in this way.

After the speed date, students were then given thirty minutes to write up a holistic action plan for their patient to present back to fellow students and the MDT members in a simulated meeting. It was only during the presentation of the second spouse member of the "patient couple" did the students realise that their patients were living in the same household, and there was then a further spontaneous discussion between the students about how each individual patient plan would require adaptation to reflect this. The whole session, including a short break and end of session questionnaire evaluation, lasted just under two hours.

The anonymised questionnaire was administered in paper format at the end of the session. The first question gave the students ten different describing words (including "practical", "tedious", "relevant", "enjoyable", "boring") and they were invited to circle as many words as they felt related to the session. There were then two free text questions-the first asked to list three things that they had learnt in the session, and the second question asked students to list up to three suggestions for improvements to the session.

3. Results

All students described the activity as one or more of practical, relevant or useful. Free text feedback included positive comments about learning about the role of different members of the MDT and gaining an understanding of different team members "focus" in patient care. One student commented upon the value of having the "real voice" of MDT members present for the activity. Informal discussion with MDT members after the session elicited a high rate of satisfaction with the session and commented upon both the student engagement and how the actions plans produced were comparable to those in practice in terms of their holistic and pragmatic nature.

4. Discussion

The MDT speed date was well received by both students and MDT members, and feedback reflected successful achievement of the aims of the activity. Since

professional practice is interprofessional, Freeth (2011) argues that it “makes sense” for some simulation-based education to be interprofessional. A key aspect of effective IPE design is perceived relevance of the activity, appealing to the shared interest in delivering good care to patients as the object of that shared interest (Freeth, 2011; Engestrom, 1999). Using patient cases in the pilot aligns to this strategy. Specifically to Primary Care, IPE has been shown to help practitioners resolve complex issues with clients and their ability to utilise other resources (Larivaara & Taanila, 2018), so for medical students to have an IPE activity during a Primary Care attachment that simulates a skill that would be required of them in the workplace further justifies its place in the undergraduate curriculum. In their meta analysis of the effectiveness of IPE in healthcare education, Gurya and Barr summarise that “the real essence of IPE at the undergraduate level springs from the fact that students are trained to learn with, from, and about several professions from the start of their studies ... this will foster their understanding about the value and significance of other professions and ... empowers students in establishing effective working relationships” (Guraya & Barr, 2018).

This innovative format could potentially be used with different groups of undergraduate students (eg student nurses, pharmacists etc) with the same aim of participants gaining an understanding of effective MDT working. However, by definition, any IPE initiative requires involvement and participation of multiple disciplines, so faculty members from these programs must be “on board” (Lash et al., 2014).

However, the pilot in this specific format proves logistically problematic to scale up to the larger student cohort (now a minimum 270 medical students in a one academic year group). There would need to be in multiple repeats of small group sessions that would require availability of suitably trained MDT members. Taking actively working MDT members out of their clinical time for education may also have a negative impact on patient care. The literature supports the argument that challenges experienced in implementing IPE activities include scheduling, logistics, and financial support (West et al., 2016).

Alternative strategies to the pilot to address the same aims include students playing the roles of the MDT member with a script, or students being supplied with either video or written scripts from other MDT members; both of these methods compromise the immersive nature and fidelity of the activity. However, it has been suggested that fidelity is less important than suspension of disbelief in terms of learning outcome (Hamstra et al., 2014). As undergraduate IPE is clearly acknowledged as “an investment in the future” (Freeth, 2011), the alternative methods outlined above are both worth considering going forward if they are well received by students and so move towards the CAIPE vision of effective IPE.

Future research in this area includes rolling out the programme to other professional undergraduate groups and running the “speed dates” and MDT meeting simulations using the alternative strategies outlined above, and seeing if sim-

ilar high levels of student satisfaction and perceived relevance are maintained. Other aligned research topics include gaining a deeper understanding of local faculty drivers and barriers to effective implementation of IPE at undergraduate level, and formal qualitative analysis of MDT members analysis of the pilot format.

5. Conclusion

This innovative and creative simulation pilot gave medical students the opportunity to learn about the role of different MDT members first-hand and how these different professions come together as a team to provide best care for the patient. Going forward, this pilot will form the basis of other small group work with similar educational aims, although for practical reasons, the format will most likely be adapted to a less high fidelity format. Whatever format that teaching takes, the focus will remain the care of the patient, with the ongoing aim of effective IPE delivery to undergraduates as an investment in the future workforce.

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References

- CAIPE (2006). CAIPE Re-Issues Its Statement on the Definition and Principles of Inter-professional Education. *CAIPE Bulletin*, 26, 3.
- Carpenter, J. (1995). Interprofessional Education for Medical and Nursing Students: Evaluation of a Programme. *Medical Education*, 29, 265-272. <https://doi.org/10.1111/j.1365-2923.1995.tb02847.x>
- Cooke, S., Chew-Graham, C. A., Boggis, C., & Wakefield, A. B. (2003). I Never Realised That Doctors Were into Feelings Too: Changing Student Perceptions through Inter-professional Education. *Learning in Health and Social Care*, 2, 137-146. <https://doi.org/10.1046/j.1473-6861.2003.00050.x>
- Dienst, E. R., & Byl, N. (1981). Evaluation of an Educational Program in Health Care Teams. *Journal of Community Health*, 6, 282-298. <https://doi.org/10.1007/BF01324005>
- Freeth, D. (2011). Interprofessional Education. In T. Swanwick (Ed.), *Understanding Medical Education: Evidence, Theory and Practice* (2nd Edition, pp. 81-96). Chichester: Wiley Blackwell.
- Guraya, S. Y., & Barr, H. (2018). The Effectiveness of Interprofessional Education in Healthcare: A Systematic Review and Meta-Analysis. *Kaohsiung Journal of Medical Sciences*, 34, 160-165. <https://doi.org/10.1016/j.kjms.2017.12.009>
- Hamstra, S. J., Brydges, R., Hatala, R., Zendejas, B., & Cook, D. A. (2014). Reconsidering Fidelity in Simulation-Based Training. *Academic Medicine*, 89, 387-392. <https://doi.org/10.1097/ACM.0000000000000130>
- Lash, D., Barnett, M., Parekh, N., Shieh, A., Louie, M. C., & Tang, T. (2014). Perceived Benefits and Challenges of Interprofessional Education Based on a Multidisciplinary Faculty Member Survey. *American Journal of Pharmaceutical Education*, 78, 180.

<https://doi.org/10.5688/ajpe7810180>

NHS England (2015). *Prime Minister's Challenge Fund: Improving Access to General Practice*. First Evaluation Report.

<https://www.england.nhs.uk/wp-content/uploads/2015/10/pmcf-wv-one-eval-report.pdf>

Okuda, Y., Bryson, E. O., DeMaria Jr., S., et al. (2009). The Utility of Simulation in Medical Education: What Is the Evidence? *Mount Sinai Journal of Medicine*, 76, 330-343.

<https://doi.org/10.1002/msj.20127>

West, C., Graham, L., Palmer, R. T., et al. (2016). Implementation of Interprofessional Education (IPE) in 16 U.S. Medical Schools: Common Practices, Barriers and Facilitators. *Journal of Interprofessional Education and Practice*, 4, 41-49.

<https://doi.org/10.1016/j.xjep.2016.05.002>