Dual professional focus clinical case processed in an interprofessional postgraduate case seminar: Experiences from participants and the perceptions of a professional observer

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Abstract

Background: Inadequate communication between professionals in operating theaters results in impaired medical performance or even in critical events. Interprofessional case seminars, however, can enhance team communication by promoting a deeper understanding of complex situations. Our aim was to evaluate how an interprofessional case seminar using a dual professional focus case in anesthesiology was perceived by the participants. Method: A case seminar was held for 20 nurse anesthetists enrolled in a postgraduate course and for six anesthesiology residents. Transcripts of the case were distributed in advance for individual study and group discussion. The evaluation was based on the responses provided by participants who completed a semistructured questionnaire and from the perceptions of a professional observer. Results: Twenty participants completed the questionnaire; 53% of the respondents had previous experience with case methodology, and 89 different statements were obtained. Of these, 48% were positive and 11% were negative. The remaining 40% of the statements related to previous experiences with case methodology and to suggested improvements. The positive statements proposed that case methodologies are suitable for sensitive issues and beneficial for meetings and exchanges between different professionals. Negative statements focused instead on lack of time, overly large groups, too much speculation, and inadequate preparation or presentations by the participants. Conclusion: Interprofessional case seminars using a dual professional focus may be
suitable for postgraduate education in anesthesia. This technique may improve interprofessional communication and may call attention to the importance of soft issues, such as ethics, communication, organization, and leadership in addition to that of the medical dimension.

**Keywords:** interprofessional learning; interprofessional communication; case discussion; case method,

### Introduction

With respect to the cooperation between nurse anesthetists and anesthetists in the surgical ward, deficits in interaction and communication may be hazardous. There are several barriers to effective and purposeful communication: Unshared or insufficiently expressed opinions, or conflicting beliefs communicated by different professionals about patients or situations, may lead to unnecessary negative consequences for the patient (Wershofen, Heitzmann, Beltermann, & Fischer, 2016). Moreover, status asymmetry between team members has led to critical communication gaps and to incorrect decisions and actions in simulated acute scenarios that involve trainees and consultants (Friedman et al., 2015). Preparing students for future collaboration has been shown to contribute to efficient and high-quality health care (Packard K, 2012), and the same may be true for professionals who have already completed their education. Therefore, it seems natural to use case seminars in the further development and simulation of the collaboration between different professionals in multi-focused clinical situations, as well as an understanding of their skills, responsibilities, and assessment. Interprofessional case seminars comprise an important teaching method with which to present complex problems. Case discussions that focus on communicative processes in the context of problematic patient situations can lead to a deeper understanding among professionals within the seminar team (Bridges, Davidson, Odegard, Maki, & Tomkowiak, 2011).

The overall objectives of the postgraduate course for the nurse anesthetists consisted of teaching the participants how to detect and to handle complex medical and interpersonal situations in clinical work. The aim of this study was to evaluate how interprofessional case seminars using a dual professional focus case (for nurse anesthetists and anesthesiology residents) was perceived by the participants and what advantages and difficulties were observed and encountered during the exercise.

Our hypothesis proposes that case seminars encourage and develop interprofessional learning in postgraduate settings. The study objective was to support this hypothesis through active listening, enhanced communication and cooperation, and an improved understanding of different professional focuses. At the same time, the use of case seminars may draw attention to any problems in the organization and leadership of the unit involved.

### Methods

In the present study, classic case seminars were used in a postgraduate course for nurse anesthetists at Linköping University. The case seminar was planned and organized based on recommendations by Nordquist and Johansson (Nordquist J & Johansson L, 2009). Anesthesiology residents were included in the seminars, which comprised a pilot project in the development of interprofessional pedagogical curricula at the Medical Faculty, Linköping University. First experiences from the interprofessional teaching, processing a dual-focused case, were resumed and have been recently published (Szabó, Nilsson, & Davidsson, 2016).
Preparations

A preset template was used to conduct case seminars in the postgraduate course for the past three years. The cases were based on real situations and were constructed so that responses and solutions could be interpreted in several ways and could cover a broad range of complex situations at an anesthesia clinic, including risk assessment, evidence in practice, and ethical dilemmas. Case transcripts were distributed to the participants three weeks prior to the seminar for individual reading and preparation. The moderators prepared for the seminar by engaging in a careful discussion of the case based on the course objectives. Maximal student engagement is critical; in order to achieve this, the seminar was organized so that the participants had the freedom to choose the discussion topics.

Participants

The case seminar was held for 20 experienced nurse anesthetists (each having at least five years of practice) and six anesthesiology residents. The seminar was moderated by a nurse anesthetist and a senior consultant in anesthesiology. Three weeks before the seminar, the participants were informed of the learning objectives and of the requirements for an approved seminar. The seminar was a part of the nurse anesthetists' postgraduate course as well as a component of the anesthesiology residents' clinical education. Case seminar was obligatory and active participation was required for successful completion of the course.

Participants prepared for the seminar by studying the guidelines, reviewing results from relevant studies, and conducting searches for evidence to support or to question the actions presented in the case. The clinical cases had a dual professional focus and were reality based; therefore, individual preparation was of great importance to the whole group in terms of what would be processed and learned through discussion and dispute during the seminar.

The setting

At the seminar, the procedure was explained to the participants. The seating in the seminar room was arranged in the shape of a half circle, and everyone wore nametags in order to facilitate communication between all participants.

The process

The seminar was moderated by a nurse anesthetist and a senior consultant in anesthesiology.

First, the seminar procedure was explained to the participants. The moderators’ task was to lead the seminar by facilitating the discussion, engage the participants, and ensure that all views would be heard. The seminar started with a five to ten minute warm-up discussion in small groups of four to six persons. After the warm-up period, the moderator asked the participants what the case was about and invited the participants to discuss it. This section involved recording different ideas of what was crucial in the present case. One moderator wrote themes on the whiteboard for everyone to view. These themes were then organized as a mind map to assist the moderators in covering the case content.
Case and case construction

Professionals working in operating theaters, but who were not involved in the actual situations, narrated the cases used at these seminars. The cases were based on real-life situations and were written as detailed stories in which only the names and places were fictional. All data and actions were authentic and were presented as the narrator experienced and remembered the situation. Clinical situations suitable for a case are usually not everyday situations; chosen instead are complex, intricate, or serious events in which proper assessment and actions are controversial and debatable, while at the same time having a dual professional focus. Clinical events that include ethical dilemmas or failures in communication are also preferred. As the situations used feature clinically demanding and complex contexts, there is no need to use red herrings, e.g. misleading information (Hafler, 1989). The case used in the current seminar is presented in Appendix 1.

The learning objectives were to make the participants aware of the importance of soft issues in clinical settings and to suggest the importance of communication and collaboration between the professions for optimal patient outcomes. In writing the case, the primary intention was to set the emphasis primarily on soft issues such as communication, teamwork, and organization of the department. The secondary intention was to encourage the participants to discuss the facts related to pathophysiology, pharmacology, and clinical anesthesia.

Based on our experience, it is conceivable that interprofessional teaching and learning is most suitable and most meaningful in postgraduate education, as both hard clinical facts and soft content, ethical considerations, and communication issues are context-bound. The context of clinical work is tied to the two professions in our case, and the discussion was aimed at facilitating the creation of a more collaborative, rather than a competitive, attitude between the professions, an achievement that is seldom realized. Indeed, the participants discussed the issues as they would have had they been in the surgical ward.

Data collection

The method used in the study consists of two separate parts: observation of the seminar and a questionnaire for the participants. The method for both the collection and analysis of the data was mainly qualitative, as the nature of the phenomenon studied focused on the participants' actions, social interactions, and experiences as well as how knowledge was constructed during the seminar (Bryman A, 2004). The observation was conducted by an independent expert observer who was introduced at the start of the seminar and positioned in a corner of the seminar room with a full view of all participants. The field notes focused on the actions of the moderators and the participants, the topics covered, and the time allotted for different phases of the seminar. The time was recorded, with 00:00 designating the beginning of the seminar.

The questionnaire (see Appendix 2) was semistructured and consisted of six open-ended questions that addressed the participants' previous experience with case methodology, their experience with interdisciplinary case seminars, what they thought of case methodology as a learning method, what was good about this seminar and why, what was bad about this seminar and why, and how could the case methodology have been improved. The questionnaire was anonymous and was distributed to the participants immediately after the seminar and collected within an hour. A total of 20 completed questionnaires were obtained from 14 nurse anesthetists and six anesthesia residents.

The analysis of both the observation and the questionnaire was qualitative. The field notes from the observation were transcribed and organized according to the different sequences of the seminar. For each sequence, duration, actions of the moderators and participants, and the topics discussed (i.e., who did and said what) were condensed,
categorized, and noted. The questionnaire responses were mostly in the form of short sentences, and each statement was analyzed and categorized. The analysis was inductive, and the categories constructed were based on the content of the participants' responses (Kvale & Brinkmann, 2014). The number of statements in each category is presented in Table 1, and represents a quantitative component of the analysis. The combined results from the observation and questionnaire were then triangulated in order to achieve a deeper understanding of the interprofessional case methodology.

Results

Field notes from the observation of the seminar

The seminar was recorded in minutes, beginning at the zero hour (i.e., 00 hours: 00 minutes).

(00:00) Beginning of seminar. A short introduction was presented by the moderators. The first task was to discuss the case openly in small groups.

(00:05) Small group discussion of the case. Groups mingled with nurses and doctors. Moderators circulated among the groups. The participants engaged in discussion, with each taking turns, and the atmosphere was relaxed and marked with laughter. It was not possible for the outside observer to identify who among the groups were nurses or doctors.

(00:20) Joint discussion: whole group. One moderator led the discussion, and the other took notes on the whiteboard.

One of the moderators asked the group to describe what the case was about.

The responses covered topics such as communication, treatment, prestige, responsibility, knowledge, respect, stress, assessment, organization, relations, routines or the absence of routines, and the reporting of events.

One of the moderators asked the group to describe the main problem in the case.

The group discussed the problem; more than half the group actively participated. The discussion regarding the case moved back and forth while covering different topics. Ranked by frequency and time, the topics focused on the following: 1) the patient; 2) roles and relations, both professional and in relation to patients; 3) medical issues; 4) information processing; 5) organization; and 6) professionalism and experience.

The moderators summed up the previous discussion and focused specifically on how to handle situations in which information must be provided to patients (in this case, giving information to a parent about a child with a broken arm). The question posed to the group was "How would you have handled this situation?"

Participants' responses focused on the organization of the clinic, relations between professionals, and the importance of providing appropriate and accurate information to patients in relation to the specific situation.

(00:35) Small group discussion of the case based on the notes/mind map on the whiteboard. One of the moderators asked the group to discuss what could be done to avoid the problem. Both moderators circulated among the smaller groups during the discussion. Participants engaged in lively discussion.
Joint discussion: whole group. One of the moderators asked the groups to offer suggestions for solutions. The responses focused on the clinic organization and climate, relations between different professions, respect, judgement, exclusion and inclusion, the risk for bullying, how to support residents during training, the working environment, and the importance of good leadership.

Final joint discussion: whole group. One of the moderators asked the group to relate the case discussion to their own experience. For the most part, the responses covered the general working environment. Overall, the participants confirmed the relevance of the case and their recognition of the problems outlined in it based on their own experience. The discussion was not explicitly summarized, but the conclusion centered on the importance of leadership, an open and permissive climate, support, good relations between colleagues regardless of position, and how to behave in the presence of patients.

Summing up. The moderators summed up the seminar and ended by presenting recommended materials for further reading.

End of seminar.

The seminar conducted in the present study can be described as a dialog between moderators and participants that moved from an overall level to a specific one that covered different aspects of the problem outlined (e.g., the patient, roles and relations, medical issues, information, organization, and professionalism and experience). Also addressed were broader issues, such as clinic organization and climate, relations between different professions, the work environment, and the importance of good leadership in everyday practice.

Results from the questionnaire

Table 1 presents the participants' responses for each of the topics covered in the questionnaire.

Table 1. Participants' responses: categories and numbers of statements.

| Topic                                      | Categories (number of statements)                                                                                                                                 |
|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Previous experiences with case methodology | • Yes (10)                                                                                                                                                         |
|                                            | • To some extent (3)                                                                                                                                               |
|                                            | • No (6)                                                                                                                                                           |
| Opinion of case methodology as a learning method | • Positive: Concrete case. Discussion in group setting. Positive climate. New perspectives/aspects. Good for discussing "soft" issues. (10) |
|                                            | • Negative: Is there evidence for this method? It makes no difference what you think. Waste of energy. (2)                                                        |
|                                            | • Other: Too few anesthesiology residents.                                                                                                                        |
|                                            | • Too much subjective speculation. (2)                                                                                                                           |
| Experience of the interdisciplinary case seminar | • Positive: Meeting of different professions. To share the opinions of others. Integration is positive for everyday work and cooperation. Good discussions! Relaxed situation. (15) |
|                                            | • Negative: Group too big (1).                                                                                                                                   |
|                                            | • Other: An open climate and mutual respect is important. Important not to cover too much at the seminar. (3)                                                       |
What was good and why?

• Different perspectives and exchanges between professions. (14)
• Good case for sensitive issues. (2)
• Mixed groups. The groups were not too big. (2)

What was bad and why?

• Lack of time. All participants will not be heard. (5)
• Bad choice of case. Group not prepared for the seminar. Too much "philosophizing." (2)
• Case featured a very serious problem! (1)

How to improve the case methodology

• Smaller groups and more time for each participant in the discussions. (3)
• Better presentations based on group discussions. (1)
• Several different cases. More concrete cases. Newer articles. (7)

The analysis resulted in 89 different statements. A total of 43 (48%) statements were positive, and 10 (11%) were negative. The remaining 36 (40%) statements were of a different character (e.g., previous experience with case methodology, suggestions for improvements, etc.) The majority of the respondents had previous experience with case methodology.

The positive statements covered case methodology as follows: in general terms, as suitable for sensitive issues, good for meeting and exchanges between different professions, and positive if linked to everyday work. The statements stressed the importance of a good seminar climate, which was noted to be the case in the current seminar.

The negative statements focused instead on the organization of the seminar (e.g., lack of time, too-large groups, too much speculation, philosophizing, and inadequate preparation or presentations by the participants).

The suggestions for improvements covered a broader perspective and included issues ranging from how to organize the seminar (e.g., smaller groups and more time for each participant) to the development of cases and article upgrades.

Noteworthy was the absence of comments and statements, both positive and negative, regarding the actions of the moderators/case leaders and their interaction with the participants. This can be interpreted in several ways, but in light of the general outcome of the analysis (i.e., the focus on the methodology and its adequacy as well as the engagement and positive climate at the seminar), the most likely interpretation is that the seminar leadership worked well. In other words, it seemed to be "transparent" to the participants and did not interfere negatively with the process.

Taken together, the results from the observations and the questionnaire strengthen the conclusion that the interprofessional dual focus case seminar is an effective method for addressing the learning objectives in postgraduate clinical education, as well as for improving interprofessional communication with respect to a broad range of issues (e.g., clinical, organizational, patient-related, professionalism-related, and ethical). The argument for this is based on the observation that several aspects converge toward this interpretation, namely the aim of the seminar, the construction of the case, the interaction and discussions at the seminar, and the outcome of the questionnaire.
Discussion

The most important finding from this survey was that the majority of the participants believed interprofessional case seminars to be meaningful and important in postgraduate or clinical residential education. The structure of the case and the organization of the seminar were deemed useful for handling difficult medical and interpersonal situations that are very similar to those in the real-world clinical environment. Although there were too few participants for a comparison analysis, both the nurse anesthetists and the residents stressed the interprofessional component as being fundamental to the experience. The discussion was noted as being purposeful for soft issues and suitable for exchanging points of view. Adverse opinions were connected to time limitations and to preparation for the seminar. Time limitation was noted as too short, and elements of general opinions, rather than well prepared statements, were observed to contribute to a less meaningful seminar.

Cases used in the seminars are generally complex and not easily understood, as the method applies to the highest taxonomy in learning (McMahon & Christopher, 2011; Nordquist J & Johansson L, 2009). Complexity in cases leads to a process of identifying potential problems, a process subserved by a larger number of participants, but in this survey, also subserved by the interdisciplinary setting. The different perspective, to some extent explained by different professionals or by different experiences (e.g., years of work experience and educational or professional role), may lead to both a broad and a detailed analysis. In clinical anesthesia practice, different professionals tend to overlap each other’s competences in order to provide the best care and the most effective medical solutions. In simulated clinical acute and non-acute situations, it has been shown that shared responsibilities and constructive suggestions may contribute to high teamwork quality and improved care, but only if the professionals demonstrate sufficient autonomy (Muller-Juge et al., 2014). Having less autonomy or weakness in an acting role indicates that someone on the team has to cover for you, and the synergy effect of teamwork is reduced. Based on these conclusions, therefore, we believe in the effectiveness of communication and problem-solving exercises such as case methods.

Issues such as preparation, philosophizing, and too-large groups may all derive from the fact that case seminars must be properly prepared for by the attender. Individual preparation is important and may determine if the seminar is considered worthy or not by the participants. Also, Nordquist and Johansson (Nordquist J & Johansson L, 2009) stated that the aims of the seminar must be known to the participants if they are to adequately prepare. It is most likely crucial that information prior to the seminar is clear as to purpose and expectations; furthermore, references may be requested.

The ideal maximum number of seminar participants is generally high; 50–100 students (Bowe, Voss, & Thomas Aretz, 2009) or even more than 200 (Barnes, Christensen, & Hansen, 1994). If all the participants actively take part in the exercise, a maximum number of 20–30 would be optimal. In the present seminar, almost all participated in the discussion, which was optimal in depth and satisfactorily completed within the given time frame.

The validity of the present study is strengthened by the use of both an observer’s field notes and a qualitative questionnaire. Additionally, triangulation has been acknowledged to strengthen the validity of this type of study. We believe that there was solid consistency of the data obtained from both the observations and the questionnaire. The study’s reliability is strengthened by the low dropout rate of participants and by the fact that the questionnaire was administered and responded to in connection with the seminar; consequently, the data reflect the participants’ immediate experiences.

The collection of the questionnaire data was anonymous and voluntary; the respondents’ professions comprised the only participant information collected. The participants were informed about the purpose of the survey. We assume
that the questionnaire responses reflect the respondents' true opinions. The limitations of the study are the low number of participants (n = 20), although, with a few exceptions, the answers seemed to be consistent.

The four basic ethical requirements that served as the guiding principles of this study are information requirements, compliance requirements, confidentiality, and utilization requirement (Bryman A, 2004).

The study is newsworthy, as it is, to our knowledge, the first to describe the use of an interprofessional case featuring a dual professional focus within the clinical context of postgraduate anesthesia education. An interprofessional case method is new in this context, as there is no available previous experience on which to draw.

**Take Home Messages**

- A dual professional focus (the usual cases have one professional focus) case may be successfully implemented in an interprofessional postgraduate case seminar.
- Negative experiences, such as lack of time, too large groups, too much speculation, inadequate preparation or presentations from the participants, have to be avoided.
- Most of the participants were pleased with the seminar, which was purposeful for the discussion of the medical dimensions, but also for the soft social dimension within the operating ward.
- This kind of seminar may strengthen the cooperation of the anesthesiological team by opening the way for the improvement of clinical outcomes in complicated anesthesiological and surgical cases.

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Appendices

Appendix 1

CASE 3 - Conflicting statements

It has been a messy day at work and now it's finally time for the last emergency patient on the program. Several elective operation cases have been set up to priority the unusually heavy emergency operation program. It is autumn but the situation on the minor anesthesia and operating theater is more similar to how it usually is during the winter when the first snow greatly increases the number of fractures as a result of slips. However, the last patient is now on the way into the room: a five-year old girl with a forearm fracture that must be fixed.

Erik Pärsson works as an anesthetic nurse at the small hospital in the region. He has worked in anesthesia and emergency care for over ten years but has in the recent years tried to get away from work in the emergency department for the benefit of a full-time job at the anesthesia clinic. Usually he works at the orthopedic rooms. He feels more at ease to actually have time to talk to the patients here. Moreover, he realized that he thinks it is challenging and great fun to have the privilege to work with children’s anesthesia. There is not a model to follow in the same manner as in trauma care in the emergency department, instead he is allowed to trust his gut instinct and adapt his work to the current situation. But right now, there have been both transfers and deletions of patients because of the many acute cases. The time is approaching four, and together with his colleagues in the operating room, he should go home in about an hour.

The patient Sara

The last patient is Sara, five years old, with a forearm fracture. A few days ago she fell from a children's play scaffold and got her arm under her with the fracture as a result. During the visit the emergency department, she received a plaster and control x-ray. Initially, it was estimated that this would be enough; no surgery was needed. The images at the x-ray control were sadly assessed inadequate, and a senior orthopedic surgeon was consulted and
ordained a new survey. The retaken pictures showed a minor deformity and orthopedist thought it was better to fix through surgery. Sara has now been home for a few days after the accident at the play scaffold. Upon arrival at the hospital's children's section in the morning they received the news that because of the many emergency operations, Sara would have to wait until after lunch before it would be her turn. Sara was allowed to drink juice and water until ten o'clock, then nothing to eat or drink.

Anesthetist Bengt

Anesthetist in charge for the day is Bengt Andersson. Bengt has for some years of time with various temporary positions, received an residents appointment at the anesthesia clinic. He has had time to harvest just over a year in role and really enjoy the work. It was this job he wanted all the time, both during the early studies, but especially during the last year of medical education. He came to the anesthesia clinic to obtain, according to him, the optimal blend of theoretical and practical performance. He is accustomed to and likes to take quick decisions to get ahead at work and he is both social and good at communicating with the rest of the team.

Bengt has already visited Sara at the orthopedic ward. He talked with Sara and Sara's mother about what would happen during the day. It turned out that Bengt and Sarah's mother, Pernilla, were classmates in medical school. Pernilla is working at a nearby hospital but now at home with Sarah's little brother. Bengt took the time and talked a little extra with Pernilla and Sara and interpreted Pernilla's anxiety before surgery to be partly a result of a bad conscience about what happened Sara at the play scaffold. Pernilla had been forced to drop the attention on Sara to favor her younger brother and Sara had then climbed to the top of the scaffold. Bengt assured that everything would happen today was pure routine and there was nothing that indicated that it would not go well. For safety, Bengt writes "intubation anesthesia" on anesthetic assessment. You do not know, Sara is perhaps still in pain and after all she drunk a few glasses of juice in the morning. Pernilla is asking about what to do and Bengt explains everything. Premedication, anesthetics, antiemetics, the tube and the time at the recovery room. It was a good meeting and Bengt is satisfied, even though Pernilla still seems more upset than the usual.

Tube or laryngeal mask?

Erik is preparing the room and then goes to take care of Sara in the waiting hall. It is late in the day and Sara has been waiting since this morning. Erik work time ends in just over an hour but he is supposed to finish even if that makes half an hour of overtime. He has been informed by Bengt about the plan and they ended up in the discussion if it was really necessary in a tube. Before Erik had read the anesthetic assessment he had prepared for a laryngeal mask, which he thought was appropriate in this case. Erik is a friend of laryngeal masks and like to use laryngeal masks when others choose to intubate; even when the patient is positioned in the lateral position and prone position. Inasmuch as the responsible clinicians think it is ok. Erik knew Bengt thought the opposite to happen with the airway - rather intubate. Gladly and often with RSI.

Sara was no exception; emergency surgery with a pain history and in addition several glasses of juice in the morning, when it became tube through RSI. Bengt had also said so to Pernilla. Erik is clear that he would prefer a laryngeal mask because Sara according to the journal received only sporadically with Panodil the past day and guidelines for preoperative fasting are met, but admits that it is Bengt's medical decisions. Personally Erik judge risks greater to intubate through RSI on vague indications compared to putting a laryngeal mask the clear indication. He also knows that Bengt's assessments brought the senior doctors' attention and that Bengt's mentor wanted to be informed of
experienced hassles when Bengt is in charge. Erik has seen the faxed copy of the notification operation with Bengt anesthetic assessment and already talked to the ongoing anesthetists, Eva, who should be in charge because it would probably be late in the day.

In the operating room

After Erik has presented itself, and talked for a while with Sara and Pernilla in the waiting room, they find themselves now in the operation room and it is time to sleep. Everything is prepared. Sara is a little drowsy from premedication and Erik could connect all monitoring and has demonstrated the syringes and the mask Sara must breathe oxygen through. When Erik is ready to start, the door opens and clinic manager Eva comes into the room. Eva apologize for that she just wants to inform herself a little about the situation and that it might get a bit repetitive questions to Sara and Pernilla. Eva notice that Bengt has prescribed "intubation anesthesia" and ticked the box for "RSI" but Eva tells Erik that it will surely not be needed, laryngeal mask is good enough.

Erik notice Pernilla reacted and she asks why Bengt does not come, he had promised to be there and take care of Sara throughout the surgery, and he had explained exactly how it would go to. It cannot just be changed! Erik hears that Eva calmly informs that she is in charge now, Bengt's work day is over. Eva tries to calm Pernilla and answer her questions: "Is it really appropriate, Bengt told me that you'd be safe than sorry." Erik retrieves the laryngeal mask and soon they can get started. He thinks that this does not feel good. Erik thinks that it is precisely these kinds of situations, he wants to avoid.

Appendix 2

Semistructured questionnaire

Do you have previous experience of case methodology? If yes, in what context?

What do you think about the case methodology as a learning method?

How did you experience the interdisciplinary case-seminar with another profession?

What did you experience as advantageous, and why?

What did you find disadvantageous, and why?

What would you suggest for the improvement of the case methodology?
Declarations

The author has declared that there are no conflicts of interest.

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