Professionalism And Dental Practice: The Importance of Good Communication

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**Background:** Effective communication is recognised as a core element of professional dental care. It is one of the nine principles laid out by The General Dental Council's (GDC) *Standards for the Dental Team*. The same standards also identify poor communication as a common factor in formal complaints. The importance of communication was reflected in our mixed-methods study of professionalism in dentistry involving participants from the dental team and members of the public. The study was commissioned by the GDC and led by the Association for Dental Education in Europe. Here we focus on the findings from the focus groups exploring understandings of professionalism in the context of dental care. The views and opinions expressed are those of the authors and do not necessarily reflect those of the GDC.

**Method:** We conducted a total of eight focus groups discussions of professionalism in dentistry: 4 with dentists (19 participants in total), 3 with members of the public (19 participants), and 1 with dental care professionals (DCPs) (13 participants). The dentists ranged from newly qualified to established dentists. The DCP group included eight dental nurses, two hygienist/therapists and two dental technicians. The public participants ranged in age from 20 to over 60. Some reported attending dental practices as private patients, others as NHS patients. Focus groups were conducted in late 2019 in three locations in England and Wales. We carried out a thematic content analysis of the anonymised transcripts using NVivo Pro12.

**Results:** Professionalism is a complex concept which is variously interpreted. The quality of communication was one key theme identified as affecting how the professionalism of the dental practitioner was judged. Although all three groups agreed that communication between the patient and the dental team is one of the most important factors determining the quality of interaction, there were differences in focus and how the issues were framed. The public groups referred to dental practice receptionists several times, often in the context of communication. In contrast, there was no mention of receptionists in the dentist and DCP groups. The public groups wanted to be addressed politely, put at ease, and kept informed about their dental care, treatment options and costs. The dentist groups recognised judgment was needed to determine what information to provide and too much information could deter patients from necessary treatment. Dentists also discussed whether good communication skills are inherent or can be taught. The DCP groups highlighted the importance of teamwork and how poor communication from one member of a team can be compensated by other team members. While some dentists argued that dental nurses should not be held to the same standards of professionalism as dentists, the DCP groups expressed a desire to meet the same high standards of professionalism.

**Implications:** Dental professionals and patients agree that communication is at the core of professionalism. However, there are differing views on what ‘good’ and ‘poor’ communication consists of, and who is responsible for ensuring a smooth interaction. We argue for the importance of educational initiatives (at undergraduate level and continuing professional development) focused on communication skills and teamwork. We believe such initiatives could further enhance relationships between dental professionals and the public and positively impact on their perceptions of the professionalism of the dental team. Such communication training needs also to address any scepticism surrounding the teaching and learning of communication skills.

**References:**


Jane Ferguson¹, Abigail Tazzyman², Kieran Walshe³, Marie Bryce⁴, Alan Boyd³, Julian Archer⁵, Tristan Price⁴, John Tredinnick-Rowe⁶

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Background: Locum doctors can be perceived as less than in comparison to other healthcare professionals. Less than in terms of safety, professionalism, ethics, and trust.¹ Consequently, locums are more likely to be complained about and reported to the General Medical Council by patients and other healthcare professionals.² These perceptions persist despite limited evidence to substantiate quality and safety differences between locums and permanently employed doctors; a review of the evidence suggests that the way in which organisations deploy and support locums also has a bearing on the quality and safety of locum practice.¹ However, the role of the organisation in ensuring quality and safety is not generally acknowledged in the rhetoric around locums. The aim of this research was to explore the experiences and perceptions of locum doctors from the perspectives of locums and those who work with them and to examine the implications for locum identity, group relations and patient safety.

Methods: Qualitative semi-structured interviews were conducted between 2015 and 2017 in England with 79 participants including locum doctors, locum agency staff, and representatives of healthcare organisations with governance and recruitment responsibilities for locums. An abductive approach to analysis combined inductive coding with deductive and theory driven interpretation. Taking a combined iterative and theoretical approach to analysis ensured that our interpretations were not restricted by theory³ but rather that theories⁴-⁶ were used in an exploratory way to make sense of our findings.

Results: Locums were not considered employees in the organisation; consequently, the professional needs of locums were not thought to be the responsibility of the organisations in which they worked and organisations took little responsibility for locum doctors. Locums were sometimes regarded as contractors who could be hired and fired at will and were there solely to undertake tasks as the organisation saw fit. Locums were generally excluded, implicitly or explicitly from governance, performance management systems and development processes and opportunities. Locums described exclusion from mandated regulatory processes for measuring, monitoring and managing medical performance, such as appraisal and audit, and were expected to source and fund their own development externally. Locum performance problems were sometimes dealt with by senior permanent NHS leaders by ‘getting rid of’ locums without addressing problems, meaning that the problems were likely to resurface elsewhere.

Implications: This transactional approach to contracting locums may be likely to increase risks to safety for organisations and the wider healthcare system. Excluding locums from professional development and governance structures and neglecting performance problems in the locum workforce may benefit local interests in the short term, but impact patient safety in the in the long run. Organisations should reflect on their use of locums and consider the impact not only for the locum, but also for patient safety more broadly.

Physician Associates in Wales

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Background: Developed in the 1960s in the US, the Physician Associate (PA) profession is still relatively new to the UK healthcare system and especially so for Wales. PAs are defined as “…medically trained, generalist healthcare professionals, who work alongside doctors and provide medical care as an integral part of the multidisciplinary team. PAs are dependent practitioners working with a dedicated medical supervisor, but are able to work autonomously with appropriate support.” They are trained to perform specific clinical tasks including taking a patient’s medical history, carrying out examinations; they see patients with undifferentiated diagnoses and analyse test results (Faculty of Physician Associates 2021).

As well as supporting doctors’ workload, PAs are seen as contributing to efficiency of care (Drennan et al 2019) and benefiting doctors and patients through enhancing the continuity of patient care (Williams and Ritsema 2014). Whilst there is a growing interest shown towards the role, PAs in some cases are met with some concern and uncertainty (BMA 2020).

The study aims to document newly qualified PAs’ experience, exploring how well the training and internships prepared them for practice, the impact of their role in terms of the contribution they make to the wider multidisciplinary team and service provision and patient responses to the role.

Method: This two-phase study adopts a mixed-methods design, using both qualitative and quantitative methods.

Phase one: PA case studies

Semi-structured interviews will be conducted with four case study PAs (two working in primary care and two in secondary care across two health boards in Wales) along with their immediate wider team (i.e. Consultants/GPs/Advanced Nurse Practitioners), management staff and their patients. Management staff working across the case study health boards will also be invited to complete an online questionnaire. Six months following their first interview PAs will be interviewed again.

Phase two: Survey of PAs in Wales

All PAs working across Wales will be invited to complete an online questionnaire distributed by email.

Piloting: All data collection processes and instruments will be piloted. Two PAs, one working in primary care and one in secondary care, will be interviewed along with one team member, member of management staff and patient. The questionnaire for PAs and management staff will also be piloted before wider distribution.

Results: Ethical approval is in place (ref: IRAS 274639). Results from the pilot stage of the study (to be carried out February 2021 to April 2021) will be analysed and included in the presentation. This will include early analysis and findings from the semi-structured interviews (conducted remotely due to Covid-19). Data will be thematically analysed using NVivo and participants anonymised.

Implications: This study is one of the first to explore the PA role in the context of Wales. Although data collection and analysis are ongoing, results from the pilot study will provide insight into the experiences of PAs working in Wales, their preparedness for practice and their teamworking and impact on patients and services in the context of challenges presented by the Covid-19 pandemic. The study will contribute to the evidence-based understanding of the PA role in terms of their impact, preparedness for practice and patient responses to the role.

References:


Qualitative Exploration of The Impact of Clinical Academic Activity Among Healthcare Professions Outside Medicine

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Presenting Author: Lisa Newington

Background: There are increasing opportunities for healthcare professionals to be involved in and lead clinical research. However, there are few roles for non-medical professions that include dedicated time for research. Non-medical professions include nursing, midwifery, allied health professions, pharmacy and psychology (NMAHPPs). In order to develop such roles, and evaluate effective use of research time, the range of impacts of clinical academic activity need to be valued and understood by healthcare leaders and managers.

Methods: This programme of work was designed to explore the nature and impacts of clinical academic activity and comprised a systematic review and interview study.

The systematic review examined the range of impacts that had been reported in the published and grey literature between 2000-2019. Screening, data extraction, quality appraisal and thematic analysis were all independently performed by two reviewers, following a pre-published protocol. Extracted data were mapped to the Visible ImpaCT Of Research (VICTOR) headings to form themes, and the content of each heading was summarised inductively from the extracted data to form sub-themes. The VICTOR framework was modified to include impacts to the clinical academics themselves.

Semi-structured interviews were conducted with 20 research-active NMAHPP clinicians and managers at a single NHS Trust. Interviews used a pre-piloted topic guide to explore individual experiences, and perceptions of clinical academic activity more broadly. Interview transcripts were analysed using the Framework Method to identify key themes and sub-themes within the data. Interviewees provided feedback on preliminary analyses and approved the final analysis.

Results: The systematic review identified 20 eligible articles. Reported impacts were mapped to seven VICTOR themes: patients; service provision and workforce; research profile, culture and capacity; economic; staff recruitment and retention; knowledge exchange; and clinical academics. Several overlapping sub-themes were identified, including the challenges and benefits of balancing clinical and academic roles, the creation and implementation of new evidence, and the development of collaborations and networks.

The content of the qualitative interviews was described in four main themes. What is a clinical academic described the perception of individuals who combined research, education and clinical care. However, there was no universally reported definition of clinical academic and there was disagreement over terminology. Visibility explored the positive reputation that clinical academics were believed to have for their institution, plus opposing reports of a lack of visibility outside their immediate clinical area. Clinical academics were associated with cultural changes that improved patient care and research awareness within their team. Finally, the impacts of the clinical academic pathway saw frustration with the requirement to apply for research funding at every stage, and concerns about discontinuity in both research and clinical services.

Implications: There was no clear definition of clinical academic either within the published literature or among interviewees within the same healthcare organisation. Agreement on this term would aid role development and evaluation, in addition to establishing a formal career pathway.

The modified VICTOR framework was a useful tool for mapping reported impacts of NMAHPP clinical academic activity, but beneath the general categories there was a complex picture of interlinking and overlapping attributes. These present key areas for organisations to explore when looking to support and increase clinical academic activity among NMAHPPs.

Interestingly, traditional impact metrics, such as publications/citations were viewed as a small component of the impact generated by these roles and may not capture the true value of this activity. However, impacts such as changes to patient care and research culture within an organisation, are difficult to measure. Impact capture for clinical NMAHPP research will require creativity to ensure that the emphasis is on value, rather than ease of data collection.
Supporting Health and Social Care Workforce Roles in The Adoption of Digital Technologies

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Background: The Wave 2 NHS Test Beds programme brought together NHS organisations and commercial providers of digital technologies. The Care City test bed planned to implement eight innovations for people with long-term conditions in East London, clustered around three specific staff roles to support implementation: domiciliary carers, healthcare assistants in primary care, and the cardiac rehabilitation team in an acute setting.

A key aim of the test bed was to develop the skills of these staff through their use and adoption of digital innovations and, thereby, improve experience and outcome for staff and service users, and alleviate workforce pressures in the long-term.

Method: We adopted a mixed-methods approach to assess both process and service outcomes, with a particular focus on the experiences of staff working with the innovations and the impact on their broader role. Following an initial literature review, a total of 87 semi-structured interviews were undertaken with the programme team, lead implementers in sites, innovators, implementing staff, and service users. We also undertook 16 participant and non-participant observations of training, engagement and co-design sessions. Our findings were analysed deductively based on the NASSS (non-adoption, abandonment, scale-up, spread and sustainability) framework.

Results: Staff engagement and development of new skills was achieved to varying extents across the three clusters. The domiciliary care cluster demonstrated the greatest evidence of workforce development, both among frontline ‘expert’ carers who developed a variety of skills, and also lead implementers who made use of project management skills to adapt the programmes to the specificity of their settings. Role development of healthcare assistants was inconsistent in primary care, although frontline staff that were involved with implementation did report the development of skills and knowledge.

The test bed evaluation showed that technology can support the development of skills in workforce roles and increase employee job satisfaction. Beyond the ability to use digital technologies, frontline workers in domiciliary care increased confidence to communicate complex information to healthcare professionals, improved their health literacy, and experienced better relationships and status with service users and their families. New skills enabled frontline workers to feel more empowered in their role. Workforce development was best achieved where appropriate infrastructure (training, supervision, established key relationships) accompanied implementation. This was crucial to ensuring care workers were not tasked with activities beyond their job remits or were exposed to stressful situations.

Implications: While staff are generally open to adopting digital innovations, adequate infrastructure and organisational leadership are essential to creating the right conditions to support the workforce and increase their confidence around use of technology. This includes training for all roles involved with implementation, supervision and support for frontline staff, and protected time for staff to undertake their enhanced roles. As the health and social care system presses ahead with the digitisation agenda, it will be important that the practical support, time, and resources are available, alongside alignment to workforce policy.

Technology can support the health and social care workforce without replacing it. Enhanced roles which create new opportunities will form an important part of the implementation of the NHS People Plan for health and a much-needed workforce plan for social care. It will be important to implement these within appropriate progression frameworks that reward skills development across pay levels, and recognise staff for the additional workload and responsibility that their enhanced role entails.
A Qualitative Exploration of How Junior Doctors and Registrars Respond to Uncertainty in The Emergency Department and The Factors They Perceive to Influence This.

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Background: Emergency departments are an increasingly pressured environment with high numbers of patient management decisions taking place. Such decisions are often characterised by risk, ambiguity and complexity. Whilst uncertainty relating to the complexity of practice or lack of knowledge can often be reduced, uncertainty due to unpredictable future outcomes or insufficient information is often irreducible. This means that whilst efforts made to reduce the uncertainty experienced by emergency physicians, such as by providing diagnostic decision tools, are vital, research informing interventions to support staff in tolerating this inevitable uncertainty and responding to it appropriately are also needed. Research suggests junior doctors have an increased tendency to admit patients in the face of uncertainty. Existing quantitative research has attributed this to doctors with less experience having a lower uncertainty tolerance than consultants, but this has not been explored qualitatively. The current study used an existing model of uncertainty tolerance, developed by Hillen et al. (2017), to explore how junior doctors and registrars experience uncertainty in the emergency department and the factors they perceive to influence this. It is hoped the factors identified, can support the development of interventions aimed at enhancing uncertainty tolerance amongst junior staff populations in emergency departments.

Method: Through purposive sampling, 14 junior doctors and registrars working in the Emergency Department of one NHS trust in the North of England were interviewed. Interviews centred on an admission decision and a discharge decision which were doubted in hindsight. Data were analysed using the framework method, allowing the data to be mapped onto the integrative model of uncertainty tolerance (Hillen et al., 2017) deductively, but also allowing highly populated categories of the model to be further refined or explored in depth.

Results: Uncertainty was responded to cognitively, emotionally and behaviourally. Such responses were dependent on individual characteristics of the doctor as well as organisational, social, cultural and patient factors. For example, attempts to reduce ambiguity made by the behavioural response of information seeking, were made less by doctors with more experience due to a difference in cognitive appraisal, where decisions were guided by gut instinct and the confidence instilled in this. This ability to seek information was also influenced by situational factors such as time of day, reducing the ability to contact specialists for medical opinions. As well as categorising the data, four meta-themes were identified, representing important relationships between themes.

Implications: There is a need for medical education and training to acknowledge uncertainty in order to promote positive coping strategies, steering away from promoting a culture of over-investigation and a 'one size fits all' approach to diagnostic investigation. It is also necessary for junior doctors to receive adequate feedback on the patient management decisions they make, increasing the exposure they get to seeing their gut instincts being confirmed, rather than being more likely to find out when decisions have contributed to adverse events. This has potential to speed up the process of developing a trust in gut instinct. Ultimately, a shift in culture where junior doctors are educated and concerned with managing uncertainty appropriately, equally as much as they are with establishing diagnoses, is required. Further research is needed to determine which of the factors identified should be prioritised for interventions to enhance uncertainty tolerance and also to establish which responses to uncertainty yield positive or negative patient safety outcomes.

The presentation in this conference would present an overview of themes generated, with two in detail, as well as discussion of the influencing factors and suggestions for practice.
Enhanced Health in Care Homes in the UK: The role of the Frailty Nurse

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Frailty Nurse roles were developed to support care homes to co-ordinate and enhance the quality of care of residents. This study aimed to explore the implementation process of the Enhanced Health for Care Homes (EHCH) framework, a proactive model of care (NHS, 2020), in one locality in the North of England, specifically focusing on the Frailty Nurse role. A qualitative method was employed, 28 semi-structured interviews were carried out at three care homes. Key stakeholders, frailty nurses, care staff and residents participated in this study. Study findings suggest that role expectations, trust and relationship building were all critical to Frailty Nurse role implementation. Despite a whole systems approach being undertaken, there were mixed interpretations of the remit of Frailty Nurses and stakeholders felt some confusion regarding the role. Within the context of this Enhanced Health in Care Homes framework, workforce availability issues necessitated a strategic decision to change the role to one of 'trainee' which further compounded confusion regarding role expectations, however this abated over time. Relationship building increased social capital and staff empowerment were the most distinct benefits of implementing the EHCH framework. These arose primarily through care home alignment; a key feature of the EHCH framework. Regular daily resident visits by Frailty Nurses also facilitated relationship building with care staff and families. This study illustrates that the introduction of roles which works in a dedicated way across care homes crosses, such as the ‘Frailty Nurse’ can facilitate enhancement of relationships by developing social capital, including trust and empowerment.
Physician Associate Impacts on Cancer Diagnosis in Primary Care: A Rapid Systematic Review

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Presenting Author: Jessica Sheringham

Background: Symptom recognition and timely referral in primary care are crucial for the early diagnosis of cancer. Physician assistants or associates (PAs) have been introduced in 15 healthcare systems across the world, with numbers increasing to address primary care physician shortages. Little is known about their impact on suspected cancer recognition and referral. This review sought to summarise findings from observational studies undertaken in high income countries on PAs’ competence and performance on processes concerned with the quality of recognition and referral of suspected cancer in primary care.

Method: A rapid systematic review of international peer-reviewed literature was performed (PROSPERO reference: CRD42019154114). Searches were undertaken on OVID, EMBASE, Web of Science, and CINAHL databases (2009-2019) supplemented by article alerts meeting inclusion criteria (up to September 2020). Studies were eligible if they reported on PA skills, processes and outcomes relevant to suspected cancer recognition and referral. Title and abstract screening was followed by full paper review and data extraction. Synthesis of qualitative and quantitative findings was undertaken on three themes: deployment, competence, and performance. Preliminary findings were discussed with an expert advisory group to inform interpretation.

Results: From 876 references, 15 eligible papers were identified, of which 13 were from the USA. Seven studies reported on general clinical processes in primary care that would support cancer diagnosis, most commonly ordering of diagnostic tests (n=6) and referrals to specialists (n=4). Fewer papers reported on consultation processes, such as examinations or history taking (n=3) Six papers considered PAs’ competence and performance on cancer screening. PAs performed similarly to primary care physicians on rates of diagnostic tests ordered, referrals and patient outcomes (satisfaction, malpractice, emergency visits). No studies reported on the timeliness of cancer diagnosis.

Implications: This review suggests the introduction of PAs into primary care may maintain the quality of referrals and diagnostic tests needed to support cancer diagnosis. It can guide future deployment of PAs in contexts like the UK, where, following regulation, their roles could be expanded to cover tasks like ordering of ionizing radiation. It also highlights the lack of research on several aspects of PAs’ roles, including outcomes of the diagnostic process.