Multi-professional healthcare and training in the workplace team — A hospital service

Patrícia Vinheiras Alves
palves@esefg.pt
Escola Superior de Enfermagem de Lisboa (Higher Education Nursing School)

Abstract:
This case study intended to research "to what extent the meetings of a multi-professional healthcare team have training potential for the different professionals that take part in them"[1].

I intended to characterise and analyse the dynamics of the functioning of the multi--professional team meetings, the relations established between the different members that take part in these meetings and the implications as regards the ongoing training process of the professionals.

The data was gathered in a Medical service of a Lisbon Hospital through participant observation of the meetings of the multi-professional team. The data was processed through analysis of the content.

The conclusions drawn are that the multi-professional team meetings have excellent training potential, given that they encompass rich debate and individual reflection that, provided these are taken on board, lead to changes in behaviour. This training potential results from processes of experiential training, self-training and socialisation that occur in the meetings. Non-formal and informal training in the workplace are also important in the evolution of the professional practice in articulation with formal training.

Key words:
Self-training, Multi-professional Team, Training in the Workplace, Ongoing Training, Experiential Training, Socialisation.

Alves, Patrícia Vinheiras (2008). Multi-professional healthcare and training in the workplace team — A hospital service. *Sísifo. Educational Sciences Journal,* 05, pp. 17-30.
Retrieved [month, year] from http://sisifo.fpce.ul.pt

CONCEPTUAL BACKGROUND

The workplace and training of healthcare professionals

The workplace enables one to apply theory in practice, using knowledge acquired therein for training situations and again for other work contexts. In this background, the professional practice of healthcare professionals has been increasingly viewed not as merely a moment of application, and is now seen as a structural element of the training process, based on moments of alternation (Canário, 1998). This "alternating pedagogy" (Malglaive, 1990) was introduced a long time ago in training courses, as is the case of courses that train healthcare professionals, because knowledge, know-how and know-how-to--be are acknowledged as important pillars in training these professionals and as being of equal importance in their training. If the theoretical knowledge can, for the most part, be acquired through formal training, the know-how-to-be and know-how is acquired essentially through experience and through interaction between people and the situation, making sense for them (Cabrito, 1999, p. 31).

In tackling the importance of training in the workplace, Charue (1992) mentioned that in an organisation the individual permanently constructs representations of the functioning of their work through the actions carried out. Hence, this will be reflected in the experience, assimilating the most relevant aspects of the work situations, acquiring skills that will allow answers to be found to new problems. Indeed, the workplace can be viewed as an essential educational space because it is in the day-to-day life of each individual and in the workplace that the actors interact, react to events, take part and make decisions (Pain, 1990). However, in this work context there are many activities that may or may not increase the training potential of the situations. These are interpersonal relations, relations with the organisation, teamwork, meetings, etc. Hence, there is a search for spaces of reflection and sharing in which the whole team can be involved in producing healthcare with quality (the main aim of healthcare professionals), and knowledge and experiences that have training potential can be exchanged, through experiential training, self-training and socialisation processes.

Experiential training, self-training and socialisation

Experiential training is a process of acquisition of knowledge based on day-to-day situations experienced by the individual. Therefore, the environment the individual is placed in, as well as the external influences (socio-professional, family, economic and political) constitute ongoing training. One of the most influential learning perspectives in the last few decades, having contributed to the understanding of the experiential learning process, was that of Kolb (1984) who tries to conciliate theory and practice through a structural learning model, highlighting four stages [2] in the experiential

training process that function in an articulated and circular form, repeating themselves continually: the experience itself, the reflected observation, the abstract conceptualisation and the active experimentation.

The different definitions of experiential training from various authors are in agreement as regards the active role of the subjects and their capacity for reflection and experimentation of everyday situations, given that practice and reflection on this practice are essential elements of experience (Bonvalot, 1991). Reflection is a means that allows subjects to develop ongoing learning in and through professional situations, within a self-training background (Canário, 1994). In these circumstances teamwork and communication of experiences in a group are of crucial importance for the healthcare professionals as they enable the problems to be defined, giving meaning to the constructed knowledge based on reflecting on experiences, with the aid of theoretical conceptions, thus forming more solid knowledge as it derives from the experience of each person (Sousa, 2000). It is through this reflection on the practice, grounded on theory, that one can again reformulate the theory, paving the way for new learning. This reflection by healthcare professionals on their professional experiences emphasises the professional connection with their workplace, and this is the starting point for the construction of knowledge and self-training.

Self-training processes are essentially processes in which each individual manages and appropriates a set of influences and experiences, reflecting on them and putting ideas in place to construct oneself as a professional and a person. Communicating the experience allows the individual to look again at the situation and to reflect, discovering aspects that previously she/he had not assigned importance to, becoming aware of problems, which will aid the development of self-training capacities (D'Espiney, 1997). Self-training is entirely up to each individual person. However, it is important that organisations create conditions to encourage it, in so doing optimising the training potential of the workplace is optimised, provided that training devices and dynamics are created in the organisation in order to stimulate and encourage the transformation of experience into learning, through a self-training process (Canário, 1994, p. 26). Hence, the training devices and dynamics in hospital involve formal training through the Ongoing Training Departments and on-the-job training, through meetings and interpersonal contacts, even if individuals are not aware of it.

In the workplace, and especially during the meeting of the multi-professional healthcare team, the actors also experience a socialisation process. This process occurs throughout the life of the individual in accordance with the surrounding environment. It includes education as a child and adolescent in the background of the family, friends, school but also education as an adult in the family environment, with friends, in the workplace and in all aspects of one's life (Lesne, 1977).

However, the individual is not only conditioned by others and the surrounding environment. Ongoing training of adults is understood as a process of socialisation insofar as individuals are simultaneously subjects, agents and objects of socialisation (Lesne, 1977), leading to the widening of the training levels to a field of articulation between the formal, non-formal and informal (D'Espiney, 1997). The individuals are objects because they are conditioned by others and by the environment, agents because they condition others and subjects because they impose conditioning on themselves.

RESEARCH QUESTION AND AIMS

The multi-professional healthcare team of the Medicine Service of a Lisbon hospital where I worked for 8 years meets on a weekly basis (usually Wednesdays) to discuss the cases of the admitted patients and to plan the interventions of the team's professionals, so as to make the work of all as effective as possible and to provide high-quality healthcare. The goal of the meeting is, indeed, to contribute to the care of the patient holistically and with quality. When taking part in these meetings over the years, I realised that I always learned new things. This gave me the idea to carry out a study about the training aspects of the multi-professional team's meetings, formulating the following question as the starting point: "To what extent do the meetings of the multi-professional healthcare team have training potential for the different professionals that take part in them?"

The focus of the study was the weekly meeting of the multi-professional healthcare team of the hospital, having defined the following specific aims:

- to describe the functioning dynamics of the meetings of the multi-professional team;
- to analyse the functioning dynamics of the meetings of the multi-professional team;
- to describe the relations between the different members taking part in the meetings of the multi-professional team;
- to analyse the relations between the different members that taking in the meetings of the multi-professional team;
- to analyse the effects the meetings have on the ongoing training process of the professionals taking part in them.

METHODOLOGY

I opted for a descriptive and interpretative case study, with a qualitative approach.

Within this framework, in this study I observed the professionals and the interactions among one another, in the background of the meeting of the multi-professional team, and I directly took part in the meeting, with the same status as the other participants.

The methodological tool used to register the empirical information was participant observation[3]. I considered participant observation the most appropriate research method in this study because it enabled a direct look at the context, which in this case is the meeting of the multi-professional team and the interactions among the members. For each meeting I stuck to predefined Guidelines for Participant Observation (Table 1) which served as a guide for the observation.

To carry out the study I constructed a form for fieldwork notes, in line with the predefined observation plan, in which I wrote notes that enabled me to subsequently write the report of each meeting, specifying the relevant events.

After the participant observation of each of the meetings, I transcribed its content on the same day and the following day, based on the notes I had made and my memory. The method I used to analyse the data was content analysis.

Table 1
GUIDELINES FOR PARTICIPANT OBSERVATION OF THE MEETINGS OF THE MULTI-PROFESSIONAL HEALTHCARE TEAM

1) FUNCTIONING RULES OF THE MEETING
• Identification of the parties involved; • Plan of seating arrangements; • Who leads the meeting? Why this person?; • Is there a person who attends all the meetings and takes on this role?; • Who asks to speak and how? Is there a specific procedure governing this?; • Duration of meetings; • Structure of meeting; • Roles of the different participants.
2) TOPICS DISCUSSED IN THE MEETINGS
• Is there a pre-established agenda, and what are the reasons behind it? If so, is it changed and added to, or is it strictly stuck to? If not, what are the reasons behind the presentation of each topic for debate.
3) CONTRIBUTIONS FROM THE DIFFERENT ACTORS
• Who speaks? How many times? For how long?; • What is the nature of the contribution?; • Under what circumstances do people speak?; • Behaviour of the actors; • Motivations and intentions of the actors (is the behaviour spontaneous or directed at somebody); • Results or consequences of the behaviours; • How much time of the meeting was profitable and how much was "conversation"? From whom? Whose fault was it?
4) INTERACTIONS BETWEEN THE MEMBERS OF THE TEAM DURING THE MEETINGS
• Relations between the behaviours of the actors (do they work together, i.e. to they take into account other professionals' opinions); • Reasons or intentions behind behaviours (behaviours directed at whom?).

Therefore, after several fluctuating readings of all the observations I undertook an individual analysis of each observation in accordance with the aspects that I deemed a common denominator, making logical and coherent sense in all the observations. Hence, I analysed the content in line with the nature of the intervention of each participant; the training potential of the meeting; the aspects that encourage training; the aspects that contribute to making the meeting less formal. I then undertook a reading of all the individual analyses, which led me to analysis per topic. Hence, several topics emerged which included all the relevant aspects of the observations in a systematised way.

The analysis of the content led to the emergence of three topics, ten categories and 20 subcategories as outlined in Table 2.

Table 2
CLASSIFICATION AND CATEGORISATION OF THE DATA

TOPICS	CATEGORIES	SUBCATEGORIES
Situations with excellent learning potential during the meetings	Situations concerning the patient	Clinical history of the patient Medication Scans Blood tests Surgery Social aspects Nursing aspects Psychological aspects Treatment
	Situations not concerning the patient	Research suggestions Reading suggestions Medicine over time Suggestions of clinical meetings
Situations with little training potential during the meetings	Situations concerning the patient	Discharge without discussion Not looking into social cases Refusal to see test
	Situations not concerning the patient	Information
Aspects that encourage training during the meetings	Experiential Questioning Descriptive Interactive Incentive Suggestion	
	Making the meetings less formal	Relative to the functioning of the meetings Relative to the participants of the meetings Relative to the leader of the meetings

PRESENTATION AND DISCUSSION OF THE DATA

In presenting the data I will briefly refer to the make-up of the team, in the course of the meetings, describing the participants and their contributions and the topics that emerged from analysing the data.

The meetings

During the 10 meetings of this multi-professional team[4] several healthcare professional took part —

the Professor (service director), the service manager, the doctors, the Admitted Patients Complementary Medicine trainees, the Admitted Patients General Medicine trainees, the trainees undertaking the fifth year of their Medical Degree, the head nurse, a graduate nurse and a level I nurse, the trainees undertaking the 3rd year of their Nursing Degree, the social worker, the psychologist, the dietician, the pharmacist, the physiotherapist, the trainees undertaking the 5th year of their Pharmacy Degree and the trainees undertaking the 5th year of their Psychology Degree.

The service director (Professor) leads the meetings[5], given that he is simultaneously the head of the service and the person who takes part in all the meetings. He only missed the 7th meeting, when he was substituted by the head of the service.

The meetings were organised with the presentations of the patients from bed 1 to bed 21, by the doctor who was monitoring each patient, or by the admitted patient doctor (general or complementary) or by a 5th year Medical Degree undergraduate who is under the wing of the said doctor. The doctors present the patients one by one from the medical point of view, describing the pathology, previous cases, justifying the tests carried out and their results, planning further tests, suggesting a diagnosis, forecasting the discharge of the patient and mentioning some questions that the family had asked. The Professor gave his opinion on the case constituting what I call "instituted intervention", and depending on the situation asks for the contribution of other professionals. The other doctors make suggestions of tests to carry out, diagnoses, discuss results of tests and their pertinence. Each member of the meeting can contribute spontaneously and does not need to formally ask to speak.

The meetings follow a predefined structure, which was never brought into question, which consisted of the participants knowing that in the meetings the doctor responsible for the patient would make the respective presentation, describe the clinical evolution and the treatment plan for this patient. I called these contributions "Meeting Structure". During and after this presentation any of the professionals can and should make their suggestions. These contributions are called "Spontaneous". The Professor would often request participation of a professional in particular due to her or his specific training, and this professional would thus become an essential resource in solving the problems of the patient. These contributions I called "Upon Request".

Table 3 outlines the number of contributions per meeting in line with their nature (split into meeting structure, upon request and spontaneous contributions).

Table 3

NUMBER TO CONTRIBUTIONS PER MEETING IN LINE WITH THEIR NATURE.

MEETING	NUMBER OF CONTRIBUTIONS		
	MEETING STRUCTURE	UPON REQUEST	SPONTANEOUS
1st	21	2	10
2nd	23	5	1
3rd	27	4	2
4th	27	4	4
5th	24	0	4
6th	27	4	10
7th	33	0	2
8th	24	4	2
9th	23	6	5
10th	26	2	10
TOTAL	*255*	*31*	*50*
	TOTAL NUMBER OF CONTRIBUTIONS IN THE 10 MEETINGS — *336*		

As shown in Table 3, the total number of contributions in the 10 meetings was 336, with the Professor (and in the 7th meeting the service head) constantly contributing, meaning it was not possible to count them. Of these 336 contributions:

- 255 derived from the meeting structure, i.e. the meeting is structured to allow the patient's doctor, his or her interns and the 5th-year medical degree students to present their patients.
- Spontaneous contributions were made on 50 occasions which shows the interest and motivation to intervene.
- Only on 31 occasions were individuals requested for information. However, in the 5th and 7th meetings nobody was asked to contribute.

The meeting with the highest number of contributions through structure was the 7th (total of 33 contributions), whereas the most upon request was the 9th meeting (total of 6) and the most spontaneous contributions were made in the 1st, 6th and 10th meetings (total of 10 contributions at each meeting).

Naturally, in the course of a meeting it was not only important to find out the nature of the contributions but also what triggered them. Effectively, the origin of the contributions is implicitly linked to the "design" and aims, even if unconscious, of the meeting. Table 4 outlines the number of contributions of the occupational groups according to their nature.

Table 4

NUMBER OF CONTRIBUTIONS OF OCCUPATIONAL GROUPS BROKEN DOWN INTO THEIR NATURE

OCCUPATIONAL GROUPS	NUMBER OF CONTRIBUTIONS			
	MEETING STRUCTURE	UPON REQUEST	SPONTANEOUS	TOTAL
Doctors	166	12	37	215
Nurses	0	8	7	15
Social Worker	0	6	4	10
Dietician	0	2	0	2
Pharmacist	0	2	1	3
Psychologist	0	1	1	2
Medical Students	89	0	0	89
TOTAL	255	31	50	336

Table 4, when we analyse the number of contributions by occupational groups, shows us that:

- Doctors are the occupational group accounting for the highest number of contributions during the meetings (215 contributions), following by medical students (89 contributions) and nurses (15 contributions). This is explained by several reasons, namely:
  - ✓ because this is the most represented group;
  - ✓ because there was a clear and unconscious trend for the clinical aspects to be given more emphasis in the meetings.

Therefore, although the meetings are an opportunity for discussion of the patients' cases in all their aspects, so as to take care of them holistically, the structure of the meetings encourages greater participation from clinical staff. Indeed, only the doctors and the medical students provided contributions through the meeting structure category. Even so, the doctors were the occupational group that took part on most occasions in all categories, either upon request (12 contributions), or spontaneously (37 contributions). Hence, although the meeting is multi-professional and encourages the participation of all people attending it, the meetings tend to be dominated by the clinical aspects, accentuated by the structure of the meeting itself, in which it is always the doctors or the medical students who present the patient. It is pointed out, however, that this aspect is not contested. However,

this structure may not make it easy for non-medical professionals to contribute in the meeting, which may lead to the loss of important exchanges of experiences that could encourage sharing and reflection among all the professionals, and consequently aid their training.

- the occupational group of nurses contributed on 8 occasions upon request and on 7 occasions spontaneously;
- the social worker took part on 6 occasions upon request and spontaneously on just 4 occasions;
- the pharmacist and dietician only contributed twice upon request and the psychologist once;
- the pharmacist and psychologist contributed on 1 occasion. The dietician never made a spontaneous contribution (which could be explained by the fact she had only recently joined the group).

In looking at the set of data we can see that:

- the participants in the ten meetings can be split into different groups depending on whether they belonged to the team and their educational level, as follows:
  - ✓ Medical trainees [6] in the 5th year of their Degree, from General Admitted Patients and Complementary Admitted Patients; Nursing trainees in the 3rd year of their Degree; Psychology trainees in the 5th year of their degree; Pharmacy trainees in the 5th year of their degree.
  - ✓ Professionals [7] - doctors; nurses; social worker; psychologist; pharmacist; physiotherapist; dietician.
- some of the participants missed a few of the ten meetings for different reasons. The individuals who were assiduously attended were: the head nurse and the graduate nurse. The graduate nurse is the researcher and as such attended all the meetings. Few nurses attended the meetings because their shifts made it difficult to do so. During the morning shift only three nurses giving direct healthcare, the head nurse and the nurse in charge are on duty. As the head nurse is absent to attend the meeting, it is difficult for the other members of the nursing team to leave the service, given that the patients require permanent healthcare. Given these constraints, it is indispensable that the nurses who take part in the meeting subsequently transmit the topics discussed to the other members of the nursing team, given that the action of these professionals in relation to the patient and the family, taking into account the healthcare provided holistically, depends on the strategies defined in the multi-professional team.
- the service director (the Professor) led the meetings. The professionals that were most represented in all the meetings were the doctors, which is unsurprising given that, despite this being a multi-professional team, it is the doctors who present the patients. The structure of the meeting shows the tendency to tackle mostly the clinical aspects, possibly at the expense of a more holistic approach;
- the Professor's requests during the meetings were essentially addressed to the nurses and the social worker.

Categories arising from the meetings

Situations with excellent training potential

The category *situations with excellent learning potential during the meetings* arises in all the meetings and occupies most of the time of each one. This category refers to situations that occur during the meetings and which, in leading to interaction and discussion among the professionals that take part in them, involve excellent potential for training. Some of these situations arise related to the patients while others are not linked to the patient. In other words, when the doctor makes a presentation of the patient from the clinical point of view, all the team members carefully follow her/his words, reflecting on them. Afterwards, whether *spontaneously* or *upon request* the other members contribute with questions and suggestions that stimulate interaction and participation from their peers. This participation takes place after reflection and processing of the subjects discussed and is based on the training and prior personal and professional experience of the healthcare workers. The excellent training potential of the meetings is based essentially on the discussion that leads to the individual and collective reflection process among the professionals and the consequent integration of knowledge (Kolb, 1984).

The meetings are based around *situations regarding the patients,* as they are the object of the healthcare. In reviewing the topics dealt with, one can see the multi-professional outlook of these meetings and consequently the caring for the patient as a holistic being. The topics are based on the presentation of the patients which encompasses their clinical history, tests carried out, measures taken and the psychological, social and nursing aspects, as well as the treatment. All of these facets contain training potential, as they encourage interaction and discussion of the professionals with regard to the case, leading to an individual and group reflection, and consequently the construction of knowledge. This process refers to the experiential learning proposed by Kolb (1984), as described.

Next comes the *situations with excellent training potential with regard to the patient* during the meetings. Just some extracts from the participant observations (PO) will be presented.

The *clinical history of the patient* takes us to the inter-relations between the patients' history and their current clinical situation, which constitute the starting point for discussion of the cases among the professionals, suggesting diagnoses, therapy and measures to be taken. The clinical history of each patient, apart from the discharges or any permanent social case, is presented at all the meetings. The following example is an excerpt from one of the PO (Participant Observations): "Dr S presented the patient in bed 4. She explained the clinical case of the patient and why he was taking medication, the diagnoses facilities requested and the results obtained" (PO1).

The *medication* decided upon derived from discussion about the ideal medication to be used in a given case and why.

The discussion regarding the scans (Thorax x-rays, CAT, REM scans) carried out on the patient and their pertinence from the diagnostic and treatment point of view led to the emergence of the *scan tests* category, which can be seen in the following excerpts from the meetings: "the Scan is put in the projector and the Professor asks: 'Where is the pneumonia described?' Dr C replies that it is to the left and the Professor continues: 'the young among you find it more difficult to see because of the overlaying cardiac image but it can be seen there…' He points to the scan projected on the wall and explains what pneumonia looks like on the Scan, saying it is the white parts" (PO3).

I believe it is important to distinguish the *blood tests* from the others as they appear very often in the meetings, as indispensable and crucial tests, which encourage discussion about the diagnosis and planned treatment to be carried out.

The *surgical intervention* category is related to the need for certain operations on patients, their pertinence and the benefits/risks for the patient.

The categories *social aspects, nursing aspects* and *psychological aspects* emerge separately. Although not occurring as often during the meetings as the others, when they do arise they cause heated discussion, reflection and questions, encouraging interactivity among the professionals. However, these subjects underpin the whole discussion of the professionals as one can note the concern to treat the patient as a holistic being. This can be seen from the following excerpts: "Dr G presented the patient in bed 14 and said that it is a complicated social case and that clinical discharge occurred some days ago. She says the family are looking for somewhere to put the patient and that this place needs Nursing support, as it is a tracheostomized case. The Social Worker said that the family had not managed to arrange a vacancy and that the patient may go home. Nurse P then pointed out that the patient could not go home because he needed aspiration and that, even if this technique was taught to the family, as well as being very complicated it entails big risks. The Professor said that a letter had to written to the administration describing the case of this patient and stated that the administration wants to increase the occupation rate by reducing the time of admittance, but with the selection undertaken at the HSM this is difficult" (PO1).

The *treatment* category was defined following suggestions from the Professor about new treatment could a patient can benefit from. This entails training potential as the Professor explains new treatments that are available to the professionals.

The *situations with excellent training potential not linked to the patient* arise mainly based on the Professor's contribution, who motivates the professionals to research into new topics, thus opening new learning horizons. It has excellent training

potential as it motivates others to read up on treatments and leads to requests for research which is the starting point to deepen knowledge, reflection and self-training. An explanation now follows about each category along with some excerpts from the PO.

The *research suggestions* arise out of the requests from the Professor to the workers to carry out research into current and important topics for performing their profession with a high level of quality. The suggestions are the driving force behind the research, reflection and deepening of knowledge, bringing medium-term fruits.

The *reading suggestions* emerge several times during the meetings, as the Professor takes advantage of almost all the questions to encourage others to read new articles, research and review literature and important books. This may well lead each professional to read more, reflect and consequently train themselves. Sometimes the Professor asks somebody to read an article and give a summary.

Medicine over time corresponds to the occasions in the meetings in which the Professor and the head of the service point out and compare the kind of procedures carried out today with those used some years ago. These contributions contain training potential as they can lead to reflection by the professionals with regard to the history of a given treatment, which enable a better understanding of the present and the future of medicine. As examples we have the following excerpts from the participant observations: "The Professor says: 'I want to remind you that formerly, in the civil hospitals, a mixture of water and alcohol was administered which was effective in the deprivation of alcohol'. Dr SF interrupted saying: 'Alcohol was also given with cinnamon…' All laughed" (PO5).

The *suggestions of clinical meetings* involve the setting of a date and time for holding such meetings on the initiative of the Professor for the professionals to attend. This information has training potential as it can encourage participation in the meetings and joint reflection, with the consequent further training of the professionals.

Situations with little training potential

Although most of the meetings are based on interactions among professionals, individual and joint reflection, stimulus towards self-training, bringing personal and professional experience of the technicians to the solving of new problems, these facets are not always involved. In other words, on occasion certain subjects arise that are not discussed as they are somewhat brushed over. These situations were included in the *situations with little training potential during the meetings* category. The category refers to events during the meetings that do not provide training potential as they do not encourage reflection and discussion. The situations with little potential for training are linked to subjects that could have excellent training potential if they were the object of discussion and reflection. In these *situations with little training potential in relation to the patient*, social problems arise which are neglected as a topic of discussion in a team, and are channelled for subsequent solving by the social worker. This brushing over of certain topics by the team, reflecting the clinical onus of the meetings, does not encourage discussion, interaction and consequent reflection. These situations are the *discharges without discussion* that almost always emerge when the patients are discharged, as the doctors, most of the time, only say that they will be discharging the patient and do not explain the situation and the clinical history up until that point. The truth is that the cases of these patients are discussed every week in the meetings. However, when they are discharged it would be useful to explain the entire history of the patient up until then, as this would lead to questioning and consequent discussion and reflection, entailing excellent training potential.

Likewise, the *non-deepening of the social cases* has little potential for training as in some situations the cases are not discussed from the social point of view. Sometimes the case is merely presented, mentioning that it is a social case and the social worker says that she will solve it but does not discuss the plan to find a solution. This discussion could have excellent training potential as it would allow professionals to discuss the social case and reflect on it in a group, and consequently people would learn from one another and thus acquire tools and knowledge needed to solve other identical cases.

Refusing to see tests also has little training potential but only happened once in a PO. Nevertheless, the occurrence should be pointed out given its singularity and the training potential that an

explanation of the test would involve. Hence, in the following excerpt the Professor refused to see the test, saying that they had already seen a lot of CAT scans (computed axial tomography scan), but wasted an opportunity that entailed excellent training potential, as one scan is never the same as another and its discussion enables reflection and potential learning. As an example of a PO: "The Professor interrupted: 'We afterwards want to see the REM' Dr T says: 'If you want to see the CAT?!'. The Professor says: 'No. We have seen CATs, but we are not so used to looking at REMs'" (PO8).

Situations with little training potential not related to the patient also arise in which *Information* is only given to the team members and there is no questioning, discussion or reflection.

Aspects encouraging training
This topic is extremely important and relevant and is highly prevalent during the meetings. It refers to the specificities of the functioning of the meetings and the professionals themselves who encourage discussion and reflection, empowering the training potential. In other words, the way these meetings work and how the participants relate to the leader and to one another during the meetings, as well as the relations that are fostered at the meetings, encourage the training of the professionals. These specificities regarding the functioning of the meeting and the permanent interaction among the individuals who take part in it subject them to a constant socialisation process, i.e. the participants are confined to the same place, interacting with one another, learning from one another, being simultaneously subjects, agents and objects of socialisation (Lesne, 1977). This category also encompasses situations that enable the reader to reflect on the important aspects during the meetings so as to make them better training tools. I am referring to the processes that occur in the meetings such as the description of the situations, sharing of experiences, constant questioning and interaction, encouragement of the Professor to stimulate research and self-training of healthcare workers. Other aspects that encourage training during the meetings are the informalisation of the meetings, not only with regard to its functioning (the random seating arrangements, the democratic nature of the participation and the handing out of cakes in the middle of the meeting), but also with regard to the participants (the relations among one another) and in relation to the leader of the meetings (his informal demeanour during the meeting).

CONCLUSIONS

The nature of the sample and the kind of study does not allow the generalising of the results, or their extrapolation to another population. However, although this is not the purpose of the study, I cannot neglect to point out the important contribution made by in-depth knowledge of a "singular case" towards general knowledge.

The meetings of the multi-professional healthcare team are a common sharing, debating and reflection facility of several professionals about their experiences in the workplace. These meetings are also part of the work context and a potential place of learning, with the meetings encompassing a training aspect. Throughout the whole of this analysis I stated that the wealth of the discourses, debate and consequent individual and joint reflection of the group regarding decisions made, have excellent training potential. One can say that they have training potential provided that the reflection process is undertaken, taken on board and leads to change.

These meetings articulate non-formal and informal situations. Non-formal, because in spite of the fact the purpose of the meeting is not to train its participants, the Professor purposely encourages a search for learning situations for the participants. Informal, insofar as this is defined as all the educational opportunities throughout the life of the individual, even if she/he is not aware of them.

This analysis also reinforces the importance and the benefits of articulation between formal, non-formal and informal training in an individual's learning and the incomparable need for training in the context of the workplace for health professionals. Furthermore, it highlights the need for opportunities to share and reflect among the professionals so that each one can look and/or look again and reflect on their experience, making its integration, and consequently self-training, possible.

Throughout the analysis of the data three learning domains have clearly arisen: experiential training, self-training and socialisation. The training during the meetings is carried out in an experiential manner, insofar as individual and collective experiences of the group in relation to their work are debated. Reflections are made individually and in conjunction, in the important decisions made in relation to the treatment of the patient. The four stages of the experiential training process according to Kolb (1984) can be observed during the meetings [8]. In order for experiential training to take place two aspects are essential: practice and reflection. These two aspects are present in the meetings as reflection is undertaken concerning the practice, i.e. in discussing the patients' cases a discussion of the professional practice of the particular professional and case in question is carried out. This debate and joint reflection about the best way to respond to the needs of a given patient are as important in the training of the individuals as their professional experience — one without the other makes no sense.

As well as the debate and the individual and joint reflection during the meetings, situations arise where people are encouraged to research, read and take part in clinical meetings. These situations entail training potential as they encourage individuals towards self-training through the appropriation of a set of influences and experiences that have taken place, reflecting on these and working on one's self-construction as a professional and a person.

A process of socialisation is also evident in the meeting inasmuch as all the actors are agents conditioning the other participants, objects, as they are conditioned by the environment and by the other members of the team and subjects, as they determine and adapt themselves to the social demands of the environment (Lesne, 1977).

Therefore, the meetings of the multi-professional teams are a non-formal and informal training device (effective to a greater or lesser extent depending on the way they function) insofar as experiential training, self-training, and socialisation processes are at play, given that the meetings are a space for conversation and sharing among the individuals necessarily conditioning the reflection and learning, even if unconscious.

Endnotes

1. I was a nurse for eight years in a Lisbon Hospital. When I started my profession I realised that I knew very little as I was learning all the time and every day on the job. That well-known sentence from the famous Greek philosopher Socrates "I only know that I know nothing" perfectly fitted my situation at the time, and I thought of it on several occasions. I also realised that this learning was heavily dependent on keeping in constant contact with others, reinforcing the idea that we learn from others. I often asked myself questions about what I saw around me as if I was a spectator and a critic watching a film in which I was also one of the actors. These observations and reflections about my professional practice and its relationship with that of others, led me to study the learning processes of individuals, to try and learn to what extent the professional practice, in involving different actors, can become a training situation, given that work always provides an opportunity to learn, depending on the richness of the content of this work (Pires, 1994).

In this background, it occurred to me that one of my weekly professional activities, the multi-professional hospital healthcare team meeting of the service where I worked (Medicine Service), could be a training activity. I therefore considered it important to carry out a study about the training potential of the meetings of the multi-professional healthcare team. I think that this issue and this project, as well as being interesting, is pertinent as it raises questions and encourages reflection about the training nature of the team's meetings, unveiling a new perspective of the meeting of the multi-professional healthcare team — the training potential of these meetings.

2. In the conclusions these stages will be outlined and transposed to the meeting of the multi-professional team.

3. I took part in 10 meetings of the aforementioned multi-professional team (from 4 December 2003 to 7 April 2004). My presence at the meetings did not cause any obstacle to those present, given that as I had been part of this team for around 8 years my presence and contributions during the meetings was perfectly natural and normal.

4. This multi-professional team is made up of the following professionals: doctors, nurses, medical auxiliaries, psychologist, pharmacist, social worker, dietician, secretary of the unit and physiotherapist. Also generally on duty at the service were: doctors of complementary and general medicine for admitted patients, who change during their training; temporary 5th-year Medical Degree trainee students; and nursing students from different years of their degree, who change throughout their training. All these individuals take part in the multi-professional team meeting during the time they are working at the service. Taking into account the specific nature of the knowledge required by the multi-professional healthcare professionals, the medical auxiliaries and the secretary of the unit do not take part in the meetings.

5. Owing to the high number of people involved, most of the meetings took place in the small amphitheatre. Here, the Professor sat in a raised chair, at the desk facing the audience, highlighting his role as a leader of the meeting. The other members sat randomly on the chairs with an incorporated table. However, and despite what can be construed as a manifestation of power by the Professor, this positioning in the form of an amphitheatre is suitable for meetings with a lot of participants (as is the case) enabling some form of interaction among the participants and encouraging the raising of questions (Rego & Cunha, 2000). It is also pointed out that there is no alternative venue where a meeting with this number of people can be held. Therefore, the question of power is more of a direct consequence of the conditions of the hospital than an explicit desire of the participants. Indeed, although the Professor is positioned in the room in a seat that highlights his leadership, the other places are occupied at random, which shows the democratic nature and openness of the team members among one another.

6. The trainees belonged to and worked with the team throughout their training placement.

7. The professionals belonged to the team.

8. In the first stage, the individual goes through a specific experience, which according to Aguilar (2005) may be past or current personal experiences, future expectations, dilemmas and problematic challenges. Transposing this to the meeting of the multi-professional team, we consider that the explanation of the whole history of the patients and the presentation of their problems and future expectations

with regard to their future clinical evolution is this specific experience proposed by Kolb (1984). In the second phase (reflexive observation), the subject "... analyses the aspects of the situation experienced, comparing them to the data of previous experiences..." (Cavaco, 2002, p. 36). During the meetings and after the presentation of the patient, the professionals ask question, share opinions and reflect, exemplifying the reflection observation proposed by Kolb (1984). In the third stage (abstract conceptualisation) the analysis carried out previously enables the individual to "...discover the concepts and general principles..." (Cavaco, 2002, p. 36). During the meetings and after the debate and reflection of the professionals, the Professor usually gives a brief summary of the debate and exchange of opinions, characterised by the establishment of a common exchange of ideas. The subject in the fourth step (active experimentation) makes "...use of this experience in future experiences, leading to the start of the learning process, repeating the first stage and so on successively " (Cavaco, 2002, p. 36). Indeed, during the meetings, cases are presented, reflection takes place and ideas are formulated about a prior action and experience of professionals, enabling the subsequent practical application of the knowledge and experience reflected on.

Bibliographical references

Aguilar, L. (2005). *Modelo de Aprendizagem Centrado na Experiência*. Retrieved May 2005 from http://216.239.59.104/search?q=cache:BDPkTUU6XdsJ:www.teiaportuguesa.com/metodocentradonaexperiencia.htm+Modelo+da+Aprendizagem+ experiencial+de+Kolb&hl=pt-PT

Bonvalot, G. (1991). Élements d´une définition de la formation expérientielle. *In* Bernadette Courtois & Gaston Pineau (eds.), *La formation expérientielle des adultes*. Paris: La Documentation Française, pp. 317-325.

Cabrito, B. (1999). *Formações em alternância: conceitos e práticas*. Lisboa: Educa.

Canário, R. (1994). Centros de Formação das Associações de Escolas: Que Futuro? *In* A. Amiguinho & R. Canário (orgs.), *Escolas e Mudança: O Papel dos Centros de Formação*. Lisboa: Educa, pp. 13-58.

Canário, R. (1998). A escola: o lugar onde os professores aprendem. *Psicologia da Educação* (Puc- S. Paulo), 6, pp. 9-27.

Cavaco, C. (2002). *Aprender fora da escola — Percursos de formação experiencial*. Lisboa: Educa.

Charue, F. (1992). L`organisation fait-elle apprendre? *Éducation Permanente*, 112, pp. 78-86.

d'Espiney, L. (1997). Formação inicial/Formação contínua de enfermeiros: uma experiência de articulação em contexto de trabalho. *In* R. Canário (org.), *Formação e situações de trabalho*. Porto: Porto Editora, pp. 169-188.

Kolb, D. (1984). *Experiential Learning*. New Jersey: Prentice-Hall.

Lesne, M. (1977). *Trabalho pedagógico e formação de adultos*. Lisboa: Fundação Calouste Gulbenkian.

Malglaive, G. (1990). *Ensinar adultos*. Porto: Porto Editora.

Pain, A. (1990). *Éducation informelle. Les effets formateurs dans le quotidien*. Paris: Éditions L'Harmattan.

Pires, A. (1994). As novas competências profissionais. *Formar*, 10 (Fev/Mar/Abr), pp. 4-19.

Rego, A. & Cunha, M. (2000). A dança das cadeiras ou a dança sem cadeiras. *Dirigir — Revista para Chefias*, IEFP (Nov/Dez), pp. 50-60.

Sousa, S. M. S. (2000). Educação, formação e Enfermagem. *Revista de Enfermagem Oncológica*, 4, 15 (Julho), pp. 25-38.

Translated by Thomas Kundert