

Caring, learning, improving quality and doing research: Different faces of the same process

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ABSTRACT

The aim of this article is to describe the similarities between the consultation process, the quality improvement (QI) process, action- and problem-based learning and participatory action research (PAR). We feel this understanding adds value to our work in enabling personal development as practitioners, fostering teamwork and demystifying the different concepts. Learning to understand the different processes becomes easier, as they have a lot in common. All four of these spiral processes follow a number of steps. They start with building a relationship/team with a patient, students, co-workers or co-researchers. The next step is identifying the problem. The present situation, as well as the required state (setting standards), is identified. An intervention can then be planned, with a follow-up evaluation to see if the situation has improved. The spiral may continue with a follow-up plan. As authors we believe that we can conclude from this that health workers, teachers, managers and researchers can learn from each other and work together more readily if they understand that they share a common action process.

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Introduction

This article presents a comparison between several processes that occupy many of us daily. We have noticed that such a comparison helps those involved to understand the similarities between these processes and the skills needed for them. They will then not be intimidated by a new context facing them, whether it be research, management or the learning/teaching field, and they can transfer the skills learnt in other fields, such as the consultation process, quickly and effectively to the new one. Those who explicitly and consciously share common values, skills and processes are also more likely to work together effectively.

Consultation and QI are two concepts that are inseparable from family medicine and primary health

care. Through the years, we have become aware that there are many similarities between the two processes. We have recognised that learning forms the basis of these processes. Looking at these processes we can identify the basic steps of action- and problem-based learning. It is therefore obvious that action research is also related, as research is basically documented learning (acquiring or constructing new knowledge).

The basic phases in PAR are described by Holter and Schwartz-Barcott as follows: Diagnosing the problem, designing the action plan, implementing the action plan and, finally, developing a theory.¹ Macaulay et al stress the importance of forming the group and understanding the problem clearly.² McNiff describes

the scheme of the cycle of PAR as follows: Planning, acting, observing, reflecting and back to planning.³

The **QI cycle** described by Lawrence and Schofield includes the following steps:⁴

- Set standards,
- Observe practice,
- Evaluate information,
- Plan improvement and go back to setting standards.

Forming the team and choosing a topic are prerequisites.

McWhinney describes the **consultation process** as follows:⁵

The patient presents cues, the doctor defines the problem and forms a hypothesis. The doctor searches for more information, negotiates management decisions, then indicates the follow-up, which goes back to revising the hypothesis, and so the

cycle continues.

Schmidt describes the steps of **problem-based learning** as follows:⁶

- Clarify the terms and concepts not readily comprehensible,
- Define the problem; analyse the problem,
- Draw a systemic inventory of the explanations inferred from the previous step to formulate learning objectives,
- Collect additional information outside the group, and
- Synthesise and test the newly acquired information.

The participatory action research process closely resembles the quality improvement cycle and action- and problem-based learning, and therefore also the consultation in the patient-centred clinical method. Each process starts with a problem or an incapacity which has a story that needs to be understood completely before detailed and specific assessments or hypotheses can be made and objectives and a plan can be negotiated that will address the real problem. Each process goes through a phase of information gathering/measuring/testing to support or develop the hypotheses further. It then goes through an action phase during which new insights are tested in real lives, contexts or practice. Through reflection on the above, new knowledge is generated. Each process takes place in a smaller or larger community of participants. All these processes aim to make things better or do things better in an ongoing lifelong process.

Comparing the consultation, QI, action- and problem-based learning and PAR

Working on the basis of the concept described above, we compiled a table to demonstrate our understanding of this idea. We identified nine possible steps which form part of the spiral process.

Step 1: Build a relationship

The consultation	Build rapport with patient and develop a relationship
QI cycle	Develop the relationship between the team members
PAR	Form the research group (develop a trusting relationship with the community)
Action & problem-based action learning	Form a learning relationship with a facilitator or co-learners

Step 2: Identify the problem

The consultation	Listen to the patient's problem, understand who the patient really is and form a hypothesis
QI cycle	Relate and understand the problem (choose a topic), understand the reasons for intervention and set standards
PAR	Listen to research group, develop an understanding of the problem and relate it to the research question
Context- & problem-based action learning	Listen to, develop understanding and relate it to the lack of knowledge or skill

Step 3: Gather further information on the problem

The consultation	Collect subjective and objective data (history taking and examination)
QI cycle	Evaluate present practice (collect data)
PAR	Collect data (input from participants)
Context- & problem-based action learning	From the background information, clarify the concepts not understood and skills that are lacking

Step 4: Define the problem

The consultation	Negotiate a specific agreed assessment (joint reflection)
QI cycle	Reflect and discuss the data with the team and define the problem
PAR	Discuss data with the group, reflect on it and define the problem (research question)
Context- & problem-based action learning	Reflect on and specify the learning needs

Step 5: Negotiate a plan

The consultation	Negotiate a management plan
QI cycle	Negotiate what to change
PAR	Put a joint plan of action in place
Context- & problem-based action learning	Formulate agreed learning objectives and plan

Step 6: Joint action

The consultation	Patient and doctor implement the treatment plan together
QI cycle	Implement the plan
PAR	Implement the planned action
Context- & problem-based action learning	Search and do/act: collect additional information from the literature or experts. Learn a skill.

Step 7: Reassess

The consultation	Follow-up visit to evaluate the outcome of the mutual accountability in the treatment plan
QI cycle	Collect data after implementation to evaluate plan
PAR	Get the group's feedback on the action
Context- & problem-based action learning	Synthesise and test the new information Account for learning: evaluate/test/measure

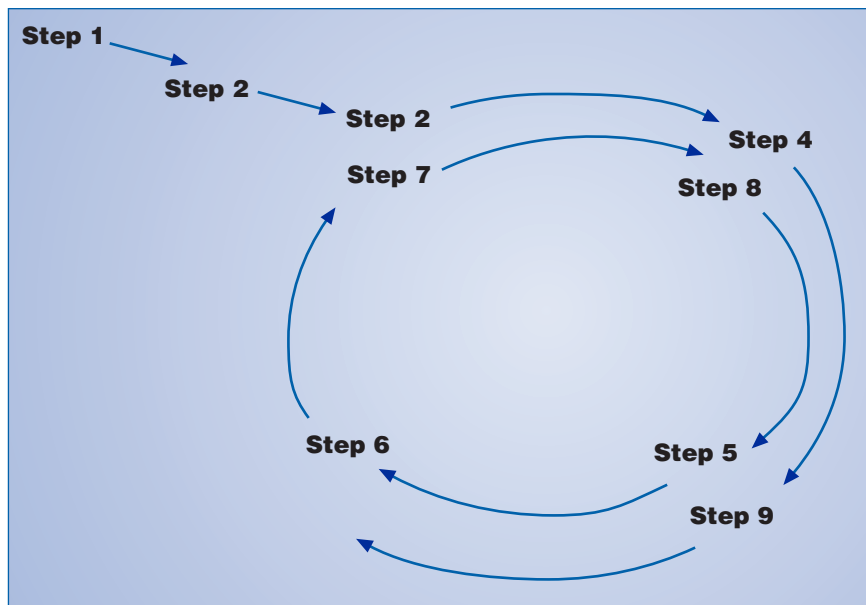
Step 8: Reflect

The consultation	Discuss the reassessment with the patient
QI cycle	Reflect on and discuss the evaluation with team
PAR	Reflect on and evaluate the action with the team and develop theories
Context- & problem-based action learning	Reflect on and specify new knowledge gained from the study and application

Step 9: Plan and restart

The consultation	Plan future management
QI cycle	Plan the next cycle with the team
PAR	Plan further action
Context- & problem-based action learning	Plan further learning objectives and actions

A model demonstrating the consultation, the QI cycle, PAR and context-based, problem-based and action learning cycles (or spirals) could be depicted as follows:



Discussion

The steps of the four processes described overlap with the four forms of practice: for clinicians, researchers, managers and teachers. We will compare these processes with the aid of an example to illustrate how they add value to each other.

The family physician uses the principles of PAR, QI and problem-based action learning daily in the consultation process. Let us use the example of a patient with Diabetes Mellitus: Patient-centredness in the consultation is important when managing any person living with a chronic illness.⁵ In essence, the aim of each consultation is to improve the quality of the control over diabetes, which is similar to that of the QI process.⁴ For this, other professionals may need to be included in the team – for example family members, professional nurses, a pharmacist and dietician. The team should collaborate to achieve maximum benefit for the patient. The problem must be identified. A baseline assessment of the patient is undertaken (blood glucose, BP, foot examination, eye examination, etc.). The results are reviewed by the team, on the basis of which an improvement plan is

formulated. During the follow-up consultation, the evaluation is repeated, reviewed by the team, and further improvement plans are made.

The same consultation can be done as a problem-based action learning process.⁶ Let us use the example of a family medicine trainee whose facilitator has provided him/her with guidelines on problem-based action learning. When he/she experiences a problem with the management of the diabetic patient, the trainee could identify the shortfalls, discuss it with the facilitator to form learning objectives, make a plan on how to obtain the relevant information, research the information, consider the application of the new knowledge with the patient and, finally, review the effect of the changed practice during the follow-up visit.

It will be beneficial to the consultation to incorporate more of the PAR principles, for example to encourage the participation and collaboration of the patient in the process. The second point would be to view the patient as part of a specific group or community. Patients usually form part of a family group, which is a subgroup of most communities. It is

beneficial to collaborate with a patient in association with his/her family. Therefore, the family physician will benefit by using the process of PAR in the consultation. This could also be beneficial to train family physicians in the use of PAR, because it will develop skills needed in the consultation process. We have experienced that the reverse is also true.

In the process of PAR, the researcher should listen and reflect frequently to ensure that all the participants understand the process and to ensure participation. Listening skills are invaluable in family practice. Similarly, subjectivity and mutuality in the relationship are important in PAR and in consultations. Some authors classify PAR as qualitative research. For the same reasons, much has been written about the relevance of qualitative research in family practice.^{7,8} Data analysis in PAR, as in other qualitative methods, is done by seeking a deep understanding of the data.⁹ This is a vital skill in family practice. Another aspect of PAR that is very beneficial to the family physician is self-reflection. Self-reflection is the ability to look critically at oneself; to identify the pros and cons of an action and to weigh the two up against each other. Self-awareness and challenge are ways of acquiring the skill. Reflection is a skill frequently used in PAR.⁹ Keeping a reflective diary/journal is also encouraged in PAR. The discipline of setting aside time to write down thoughts and experiences regularly is another way to develop the skill of reflection. The importance of this skill for practitioners in general has been strongly supported by Tervalon and Murray-Garcya.¹⁰ This skill is also very helpful in family practice.

Ultimately, the aim of a family physician is to enable a patient to become healthy. Israel et al stated

that PAR has the potential for empowerment because it embraces the basic components of empowerment theory, namely participation, critical awareness and collective action.⁹

The benefit of understanding the similarities between these four processes is that it demystifies the aura surrounding some of these processes. The skills required to participate in these processes are inter-transferable. A person skilful in the patient-centred clinical method would easily slot into a participatory management process, be a student-centred facilitator (teacher) or a co-researcher in PAR.

Conclusion

We described four comparable processes, namely a participatory research process (PAR), the patient-centred clinical method, a participatory management process (QI cycle) and a learning process. We would like to suggest that lessons learnt from dealing with patients in the consultation are applicable to participatory management, student-centred teaching (or learner-centred facilitation of learning) and research (PAR and other forms of research, such as qualitative research) and *vice versa*. Family physicians thus have a great advantage from their training, as learning the patient-centred consultation process in depth will enable trainees and practitioners to master the skills in the other areas without the amount of

effort required by novices. Acquiring the ability to be competent in QI, PAR and teaching/learning is therefore less intimidating, and should also remove some barriers between

the different groups.✚

Competing interests

None declared.

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