A Novel Role for Students in ICU Relatives Liaison

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Uncertainty has been the overwhelming theme of the COVID-19 pandemic and this is certainly true of its impact on medical education. As medical schools suspended teaching, students, including ourselves, were quick to volunteer for innovative projects within community and hospital settings. One such opportunity arose within Oxford’s critical care units. The pandemic led to an almost overnight change in hospital visiting policies and this, together with the need for staff to be wearing Level 2 personal protective equipment (PPE), made it quickly apparent that communication between staff, patients and relatives would also change. A relatives liaison team (RLT) was created, where we (six fifth-year medical students) were recruited to work alongside a team of intensive care unit (ICU) nurses, all of whom would be working in a role they had never done before. Over approximately three months, this role exhibited a range of educational constructs and provided us with an unparalleled learning experience in the domains of communication, partnership and teamwork.¹ We present our experience, learning points, and ideas for incorporation into a post-COVID-19 medical school curriculum.

Our primary role was to provide daily clinical updates by telephone to relatives: we were an integral part of the intensive care team, an experience different to our usual placements (Figure 1). Initially we learnt through active apprenticeship,² with intensive care consultants as role models. We felt included in the new ICU team through the provision of tutorials on common topics and direct observation and feedback on the quality of our telephone updates from consultants. As we became more familiar with our role and hospital admission rates increased, the way we learnt had to change. We became part of what Lave and Wenger term a ‘community of practice’³: our transition from peripheral newcomers to core participants in the ICU team was accompanied by continuous skill development through regular interactions with nurses and consultants. When preparing to call a relative, there were real-world repercussions of what we said and how we said it. Early on, we made mistakes by overwhelming worried relatives with information, increasing already high anxiety levels. We quickly became aware that if we communicated poorly, it could have serious consequences, providing a situated learning experience.⁴

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Interprofessional integration with nurses was critical to our learning. Medical student interaction with nursing staff is limited in placements, but our experience traversed these boundaries as we and the dedicated nursing team had to cooperate to facilitate good care and support each other. Both the nurses and ourselves contributed a different skillset in terms of clinical experience, biomedical knowledge, and communication skills, and we were able to learn from each other in a non-artificial environment. Interprofessional learning in the acute setting gave us a valuable...
different perspective from that of shadowing doctors, and, as we proved ourselves helpful assets, the nurses expressed their appreciation and respect for our work, highlighting the educational benefits of multidisciplinary interaction. 4

Finally, there was collaborative learning among the six of us. At least two of us worked at any one time, which meant that we could discuss salient points from a ward round before calling a relative. Moreover, we could debrief with each other after difficult telephone conversations, as we also did with a consultant psychiatrist in weekly reflection groups. This dual reflection, at both peer and mentor level, allowed us to develop our own individual practice. 5 As we have all said aloud, we would have been unable to do this were we working alone, once again reinforcing the active community of practice 3 so fundamental to our development.

For all of us, this has been the single most valuable experience in our medical studies – so, how can this be replicated in ‘normal’ medical school? One option is increasing continuity of relationships through longitudinal placements 6 in which we have an integrated role within a particular interprofessional team throughout the year – a practical and sustainable avenue for development. Additionally, greater real-world responsibility, for example a designated role in communication with patients and relatives, would emulate our situated learning. 4 This is daunting and would require careful supervision, but our experience has proven that active apprenticeship 2 is invaluable for understanding what it means to be a doctor and member of an interprofessional team.

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Our experience highlights fundamental concepts of modern medical education: situated learning 4 within an interprofessional team created a community of practice 3 during an actively evolving pandemic, with strong emphasis on longitudinal personal development. 6 Together with multiple levels of reflective practice, this created what was for us an unparalleled environment for learning. COVID-19 has created a crisis like no other, but we believe that this can and should be a force for disruptive innovation, making medical education a more active, engaging and interprofessional discipline.

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CONFLICTS OF INTEREST
None.

ETHICAL APPROVAL
Not required.

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