

## Table of Contents

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<b>Introduction (English)</b> .....	3
<b>Introduction (French)</b> .....	4
<b>2009 Alan Blizzard Award Recipients—Photo</b> .....	5
<b>Section A—Collaborating Team</b> .....	6
<b>Section B—Nature of Features of Collaboration</b> .....	7
<b>Section C—Abstract</b> .....	8
<b>Section D—Paper</b>	
Institutional Context .....	9
Goals of the Project .....	9
Project Description .....	11
<b>Section E—Impact on Student Learning</b>	
The Participants .....	14
Module Evaluation—Satisfaction and Unexpected Outcomes .....	14
Knowledge Test.....	15
Impact on Attitude.....	15
Three Month Follow-up with Participants.....	16
Faculty Focus Group .....	16
Future Developments .....	17
Bibliography .....	18
References .....	19
Figure 1 .....	21
Figure 2 .....	22
Figure 3 .....	24
<b>Section F—Additional Documentation</b>	
Appendix 1:	
Link to Module and Contact Information for Access.....	24
Acknowledgements .....	24
Appendix 2:	
List of Professional-Specific Objectives for the Module "Total Pain" .....	25



## Introduction

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The Alan Blizzard Award was created by the Society for Teaching and Learning in Higher Education (STLHE) to honour its former President, Alan Blizzard (1987-1995), on his retirement, for his significant contributions to the Society. Designed to recognize and stimulate collaborative efforts to strengthen and give greater visibility to effective university teaching and learning, the Award encourages and disseminates scholarship in outstanding collaborative teaching and learning. Each year, the project selected for the Alan Blizzard Award is presented by the team during a plenary session at the Society's annual conference. The monograph describing the project is circulated to all Canadian universities.

The concept for the Alan Blizzard Award was developed by a committee including Chris Knapper (President, 1982-1987), Alan Blizzard (President, 1987-1995), Pat Rogers (President, 1995-2000), and Dale Roy (Coordinator, 3M National Teaching Fellowships Program). The Award is sponsored by McGraw-Hill Ryerson's Higher Education Division. The Society is particularly grateful to Marlene Luscombe of McGraw-Hill Ryerson, for advice in the conceptual stages of the design of the Award and for McGraw-Hill Ryerson's ongoing support of this significant program through Patrick Ferrier, President of the Higher Education Division. McGraw-Hill Ryerson supports this Award as part of its focus on student learning and faculty teaching. For more information visit [www.mcgrawhill.ca/highereducation/](http://www.mcgrawhill.ca/highereducation/)

This year, nine applications were received from eight Canadian universities. This monograph presents the 2009 Alan Blizzard Award submission, "Complex care, complex issues: innovations in development and content for effective team learning online." This project involves a wide collaboration with students, community-based clinicians and faculty from several faculties at the University of Ottawa and Saint Paul University. Readers who are intrigued by the possibility of adapting this project to their own institutions are encouraged to contact the authors directly or visit the Total Pain project website: <http://totalpain.uottawa.ca/TotalPainWeb/main.html>

I thank Dr. Joy Mighty, STLHE President, Dr. Arshad Ahmad, Chair, STLHE Awards Committee, Sylvia Riselay, STLHE Administrator, and the members of the 2009 Selection Committee: Alan Blizzard, Alice Cassidy, David Dunne, Susan McCahan, Dana Paramskas, and Pierre Zundel. Their time, attention, care, and candid and careful deliberations honour and practice the ideal of collaboration informing the Alan Blizzard Award.

For more information and guidelines for submitting a nomination for the 2010 Alan Blizzard Award, visit the STLHE website at [www.mcmaster.ca/stlhe/awards/alan.blizzard.award.html](http://www.mcmaster.ca/stlhe/awards/alan.blizzard.award.html)

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## Introduction

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Le prix Alan Blizzard a été créé par la Société pour l'avancement de la pédagogie dans l'enseignement supérieur (SAPES) en l'honneur de son ancien président, Alan Blizzard (1987-1995), maintenant à la retraite, pour l'honorer de son immense contribution à la Société. Conçu pour reconnaître et stimuler le travail de collaboration qui a contribué à accroître le rayonnement et la visibilité de l'enseignement universitaire, le prix encourage et fait connaître la recherche en enseignement et en apprentissage. Chaque année, l'équipe de la SAPES présente le projet digne du prix Alan Blizzard durant une séance plénière de la conférence annuelle de la Société. La monographie décrivant le projet circule dans toutes les universités canadiennes.

Le concept du prix Alan Blizzard a été développé par un comité formé de Chris Knapper (président, 1982-1987), Alan Blizzard (président, 1987-1995), Pat Rogers (président, 1995-2000) et Dale Roy (coordonnateur, Programme de prix d'excellence en enseignement 3M). Le prix est financé par la Division de l'enseignement supérieur de McGraw-Hill Ryerson. La Société remercie Marlene Luscombe de McGraw-Hill Ryerson, pour ses conseils dans les étapes de conception du prix. La Société remercie également McGraw-Hill Ryerson, par l'intermédiaire de Patrick Ferrier, président de la Division de l'enseignement supérieur, pour son soutien continu à cet important programme. McGraw-Hill Ryerson finance ce prix dans le cadre de l'appui apporté à l'apprentissage chez les étudiants et à l'enseignement du corps professoral. Pour obtenir plus de renseignements, visitez le site [www.mcgrawhill.ca/highereducation](http://www.mcgrawhill.ca/highereducation).

Cette année, nous avons reçu neuf candidatures provenant de huit universités canadiennes. Ce document présente le projet gagnant du prix Alan Blizzard 2009, «Complex Care, complex issues: innovations in development and content for effective team learning online». Ce projet implique une collaboration impressionnante entre étudiants, cliniciens oeuvrant dans la communauté et professeurs de plusieurs facultés à l'université d'Ottawa et à l'université Saint-Paul. Nous encourageons les personnes qui sont intéressées à adapter ce projet dans leur propre établissement à communiquer directement avec les auteurs. Site du projet <http://totalpain.uottawa.ca/TotalPainWeb/main.html>

Je désire remercier Joy Mighty (Ph.D.), présidente de la SAPES, Arshad Ahmad (Ph.D.), directeur du Programme de prix de la SAPES, Sylvia Riselay, administratrice de la SAPES, ainsi que les membres du comité de sélection 2009: Alan Blizzard, Alice Cassidy, David Dunne, Susan McCahan, Dana Paramskas et Pierre Zundel. Le temps et l'attention qu'ils ont consacrés à ce travail ainsi que les délibérations attentives qu'ils ont eues à ce sujet témoignent de leur engagement envers l'idéal de collaboration prôné par le prix Alan Blizzard.

Pour obtenir plus de renseignements ou connaître la démarche à suivre pour soumettre une candidature pour le prix Alan Blizzard 2010, visitez le site Web de la SAPES: [www.mcmaster.ca/stlhe/awards/alan.blizzard.award.html](http://www.mcmaster.ca/stlhe/awards/alan.blizzard.award.html)

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**Complex care, complex issues:  
innovations in development and content for effective team learning on-line**



**From left to right**—Brad Genereaux, Susan Brajtman, Patti O’Brien, Lynda Weaver, Peter Barnes, Pippa Hall, Daniel Mroz, Beckie Tingley and Tim Willett.

## Section A—Collaborating Team

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### Acknowledgements

The development of this learning module has been supported by a University of Ottawa Interdisciplinary Project Award and by Health Canada through the Inter-professional Education for Collaborative Patient-Centred Practice Initiative, awarded to the Institute of Inter-professional Health Sciences Education, centred at the Council of Ontario Universities.

## Section B—Nature and Features of Collaboration

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Based on our collaborative experiences and relationships developed through the University of Ottawa's inter-professional education (IPE) course '*Death Made Visible: An Interdisciplinary Exploration of Death & Dying in Literature*', we were convinced that narrative and palliative care were powerful approaches to inter-professional learning.

Recognized challenges of implementing effective IPE include scheduling common learning times across curricula and designing programs to meet needs of different learners. Through a wider collaboration with students, community-based clinicians and faculty from several faculties at the University of Ottawa and Saint Paul University (see Appendix 1), an on-line learning module was developed, using narrative and focusing on suffering/'Total Pain' in a terminally-ill patient.

A "narrative developer" team of four students was assembled: one completing first year of medicine; one just completed fourth year of medicine; one completing first year of nursing; one completing her Masters in English Literature. In collaboration with academic faculty, inter-professional and profession-specific learning objectives were developed for: medicine, nursing, physiotherapy, occupational therapy, social work and spiritual care. The narrative team conducted interviews with a content expert team of palliative care practitioners, exploring the concept of suffering and total pain. They created an extensive profile of a fictional patient with advanced terminal illness and multi-dimensional suffering, using this to author an extensive first-person narrative.

Collaboration with an instructional design and technology team followed, transforming the story into multiple short segments ("bubbles"), each reflecting a short conversation with the patient. Theatre Department members brought the narrative to life through photo, video and audio clips. Using innovative software modified for the project, these bubbles were assembled so that each student could explore the narrative according to his/her own interest, but no one student could navigate the whole story independently. Collaboration was required to address the patient's suffering. The module was co-facilitated by faculty from different professions.

## Section C—Abstract

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**Background**—Inter-professional education (IPE) is a response to the need for more effective, collaborative, patient-centred teamwork in health care today. Due to advances in health care technology and an overall aging population, more Canadians are living with complex and chronic illnesses. Providing care and the support required for these individuals and for their families becomes challenging, as no single health care professional can be expected to address all these needs alone. There is also a serious shortage of health care professionals to provide the necessary care and support. Future health care providers must be prepared to work in this new environment.

Preparing students who will be able to demonstrate effective collaborative person-centred practice has proved challenging. Some of these challenges include addressing the different learning needs of multiple learners and scheduling common learning times across curricula. A unique collaboration between community-based clinicians, students and faculty members from several Faculties at the University of Ottawa and Saint Paul University has resulted in an on-line learning module designed to address some of these challenges. This on-line learning module combines independent and group learning activities to address common and profession-specific learning objectives. The foundations for the module are built upon theoretical frameworks from social sciences, on-line learning as well as principles of androgogy.

**Methodology**—The dynamic, facilitated module uses a patient narrative to portray a terminally ill patient experiencing a complex combination of physical, psychosocial and spiritual issues (“suffering”). We brought together students as well as academic, clinical and technological experts to develop the engaging story, educational methodology and innovative online interface. Each learner chooses a unique navigation strategy: No one learner can navigate the whole story, so they must share their understandings to develop a collaborative care plan. With ethics approval, volunteers were recruited to pilot the module. Evaluation data included pre-post responses on a validated attitudinal questionnaire; pre-post case study reports; a learner satisfaction questionnaire and a three-month post-module survey.

**Results**—Students, representing nursing, medicine, spiritual care and physiotherapy completed the module. Sixteen were women, two were men and two unknown; 56% had experience with on-line learning; 55% had no previous inter-professional experiences. High pre-module attitudes towards health care teams increased slightly. All were highly satisfied with the learning experience. Pre-post case studies showed learners doubled their identification of spiritual and physical issues and identified the need for teamwork five times more frequently.

**Conclusion**—In conclusion, we are encouraged by the development and preliminary evaluation of the module. The goal of promoting inter-professional collaborative learning using a web-based narrative appears to have been achieved. Students also demonstrated an increase in their appreciation of the elements contributing to a patient’s suffering. Future plans include technical upgrading of the module (primarily aesthetics), delivery of the module to more students locally as well as across Canada, and moving the module to a completely online learning experience by replacing the face-to-face sessions with synchronous web conferences. Exploration of the use of the module with practicing clinicians will also be undertaken.



## Section D—Project Description

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### **Institutional Context**

Beginning in 2002, faculty at the University of Ottawa's Faculties of Health Sciences and Medicine and Saint Paul University collaborated in the delivery of the inter-professional course 'Death Made Visible: An Interdisciplinary Exploration of Death and Dying in Literature'. Having completed the eighth year of the course in 2008, students, clinicians and faculty who co-facilitate the small group sessions with the three core teaching faculty members continue to show enthusiasm and support for it, and its popularity increases. This course has demonstrated the power of narrative in teaching about both palliative and inter-professional care (Brajtman, in press; Hall et al, 2006).

Patient- and family-centred care delivered collaboratively by an inter-professional team is necessary to meet the often complex needs of patients facing life-threatening illnesses and the needs of their families. Despite this expectation, education in palliative end-of-life care for pre-licensure students is suboptimal (Brajtman et al., 2007; Oneschuk et al., 2004), and health care professionals are not educated to work collaboratively (Hall, 2005). It is essential to provide future health care professionals with opportunities to develop the attitudes and skills required to deliver collaborative comprehensive end-of-life care that addresses the various dimensions of suffering.

Inter-professional education (IPE) is challenged by the complexity of scheduling educational activities for different groups of learners (Oandasari et al., 2005) and best practices for this educational field are lacking as the research is newly emerging (Zwarenstein et al., 2005). For pre-licensure students, IPE requires finding common time in busy curricula and creative ways to integrate new material into an already full curriculum. In addition, levels of student maturity differ across programs, as do class sizes (e.g. 140 medical students, 80 nursing students and 10 spiritual care students).

Building on the learning gained from 'Death Made Visible', an inter-professional team of palliative care practitioners and educators developed a web-based learning module called "Total Pain" for pre-licensure learners in order to address the challenge of teaching collaborative patient/person-centred practice (CPCP) through IPE. E-learning developers at the University of Ottawa, with support from the virtual 'Institute for Inter-professional Health Sciences Education' (IIHSE), created this online module to accommodate busy schedules and curricula, and to enable small groups of various professionals to interact asynchronously but collaboratively.

The project began in 2005, funded by the University of Ottawa's Interdisciplinary Initiative, to develop the narrative and to begin the development of the appropriate software needed to realize the innovative educational approach. In 2006, further funding was received through Health Canada's Inter-professional Education for Collaborative Patient-Centred Practice (IECPCP) initiative as part of the funding for the development of the virtual Inter-professional Education for Health Sciences project, whose goal was to develop on-line inter-professional learning modules.

### **Goals of the Project**

The goal of the learning module was to design and build a web-based application that would present a navigable story web with multiple opportunities for independent navigation through a patient's narrative. The module would provide opportunities for student interaction and collaboration within the virtual space. Facilitation of the module by faculty representing different professions would

enhance inter-professional collaboration. The primary learning outcomes of the module were to enhance the students' appreciation for CPCP, inter-professional collaborative skills, and to improve their ability to address suffering, as demonstrated by the development of a holistic inter-professional care plan. Specific inter-professional learning objectives are listed below. The profession-specific objectives can be found in Appendix 2.

On completion of the total Pain Module, all learners will be able to:

1. Define Palliative Care and List its Goals

#### **Pain**

2. Identify and discuss the different dimensions of Total Pain: physical; psychological/emotional; social/cultural; spiritual.
3. Distinguish pain from suffering and give examples of empowering, empathic questions one can use to investigate suffering.
4. Discuss common myths surrounding the use of opioids.

#### **End of Life**

5. Discuss the concepts of dignity, hope, compassion, healing and loss in the context of life-threatening illness.
6. Discuss the ethical issues raised by, and the differences between, (a) physician assisted suicide; (b) euthanasia; (c) terminal sedation; (d) withholding therapy; and (e) withdrawing therapy.
7. Identify ethical decision-making tools and how to utilize hospital ethics committees.
8. Discuss how continuity of care can enhance quality of end-of-life care.

#### **Empathy**

9. Reflect on the concepts of meaning in illness and meaning in life.
10. Discuss the concept of spirituality as a universal human attribute.
11. Discuss end-of-life issues from the perspective of a person with a terminal illness and from the perspective of his/her family.

#### **Grief/Bereavement**

12. Discuss the difference between uncomplicated and complicated grief reactions.
13. In this story, identify at least four risk factors for complicated grief in the patient's family.

#### **Team/Professional Scope of Practice**

14. In general terms, discuss your profession's role (i.e. physician, nurse, social worker, occupational therapist, spiritual care provider, physiotherapist) in an interprofessional team.
15. Contribute to developing a holistic care plan in collaboration with other disciplines/professions, such as social worker, occupational therapist, physiotherapist, physician, nurse, spiritual care professional.
16. Discuss the roles of different health care team members in managing total pain.
17. Reflect on personal values and personal experiences when caring for a person with severe suffering.
18. Identify areas in the patient's care where one's own profession is ill-prepared to address the patient's needs (i.e. areas in which other professions have the required expertise that your profession does not and should be consulted).
19. Explore openness to complementary therapies, e.g. massage, acupuncture, music therapy.

20. Discuss what follow-up the patient, partner and family will require after discharge, the role each profession plays as part of an out-patient health care team, and how this care should be coordinated.
21. Identify the tools and resources that are necessary to discharge the patient to move him into home care.
22. Demonstrate elements of collaborative interaction when participating in the interdisciplinary class:
  - a. cooperation: acknowledge and respect others' opinions and viewpoints while maintaining the willingness to examine and change personal beliefs and perspectives;
  - b. assertiveness: support one's own viewpoint with confidence;
  - c. responsibility: accept and share responsibilities, and participate in group decision-making and planning;
  - d. communication: effectively share important information and discuss and exchange ideas;
  - e. autonomy: able to work independently;
  - f. coordination: efficiently organize group tasks and assignments;
  - g. trust: demonstrate mutual trust and respect in one another's decision-making pertaining to patient-care.

The number of professions and professionals involved in the project required coordination and on-going motivation. The dedication of the central development team maintained the enthusiasm and cooperation of all involved. The students, hired over the summer period, were crucial to the project's success. The students brought enthusiasm, energy and insight to the project. Their flexible schedules, and regular progress meetings during the development phase were the foundation of the innovation. The story they built captured the imagination of everyone who worked on, and contributed to, the project. This motivated us to overcome any organizational barrier.

The main challenge faced by the project has been the technology. The initial development team was part of the University of Ottawa, Faculty of Medicine's iMed group, the goal of which was the development of technological innovations to enhance learning. This group was eliminated in the winter of 2006 requiring the on-going dedication of the remaining development team, including some who were now only available on a consultation basis, as well as the management team and technology team, to continue to support the work. Technological glitches and instructional design issues became evident in the pilots, audio and video enhancements needed to be added, and the software required much programming expertise. Fortunately, we do have a dedicated group of individuals and have been able to overcome these challenges.

### **Project Description**

Development of the e-learning module began by assembling a team of "narrative developers" composed of four students: one completing her first year of medicine; one who had just completed his final fourth year of medicine; one completing his first year of nursing; and one just completing her Masters in English Literature. Common inter-professional learning objectives and profession-specific learning objectives were developed in collaboration with academic faculty for pre-licensure students in six specific health care professions: medicine, nursing, physiotherapy, occupational therapy, social work and spiritual care.

The narrative team conducted interviews with a content expert team of palliative care practitioners with academic and community experience to explore the concept of suffering and total pain, in addition to conducting a literature review on suffering. From this information, the narrative team created an extensive profile of a fictional patient who has advanced terminal illness and multi-dimensional suffering. They created an entire life history, including physical, emotional, social and spiritual facets. From this profile, 49 monologues (1-4 paragraphs of text, written in the first person) were derived. Each monologue was housed within its own 'bubble.' The monologues/bubbles were arranged into physical, psychological, social and spiritual domains (see Figure 1), based on the Canadian Hospice Palliative Care Association Norms and Principles of Practice (Ferris, et al., 2002). Connections between bubbles were based on the probable direction a clinician may wish to take the conversation if given the information in a real clinical encounter. To enhance the module, many of the text monologues were supplemented with video, audio and/or photos, with character development and performance prepared in collaboration with the Theatre Department at the University of Ottawa.

To allow learners to independently and asynchronously explore the extensive patient narrative, the e-learning experts and an academic development team built an interface, into which ThinkMap technology was embedded (ThinkMap Inc., New York, NY), a Java-based concept-mapping application. ThinkMap linked the monologues/bubbles together in such a way that each student could guide his/her own 'conversation' or exploration in the direction he or she chose, depending on the learner's interest in what was said by the patient (see Figure 2). Navigation was deliberately designed so that no individual learner should be able to uncover the entire story, thus requiring the group to share information in order to collaboratively develop a comprehensive plan of care. Time limits on access to the patient were imposed (one hour in the first week and 30 minutes in the second week) and many pathways were 'one-way streets,' meaning that guiding the conversation in a particular way would not guarantee that the original topic could be immediately revisited. Web-based learning tools (including reference material, an electronic medical record where students would enter inter-professional progress notes, a discussion forum, and a private notepad) were built into the story navigator system. To simulate actual clinical situations, learners could not access the patient's chart initially (they were told it was unavailable) thus requiring them to listen directly to the patient. If, during an episode of listening to the patient, the student 'ignored' him for seven minutes (i.e. did not formally leave the narrative or click to a new bubble), a notice would pop up indicating that the patient felt that he was being ignored and asking the learner to come back later.

The technology team at the University of Ottawa provided the website design, programming and technical support for the module development. The management team of the IIHSE provided overall supervision for the project. The module was designed to be completed by learners over a two-week period, with a total time of 12 hours deemed necessary for navigation, interaction, access of resources, progress note entry and final development of the inter-professional care plan.

Four pilots of the module were conducted. Participants from any year in their professional pre-licensure program were accepted. Initially, three face-to-face sessions were scheduled for the module: one at the start to introduce the module; one at the mid-point to discuss progress; and one at the end to develop the care plan and enter it into the chart. It became clear in the first pilot that the beginning and mid-point sessions were not necessary, as the students were quickly able to communicate asynchronously. Therefore, the module was redesigned with initial asynchronous on-line exploration and discussion, but maintaining the final face-to-face session. Participants at remote sites could join this final session by teleconference. Learners were expected to exchange their ideas, questions and concerns in the discussion forum and enter a profession-specific progress note in the patient's electronic chart. If more than one learner from each profession was participating, they were expected to collaborate to

produce a single progress note for their profession. Online co-facilitation was provided by two faculty members from different professions who were experienced in palliative care and had preparation in online facilitation techniques. In the final session, after the learners had developed their collaborative inter-professional care plan, one faculty member role-played the patient, engaging the students in the realistic discussion about how the care plan could best be realized for him.

### **Evaluation Strategy**

Evaluation data for the four pilot projects were gathered using multiple methods targeting Kirkpatrick levels 1 and 2 (Kirkpatrick, 1994). All participants provided basic demographic data. Evaluation forms differed for the first three pilots compared to the fourth, as it was part of the IIHSE study.

For the first three pilots, learners provided:

- data on their previous experience with e-learning and inter-professionalism;
- pre- and post-module “Attitudes Towards Healthcare Teams” questionnaires (Leipzig et al., 2002); 21-item test, measuring: a) attitudes towards value of a healthcare team; b) attitudes towards efficiency of a healthcare team; and c) attitudes towards physicians sharing the leadership role.
- post-module satisfaction questionnaires;
- pre- and post-module open-ended knowledge tests;
- 3-month post-module reflections via email questionnaires.

As this was piloted with volunteer students, no summative evaluation of the students was included. Students were encouraged to participate in the discussion forum, to post their progress notes and to participate in the inter-professional care plan development, all potential content areas for evaluation by faculty. An open-ended pre- and post- knowledge test asked participants to identify factors contributing to a patient’s suffering after reading a brief case synopsis. Faculty reviewing the responses assigned one mark for every issue identified according to the Canadian Hospice Palliative Care Association’s “Domains of Issues Associated with Illness and Bereavement” (Ferris et al., 2002).

The fourth pilot was part of a larger IIHSE study so participants completed the “Interdisciplinary Education Perception Scale” (IEPS) (Leucht et al., 1990) instead of “Attitudes Towards Health Care Teams,” and completed an IIHSE module feedback form, which differed from the previous post-module questionnaire. The 18-item IEPS measures a) Competence and autonomy; b) Perceived need for cooperation; c) Perception of actual cooperation; and d) Understanding of others’ value. Individual navigation of the module was tracked for the learners in the fourth group as this was the first time all the audio and video clips were functional.

The project received approval from the University of Ottawa and the Ottawa Hospital Research Ethics Boards. All statistical analyses were completed using SPSS version 16 (SPSS Inc., Chicago, IL).

### The Participants

A total of 20 health care students volunteered to participate in the Total Pain pilots; 15 in the first three (n = 6, 3, 6, respectively) and five in the fourth. Table 1 indicates the learners' professions and years of study. Sixteen participants were female, two were male, and two did not supply their gender. Students were asked why they volunteered for the module (respondents could give more than one reason). Common responses included: interest in palliative care (35%); an interest in learning, in this course, in general (35%); interest in collaboration and IPE (45%). Of the 20 participants, 55% had no previous inter-professional experience. All participants rated themselves as 'intermediate,' 'experienced' or 'very experienced' with computers and 60% held 'positive' or 'very positive' attitudes towards computers.

**Table 1—Pilot learners' levels of education and professions**

Profession	Level of Education					TOTAL
	1st Year	2nd Year	3rd Year	4th Year	Unknown	
Nursing				5		5
Medicine	3	1	3			7
Spiritual Care (Masters)	1	2		1		4
Physiotherapy			1	1		2
Unknown					2	2
<b>TOTAL</b>	<b>4</b>	<b>3</b>	<b>4</b>	<b>7</b>	<b>2</b>	<b>20</b>

### Module Evaluation—Satisfaction and Unexpected Outcomes

Selected results from the students' post-course satisfaction questionnaire are shown in Table 2 for the first three pilots and in Table 3 for the fourth pilot. Participants enjoyed working with the module and felt they had learned about collaborative practice.

Interestingly, after they had developed their care plan and completed the course requirements in the first pilot's final face-to-face session, the learners asked anxiously about what happened to the patient; i.e. did he go home, did his suffering subside, did he die comfortably? This was entirely unexpected for the facilitators. Therefore, for the subsequent pilots, the project team developed an information sheet describing how the care plan was actually implemented and how the reduction in the degree of suffering allowed the patient to return home with improved community supports.

**Table 2—Selected Likert-scale ratings from learners in the first 3 pilots (N=15) regarding reactions to the module**

Survey Question	Mean score (1 = Strongly Disagree, 5 = Strongly Agree)
The program was in line with my expectations	4.4
The program kept my interest	4.9
As a results of my participation in this module, I have gained new knowledge	4.6

**Table 3—Selected Likert-scale ratings from learners in the 4th pilot (N=5) regarding reactions to the module**

Survey Question	Mean score (1 = Strongly Disagree, 5 = Strongly Agree)
The program taught me about IPE	5
I learned to work with and from others	5
The program taught me about collaboration for better care	5
I identified shared tasks: joint solutions and decisions	5

Another unexpected outcome was the compilation of a bank of profession-specific progress notes. This became important when, in pilots #2 and #3, some professions were not represented among the learners. To complete the learners’ full understanding of the patient, the faculty either built upon previous students’ notes or provided the missing professions’ assessments and progress notes. Thus the module can be run with a group of learners even if one or more professions are not present.

The story navigation routes of the learners in the fourth pilot (n=5) were analyzed, and showed the spiritual care students (n=2) explored some physical issues but focused primarily on the spiritual and social aspects of the story. The medical students (n=2) explored some psychosocial aspects but spent most of their time in the physical domain. The nursing student (n=1) explored each domain extensively.

### **Knowledge Test**

Eleven of the 15 participants (73%) in the first three pilots completed the assigned pre- and post-module knowledge case studies test (it was not used in the 4th pilot). Figure 3 shows a comparison of responses. Comparing pre- to post-module data, learners’ scores doubled for their identification of both spiritual and physical factors that contribute to the patient’s suffering, and they explicitly mentioned the need for ‘inter-professional collaboration’ five times more frequently.

### **Impact on Attitude**

As previously discussed, pre- and post- tests were different for the first three pilots compared to the fourth because the host agency was different for the latter. For the first three pilots (n=15), participants’ pre- and post module mean scores on all three subscales of the Attitudes Towards Health Care Teams were high and paired sample t-tests found no significant differences on any subscale. While

there were only three respondents to the IEPS in the 4th pilot, their pre- and post-module scores were close (249 vs. 259) and lower than the normative data in the original reliability testing (262). The high pre-module scores may reflect the self-selection of participants for the pilot modules.

### **Three Month Follow-up with Participants**

Seven of the 15 students (47%) in the first three pilots responded to the 3-month post-module follow up emails. Comments on the module included: effectiveness of the case-based format and the excellent quality and/or usefulness of the resources and reference articles provided (n=4); a desire to learn more about specific topics (n=2); a suggestion to include mental health workers (n=1); and the assessment technique being unrealistic to physiotherapy (n=1). Six of the seven respondents reported it was essential to meet face-to-face in order to develop the care plan at the end of the module. Six respondents mentioned the online facilitation by faculty was excellent and useful. For example, one person said, *“we received input from the coordinators which was very insightful and helpful”* and another said, *“our facilitators shaped our discussions and allowed us to get the most of the experience.”*

This quote from one respondent sums up his/her online experience: *“The online story of Neil was innovative and allowed us to get a real sense of how the interviewing process works and how to integrate information from all aspects of a person's life. The online simulation added depth and richness to the project and has the ability to enhance medical application in the future by enabling people at different locations the opportunity to be part of a unique educational experience and participate without requiring face-to-face interaction.”*

When asked how relevant the module was to their studies or clinical experiences, they felt they had learned about collaboration (n=4), had gained interpersonal skills (n=3), and were applying these new skills related to total pain in their clinical work (n=2).

### **Faculty Focus Group**

A focus group was held after the first pilot with the faculty who developed the module; 7 of the 9 were able to attend and 3 of these were facilitators of the first pilot. They identified successes as: project leadership; realism of the story; blended online and face-to-face format; and restricting learners' time to explore the narrative. The facilitators noted that learners had shared their perspectives and explored why the same information one learner had heard was interpreted differently by another. They also noted that in the group discussions (face-to-face and online), the learners talked about the potential roles each profession had to play in addressing the patient's suffering, and that each had unique and important contributions to offer to the care plan. Indeed, the facilitators reported how some of the learners had felt helpless initially, until colleagues from other professions explained how they were able to assist with those troubling dimensions. Facilitation (online and face-to-face) was not found to be onerous, but co-facilitation by faculty from different professions was deemed essential. The learners' final care plan demonstrated a collaborative approach with each profession equally represented. The faculty identified issues for improvement, such as problems accessing online learning material through a library portal; too much reading material delivered at one time; initially too much time for students to explore the narrative; and technical problems with the online module. These issues were addressed for the subsequent three pilots.



## **Future Developments**

Future plans include technical upgrading of the module, delivery of the module to more students, and moving the module to a completely online learning experience by replacing the face-to-face sessions with synchronous web conferences. Exploration of the use of the module with practicing clinicians will also be undertaken. The module and the results of the pilot projects have been presented at national and international conferences. The module will be made available for use by other faculties and universities through the IIHSE, with the plan for this dissemination in the spring of 2009. There has been keen interest expressed internationally about this program as it appears to directly address the professional competency of inter-professional collaboration in the preparation of pre-licensure students for their professional practice. We will also explore developing a framework that professors and students could easily use themselves to develop their own multi-dimensional educational experiences.

## **Bibliography**

### **Theoretical Frameworks for the Total Pain Inter-professional Learning Module**

Inter-professional education (IPE) refers to occasions when two or more students/learners from different professions (i.e. not simply different disciplines within the same profession) learn with, from and about each other to enhance patient care (Barr, 2002). The optimal time in the educational cycle of health care providers' training to introduce the knowledge, skills and attitudes necessary for CPCP, and how best to do it, is still being debated (Hall, 2005; Choi & Pak, 2006).

Petrie described the challenge of effective collaboration as early as 1976. He describes the different cognitive maps each individual develops during his/her development as a person and as a professional, and how "quite literally, two disciplinarians can look at the same thing and not see the same thing" (Petrie, 1976, pp 35). For effective collaboration to take place, Petrie suggests a need to provide a single idea/issue/focus that requires team members to develop a common understanding and a new common language to effectively share information. This work results in a new common vision which is greater than the sum of its parts. Petrie refers to this concept as "idea dominance" (Petrie, 1976, pp 32).

Idea dominance can be applicable to IPE as well as CPCP. Using a patient's narrative as the focus for presenting information to learners (Charon 2001a; 2001b) offers some interesting educational opportunities to demonstrate how two individuals can listen to the same thing but not necessarily hear the same thing. With identical information being presented, personal and professional differences in perception/interpretation can be explicitly identified and explored to develop inter-professional understanding. The use of narrative has been identified a means of breaking down interpersonal and inter-professional barriers and can create new levels of trust and respect between health care providers (Herbert et al., 2007) and literature has been used as a source of rich narrative, introducing students to different perspectives through dialogue and discussion (Hall et al 2006, Montgomery 2001; Montgomery Hunter 1995).

Engström (2001) proposes a theory that provides a social sciences lens to discuss effective collaboration. Similar to Petrie's cognitive mapping concept, Engström's Activity Theory puts forth that an individual's (e.g. individual team member's) goals and objectives result from an intricate interplay of the signs and tools he/she has learned to use, the community of which he/she is part, and the rules and division of labour learned through life and through training. Thus, each member of a health care team will have his/her own Activity System. Team members must learn to appreciate and collaborate with

each other's unique 'Activity System,' which will require a willingness to adapt one's own. Illeris (2004) suggests that only when there is some tension in one's own experiences will there be a readiness to learn and change.

Similar to Petrie's idea dominance concept, Engström's also proposes Knotworking Theory (1999; 2001). In a clinical encounter, all team members (including the patient and family) are drawn together around a common issue related to the care needs of the patient. This issue is at the centre of the team's relationships and, as the issue changes, different 'threads' of each team member's Activity System are needed to address it. Over time, different members of the team may be needed to join the 'knot' around the issue, and others are dropped from the knot as they are no longer needed. The individuals involved must learn to appreciate each others' perspectives as well as developing effective working relationships, recognizing the different Activity Systems contributing to the knotworking. Because issues continuously change over time, the team members must be continuously aware of the factors influencing their relationships within the knot.

D'Eon (2005) suggests that, in addition to the learning domains of knowledge, skills and attitudes, the social/relational domain is particularly relevant to IPE. He suggests careful structuring of IPE learning tasks, beginning with simple learning activities (e.g. simple paper case) involving two disciplines/professions, with small groups of 2 to 4 individuals, and progressing to more complex activities with more disciplines/professions (e.g. complex case in realistic or real-life setting with many team members).

Taking into account the above theories, educators can develop learning activities that simulate an issue (knot or idea dominance) enabling learners to explore and better understand their interactive Activity Systems. The activity should introduce enough tension to motivate the learner to consider new perspectives and the complexity of issues and number of participants should be targeted to the level of the learners' experiences in the social/relational domain.

Within medicine, palliative care is a discipline that relies heavily on inter-professional teamwork to meet the complex care needs of patients (Ferris et al., 2002). Palliative care is the holistic care of a person who is living with a life threatening illness (Ferris et al., 2002; World Health Organization, 1990). As such, practitioners must, as a team, become familiar with the patient's 'story' that includes the physical, emotional, social and spiritual domains of his/her life. "Total Pain" is a concept used in palliative care that encompasses a patient's suffering in all of these domains (Ferris et al., 2002). Therefore, palliative care lends itself well to the use of a complex, well-developed narrative (the idea dominance or knot) through which learners can be introduced to a patient, to each other and begin to explore each other's understanding of the story. Caring for individuals with terminal illness often produces tension in health care providers, causing such feelings as helplessness, depression and fear, and can be perceived to be in stark contrast to the medical model which focuses on cure (Brenner, 1999).

The hypothesis for this on-line learning module is that, when Total Pain is effectively replicated through a narrative for small groups of learners from different disciplines/professions, enough tension is introduced into each of the learners' Activity Systems that he/she will be willing to seriously consider other perspectives. The Activity Systems of the participants can be made explicit, discussed and adapted, enabling inter-professional learning.

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Figure 1—"Bubbles" connections and domains of narrative content

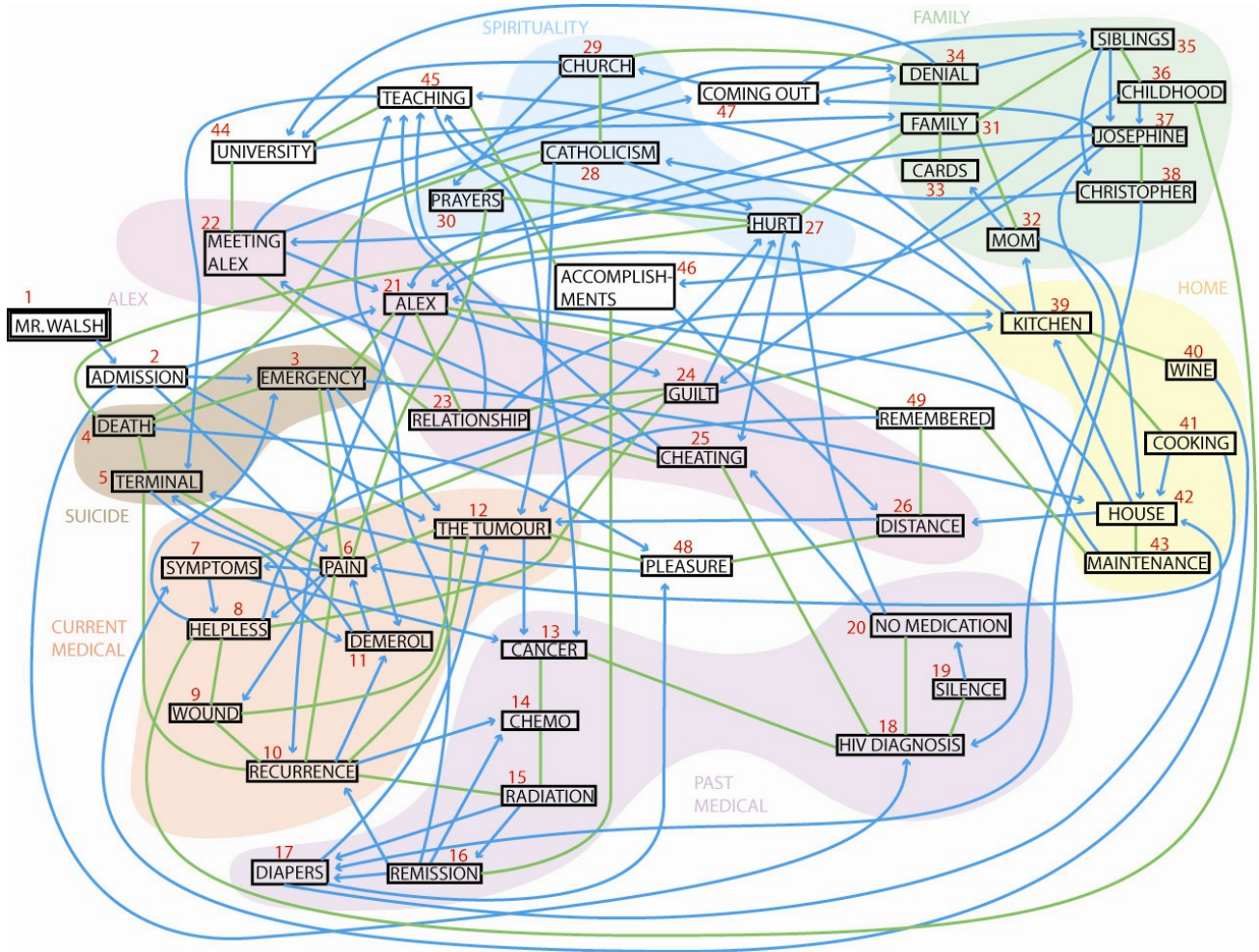


Figure 2 (A)—An example of the content of a story ‘bubble’; (B) The student’s interface, showing the story navigator and some of the additional learning tools.

A

TOTAL PAIN v0.4.3.3 - Talking with Neil Leave Neil

*You have 33:00 min left with the patient and 6:50 min until he feels ignored.*

### ALEX (click below to return)

**Alex**



Alex is my partner. He's been taking care of me, but he's in New York on business. Please don't try to contact him. I don't want him to see me like this.

He's been away for about a week. At first he was hesitant about going.

"Who will take care of you?" he said. "It's not an important conference. I can send my assistant."

But I could hear how badly he wanted to go, and I could tell how much he wanted to be sleeping in a clean hotel room free of bandages and gauze and visible pain, so I told him to go. There was so much guilt in his voice when he said goodbye. You can hear guilt beneath the surface of most of our conversations these days.

Choose next topic ...



Add Note:

---

Add!

Resources:

**Learning Resources**

- [Open!](#)

**Electronic Medical Record**

- [Open!](#)

**Progress Notes**

- [View Notes](#)
- [Add Note](#)

**Notepad:**

[Note written 2008-12-04 17:52:43.0](#)

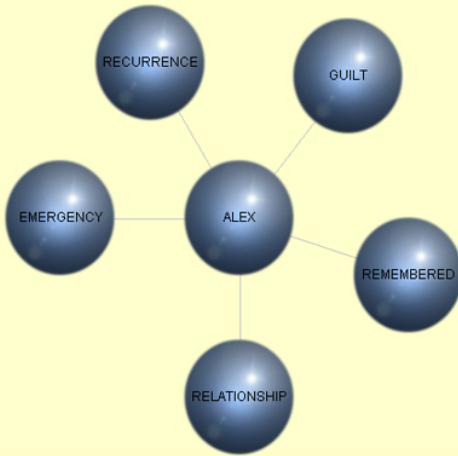
Neil is ## years old...

B

TOTAL PAIN v0.4.3.3 - Talking with Neil Leave Neil

*You have 29:49 min left with the patient and 3:52 min until he feels ignored.*

### WHAT DO YOU WANT TO KNOW?



Add Note:

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Add!

Resources:

**Learning Resources**

- [Open!](#)

**Electronic Medical Record**

- [Open!](#)

**Progress Notes**

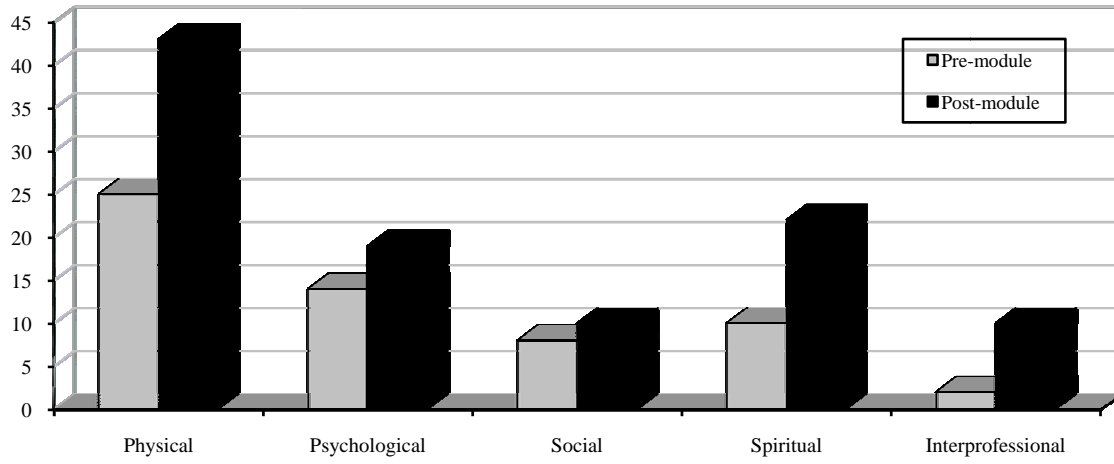
- [View Notes](#)
- [Add Note](#)

**Notepad:**

[Note written 2008-12-04 17:52:43.0](#)

Neil is ## years old...

Figure 3—Pre- and Post-module Knowledge Test Results, n=11.



## Section F—Additional Documentation

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### APPENDIX 1

**a. Link to Module & contact information for access**

<http://totalpain.uottawa.ca/TotalPainWeb/main.html>

To gain access to the module, please contact Beckie Walbourne ([bwalbourne@bruyere.org](mailto:bwalbourne@bruyere.org)) for user id and password.

**b. Acknowledgements**

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**APPENDIX 2****List of Profession-Specific Objectives for the Module 'Total Pain'****Medicine**

1. Discuss the components of an effective pain history.
2. When discussing physical pain, differentiate between the symptoms, signs and pathophysiology of nociceptive (somatic, visceral), referred and neuropathic pain.
3. Outline the WHO approach to the management of cancer pain.
4. Discuss the use of opioids for chronic malignant pain management:
  - a) Identify which opioids are appropriate and which are not.
  - b) Identify appropriate routes of administration.
  - c) Explain the structure of a pain medication regimen, including regular dosing and break-through dosing.
  - d) Know the most common side-effects of opioid use (constipation, sedation, respiratory depression, and opioid toxicity) and their frequency, prevention and treatment.
  - e) Discuss common misconceptions about addiction and respiratory depression with opioid use.
5. Discuss co-analgesics that may be useful in managing various types of pain, including NSAIDs, anticonvulsants (e.g. carbamazepine, gabapentin), tricyclic antidepressants, steroids (e.g. dexamethasone) local anesthetics and radiation therapy.

6. Identify at least two complementary treatment methodologies useful in managing pain.
7. In this case, identify and discuss other medications or psychosocial/spiritual approaches that may be helpful in managing the patients' palliative symptoms, such as anorexia, anxiety, nausea, constipation and dyspnea.
8. Identify and discuss some of the barriers to pain assessment and management.
9. Discuss the assessment of psychosocial and spiritual issues, including grief.

### **Nursing**

1. Discuss how to assess pain in patients with cancer, HIV and other conditions.
2. Discuss appropriate pain assessment tools.
3. Differentiate between different types of pain (neuropathic, visceral, nociceptive, and referred), as well as the other facets of total pain (psych, soc, spiritual) and discuss the assessment and treatment of each.
4. Identify and discuss some of the barriers to pain assessment and management.
5. Discuss the use of opioids for chronic malignant pain management:
  - a) Identify which opioids are appropriate and which are not.
  - b) Identify appropriate routes of administration.
  - c) Explain the structure of a pain medication regimen, including regular dosing and break-through dosing.
  - d) Know the most common side-effects of opioid use (constipation, sedation, respiratory depression, and opioid toxicity) and their frequency, prevention and treatment.
  - e) Discuss common misconceptions about addiction and respiratory depression with opioid use.
6. Discuss co-analgesics that may be useful in managing various types of pain, including NSAIDs, anticonvulsants (e.g. carbamazepine, gabapentin), tricyclic antidepressants, steroids (e.g. dexamethasone) local anesthetics and radiation therapy.
7. Describe the WHO analgesic ladder to guide selection of analgesics for pain management.
8. Identify at least two complementary treatment methodologies useful in managing pain.
9. Discuss how to assess and manage a fungating malignant wound, and considering the impact of complications such as urinary and fecal incontinence on the wound care.
10. Discuss the emotional and physical challenges of a fungating wound for each of the following: the patient, the family and the nurse.
11. Discuss how to conduct an assessment of bowel discharge as well as the pharmacological and dietary management of frequent loose bowel discharge.

## **Occupational Therapy**

1. Discuss the role of the occupational therapist as a member of an in-patient health care team and as a member of a home-care team.
2. Identify positioning strategies (including use of adaptive equipment) to aid in pain management.
3. Identify safety issues in the home and in the hospital and discuss strategies to deal with them.
4. Discuss the idea of *personally meaningful activities* with reference to Harvey Chochinov's Dignity Enhancing Model, and apply this concept to the patient in the case.
5. Discuss the role of *energy conservation* as it applies to helping the patient manage his day.
6. Identify the tools and resources that may assist the patient and partner to make a comfortable and safe transition home.
7. Discuss any ongoing home-care help this patient may require after discharge.

## **Physiotherapy**

1. Discuss the role of the physiotherapist as a member of an in-patient health care team and as a member of a home-care team.
2. Understand how to appropriately coordinate physiotherapy interventions with medication regimens.
3. Identify physiotherapeutic interventions for non-pharmaceutical pain relief.
4. Identify positioning and mobility strategies to aid in pain management.
5. Discuss the role of physical fitness in this patient's life.

## **Social Work**

1. Discuss the role of the social worker in the psychosocial, emotional, financial, familial, communicative and spiritual needs of the patient.
2. Discuss the role of the social worker in connecting the family to the patient, and providing a family perspective to the team.
3. Identify financial supports that the patient and primary caregiver may have access to and assess the need for financial assistance in this case.
4. Discuss home care services that are available for the patient with reference to the *Community Care Access Centre*.
5. Assess the partner's risk of bereavement and discuss the need for follow-up.

6. Identify and discuss the concept of anticipatory grief for the patient.
7. Discuss how to provide on-going counseling to both the patient and his partner (and any other family members that may surface).
8. Discuss how to provide advocacy for the patient and his partner.
9. Identify resources that may be helpful to the patient and/or partner and family members (e.g. books, articles, support groups)

### **Spiritual Care**

1. Identify and discuss the five principles of spiritual care:
  - a) meaning and purpose
  - b) belonging
  - c) relationship to self, other and God/deity
  - d) creativity
  - e) hope
2. With reference to the patient in the story, discuss the concept of a healthy death, and the role of the spiritual care worker in helping the patient achieve this.
3. Identify and discuss the spiritual needs of the partner/family in this story.
4. Identify and discuss the roles of each of the following in caring for a palliative patient: nurse, spiritual care worker, clergy, social worker, physician, occupational therapist and physiotherapist.
5. Identify tools that can assist in spiritual assessments.
6. Discuss the role of the spiritual care worker as an advocate for the patient, a support for the partner/family, and a spiritual and professional resource to other members of the health care team.