

BEME Collaboration

PROTOCOL

Health care professionals' learning through collaboration in primary health care: a realist review of what works, for whom and in what circumstances.

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Background

During the last decades changing population needs called for a change in the organisation of health care services and in care delivery by health care professionals. Rapid demographic and epidemiological transitions (more older people with chronic multi-morbidity) and patients becoming more proactive in their health-seeking behaviour have led to the expanding set of tasks and responsibilities put upon the shoulders of professionals who are caring for other people (Plsek 2001; Frenk 2010). Health care delivery requires a shift from reactive clinical work (curing the diseased on individual level) to proactive clinical and organisational work (promoting health and well-being, preventing diseases and controlling complications on population level) (Paulus 2012). This has been described e.g. in the Chronic Care Model. As a result, the growing complexity of patient management requires coordination of care across time and space. A central position of primary health care with interprofessional collaborative practice is advocated as a way of strengthening health systems and improving health outcomes (Bohmer 2010; Gilbert 2010; The World Health Report 2008).

Literature on workplace learning (WPL) acknowledges that working and learning are inseparable and fundamental (Eraut 2007). Interprofessional learning is 'learning arising from interaction between members (or students) of two or more professions' (Hammick 2007). This may be a product of interprofessional education (defined as learning with, from and about one another to facilitate collaboration in practice) or may happen in the workplace when health care providers from different disciplines work together in taking care for the same patient (Parboosingh 2002). Lave and Wenger described the idea of learning through participation in their 'communities of practice'-model which has been reported on and amended repeatedly since ((Lave and Wenger 1991); Li 2009; Ranmuthugala 2011). It is unclear though how this model can be used in primary health care.

The organisation of training and education of health care professionals before and after graduation shows major differences. Workplace learning ('learning by doing') is generally accepted as the way students learn during undergraduate medical traineeship and has been studied extensively for postgraduate students (Dornan 2007; Theunissen 2008). In these situations learning is the goal of participation in practice. The learner (student), the teacher (health care professional as supervisor) and the workplace (the clinical setting) are organised to develop competences for the new professional-to-come. The situation is completely different after graduation, when health care professionals have to engage in programs for continuing professional development (CPD) in order to guarantee high-quality care throughout their career. Although CPD should encompass more than attending to continuing medical education (CME) sessions, these sessions are predominantly present in the education of doctors (Agius 2008; Mahmood 2010). Literature shows the limited value of these CME sessions in acquiring clinical competences or sustainable benefits on professional behaviour or on patient health outcomes (Marinopoulos 2007, Davis 1999; Forsetlund 2009). Moreover, after a couple of years in practice the theoretical knowledge of doctors decreases and literature suggests that the quality of care provided is inversely proportional to the number of years in practice (van Leeuwen 1995; Choudhry 2005). These findings reinforce the concerns of the general public as they ask for periodical evaluation of doctors in order to guarantee high quality care (Shaw 2009; Norcini 2005). Nevertheless there is very little evidence at present that recertification or revalidation of physicians has an effect on outcomes (quality of care delivery).

This accounts for the legitimate interest in studying workplace learning during practice as a means for maintaining lifelong professional competences in primary health care.

After graduation and during the lifelong career of health care professionals, patient care is the main focus of all activities and the learning that takes place (also called workplace learning) is often considered a side-effect of practice (Eraut 2000). This workplace learning has been described and models have been proposed mostly based on qualitative research (Eraut 2004; Eraut 2007). As described in a recent WHO paper, the call for collaborative practice goes for all health care professionals and so workplace learning concerns all professionals and disciplines (Gilbert 2010). It is not clear which part of professional competences can be acquired by this way of learning. Does interprofessional collaboration (IPC) enhances knowledge, raises skills or influences attitudes? And which knowledge, skills and attitudes? Is there a difference between professionals? And who is learning from whom? It is also not known in what circumstances and to what extent this workplace learning takes place. Previous reviews have been written on interprofessional collaboration and interprofessional education (IPE). Zwarenstein et al. assessed the impact of practice-based interventions designed to change IPC (Zwarenstein 2009). Reeves et al. assessed the effectiveness of IPE interventions, evaluating outcome measures on patient/client level and health process (Reeves 2013). Both reviews however, focus on care delivery, patient health status and IPC as outcomes, but did not focus on the professional development of the individual caregiver, which will be addressed in our review. Hammick et al. reviewed the available evidence on IPE limiting the search to formal educational interventions whilst our review focuses on the learning which takes place during practice (Hammick 2007).

Another difference with previous reviews (besides the different focus) is the methodology we chose to use. Workplace learning comprises more than acquisition of knowledge (which can be evaluated in an effectiveness review). It involves complex relationships between health care professionals interacting in a non-linear fashion to produce outcomes which are highly context dependent. Describing workplace learning in a broader way than just looking for the effectiveness 'meets the needs of the users' and focuses on 'the actual doing' of the participants (Thistlethwaite 2012). Therefore we chose the realist review methodology in trying to understand what works, for whom, in what circumstances, in what respects and why (Pawson 2005, Wong 2012) (for more information see 'Methods')

Understanding workplace learning can help us to optimise the efficiency of it. Workplace learning might thus become a complement to CME in the lifelong learning/continuing professional development trajectory of every individual health care professional.

Having a firm theoretical background on workplace learning might inform researchers in setting up future primary studies or interventions on this topic.

Glossary

- **COLLABORATION** (or collaborative practice) in health care occurs when multiple health care workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings (http://www.who.int/hrh/resources/framework_action/en/). For the purpose of this review we intend to look at collaboration between health care workers of the same professional backgrounds as well.

- PRIMARY HEALTH CARE: (Syn. first contact care, PRIMARY CARE) WHO (Alma Ata 1978) defined primary health care as follows: Primary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part of the country's health care system, of which it is the nucleus, and of the overall socio-economic development of the community. Primary health care can be delivered by PHC nurses, physicians or health professionals with a shorter medical training ("barefoot doctors", physician assistants) (<http://www.ph3c.org/>).
- WORKPLACE LEARNING: definitions and descriptions of workplace learning in literature are very heterogeneous. For the purpose of this review we purposively used a broad description to start with: 'the learning which takes place during clinical practice after graduation'.

Review objectives

This review aims

- To describe the process of learning through collaboration in primary health care.
- To describe all conditions influencing the presence, the characteristics and the effectiveness of WPL through collaboration.

Research questions

- Who is learning?
- What is being learned?
- When is being learned?
- How is being learned?

during WPL through collaboration in primary health care.

- Which
 - personal (patients' and professionals' characteristics),
 - interpersonal,
 - organisational (practice organisation),
 - structural factors (society, health care organisation in general)

influence the presence, characteristics and effectiveness of WPL through collaboration?

Methods

Workplace learning results from complex interactions during practice. Contextual factors influence human behaviour and triggers mechanisms to generate outcomes (Wong 2012).

The same interactions in different contexts can lead to different outcomes. The link between context, mechanisms and outcomes can be explored with realist research. A realist review is an interpretative, theory driven narrative summary that uses cross-case comparison to understand and explain how and why different outcomes have been observed in a sample of primary studies (Pawson 2005).

Middle-range theories can be tested against the data. We preferred to formulate a number of statements based on a scoping literature review (see e.g. Walshe 2010). Literature will now be searched in order to fortify, falsify or change the statements leading to a comprehensive theory on workplace learning in primary care.

The statements which have been formulated are the following:

1. For whom
 - a. Every professional learns from others (within the same profession or between different professions) during practice
 - b. The willingness to learn influences the learning
 - c. The number of years in practice influences the learning
2. By whom
 - a. Every professional facilitates others' learning during practice (within the same profession or between different professions)
 - b. Professional expertise influences the effectiveness of the facilitator
 - c. Being a facilitator for others can be learned
3. What
 - a. Learning during clinical practice is guided by actual patients' care needs
 - b. Learning needs assessment influences learning
 - c. During collaboration, new knowledge can be created (besides circulating knowledge between professionals)
4. Which circumstances
 - a. Interprofessional relationships affect learning through collaboration
 - b. Interprofessional hierarchy affects learning through collaboration
 - c. The workload influences the learning
 - d. The history of a team working together influences learning during practice
 - e. A shared aim or responsibility of a team influences the learning
 - f. Difficult clinical situations have a learning potential
5. How
 - a. Learning during practice is partially implicit
 - b. Demonstrating learning behaviour affects facilitator's behaviour
 - c. Demonstrating facilitating behaviour affects learners' behaviour
 - d. Reflection on practice is a major process during learning

- e. Participating in practice has a better learning outcome than observing practice by others
- f. Workplace artefacts can be used for learning during practice
- g. Learning during practice can be planned or unplanned

Search sources and strategy

Our search strategy will target core bibliographic databases such as: Medline, Embase, CINAHL, ERIC, BEI and PsychINFO. According to the BEME recommendations for systematic searching (Haig 2003), additional databases will be consulted, as well as hand searching, snowball sampling and searching of the grey literature will be done.

We will combine search terms in the tables below to build the initial PubMed search strategy.

Learning
"Learning"[Mesh] OR "Learning"[All Fields]
"Models, Educational"[Mesh] OR "Models, Educational"[All Fields]
"Problem-Based Learning"[Mesh] OR "Problem-Based Learning"[All Fields]
"professional development"
"workplace learning"
"participatory learning"
"shared learning"
"collective learning"
"community-based learning"
"informal learning"
"work-based learning"
"team-based learning"
"interprofessional learning"
"practice-based learning"
"professional development"
"open learning"
"situated learning"
"self-regulated learning"
"action learning"
"lifelong learning"

Collaboration

“Cooperative Behavior”[Mesh] OR “Cooperative Behavior”[All Fields]
“Interprofessional Relations”[Mesh] OR “Interprofessional Relations” [All Fields]
“peer collaboration*”
“community of practice”
“collaborative practice”
multi-profession* OR multiprofession*
multi-disciplin* OR multidisciplin*
inter-profession* OR interprofession*
inter-disciplin* OR interdisciplin*
team*

Primary health care

“Primary Health Care”[Mesh] OR “Primary Health Care”[All Fields]
“Public Health”[Mesh] OR “Public Health”[All Fields]
“Family Practice”[Mesh] OR “Family Practice”[All Fields]
“Patient Care Team”[Mesh] OR “Patient Care Team”[All Fields]
“Health Personnel”[Mesh] OR “Health Personnel”[All Fields]
“primary health care team”
“medical practice”
“family care”
“primary care practice”
“family medicine”

As the review moves on, additional searches will be done to complement the initial search. Emerging themes, theories or concepts will inform the new searches. Data from these additional papers will be used to support, refute or refine initial statements and emerging concepts .

Since most of the literature on WPL starts from the nineties, we will limit the search from 1990 until present.

Study selection criteria

Inclusion criteria:

Studies will be included according to their relevance to the aim of the review:

Setting	Perspective	Interest (topic of)	Evaluation
Primary health care	Health care professionals	Learning processes must be described*	What has been learned? How is being learned? Has the learning been assessed?

*The descriptions may be in the method section (e.g. intervention study) or in the result section (e.g. interview study on experiences and beliefs towards workplace learning).

All study designs will be considered.

Exclusion criteria:

- We will exclude articles exclusively describing classroom based education.
- If the learning context and processes are insufficiently described, the article will be excluded.
- If the study population consists solely of undergraduate and graduate students or hospital health care professionals, the paper will be excluded.
- Articles not written in English, French, Dutch or German will be excluded.

Two reviewers will independently evaluate the retrieved articles and determine the suitability for inclusion in the review, according to the inclusion and exclusion criteria. If differences arise after retrieving, a third author will be consulted.

Procedure for extracting data and quality assessment

The quality of the quantitative studies will be assessed according to the assessment tools at:
<http://handbook.cochrane.org/>

Qualitative research will be appraised using the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI) (<http://www.joannabriggs.edu.au/documents/SUMARI%20User%20Guide.pdf>). This tool is chosen because it scores well on interpretive and theoretical validity and takes context into account, which is particularly important in realist synthesis (Hannes 2010).

The data extraction sheet will be built by using the statements which have been formulated initially (see 'methods') with addition of following questions:

- Which definition of workplace learning is used by the authors?
- Which theoretical framework or background concepts are being used (e.g. social learning theories)?
- What is the content of the learning?
- Which assessment method is being used?
- What is the outcome of the assessment?
- What is the study design?
- What is the study quality?

The studies will be reviewed to identify data which support or refute the initial theoretical statements or which add additional issues.

Synthesis of extracted evidence

Data will be mapped in NVivo. Cross-case comparison will be done looking for emerging patterns. The initial statements (see Methods) will be corroborated or modified using the data. NVivo software will be used to arrange these patterns and statements into categories and concepts and to visualise a model or theory on workplace learning in primary care. Data from additional searches will be used to refine the model.

Publication will be prepared according to the RAMESES publication standards for realist syntheses (Wong 2013).

Report on the pilot study

Search sources and strategy

The search strategies have been built with the assistance of a librarian.

To build the initial Pubmed syntax, we combined search terms related to “Learning”, “Collaboration” and “Primary Healthcare”. Furthermore, relevant papers from a previous scoping search on workplace learning were hand searched to retrieve additional keywords. Every search term has been discussed to ensure fitting within the scope of the research question.

Since most of the literature on WPL starts from the nineties, the search was limited from 1990 until present.

The thesaurus of ERIC database differs from Pubmed. Attempts were made to use similar keywords in the search syntax.

EndNote X7 is used to import the resulting citations and abstracts.

Appendix I gives full search syntax for Pubmed and ERIC database.

Note: adaptations will be made for the other databases, described in the protocol.

First results of the search strategy

The Pubmed search yielded 3744 citations; the ERIC search provided 849 citations, of which duplicates need to be removed.

Two reviewers, PP and FM, independently screened the first 1000 titles and abstracts of the Pubmed search and determined the suitability for inclusion in the review, according to the inclusion and exclusion criteria. PP hereby selected 68 items, FM selected 84, of which 29 joint abstracts. After discussion and reaching a consensus the reviewers agreed to keep another 34 abstracts for full retrieval. Of this total of 63 selected abstracts, 4 full papers could not be obtained.

Both PP and FM read the remaining 59 full articles and ultimately elected 6 full papers, of which 5 joint papers and 1 after discussion and reaching a consensus.

Reasons for exclusion at the stage of full article selection were insufficient description of the learning process, the study population being solely students or health care professionals working in a hospital, theoretical papers not containing primary data.

Example of the first results of the extraction and synthesis of data

Using NVivo software, the first two articles have been analysed by two researchers independently to test our extraction and synthesis method. From the first article, 46 references (quotes or data) have been made to 23 nodes (statements) in the coding sheet. From the second article, 5 references have been made to 4 nodes (statements) in the coding sheet.

Example 1:

To the statement: 'A shared aim or responsibility of a team influences the learning', the following text has been coded :

The first source of reluctance was caused by doubts about the usefulness of MCD (Moral Case Deliberation). These doubts were expressed mainly by the nursing staff. Some nurses and care assistants said they did not experience moral problems (or frame their problems as moral problems) and therefore did not experience a need for MCD. Three different causes for this were described by interviewees. First, MCD was perceived as a tool for solving problems and mediation only in case of (persisting) conflicts within the team and therefore not necessary in a team with good inter-personal relationships. "I can imagine MCD would be beneficial when a team is really divided. but I don't have that experience, being in a team that is like a safe and warm nest." (IV, care assistant, Care Home)

This paragraph does not alter the initial statement but can add a dimension: the 'shared aim or responsibility' can also mean a shared view on team functioning. A joint reflection on team functioning can stimulate the willingness to engage in team learning. This single data is insufficient to modify the initial statement. However, it inspires researchers to look in other articles for similar quotes.

Example 2:

To the statement: 'Difficult clinical situations have a learning potential', the following text has been referred :

Grasping the moral dimension Most participants were not fully aware of the moral issues in their daily practice or found it hard to grasp the moral dimension in the difficult situations they experienced. All MCD participants were asked to write down a case for every meeting. Some participants initially thought moral issues in their work were limited to the 'difficult' residents on the ward. One of the nurses in the care home confessed she had not written a case for the coming MCD session, because she felt she had 'run out of' moral issues. Over time it became easier to write a case description. Through the presentation of the cases participants practiced articulating their dilemmas, both on paper and verbally. This resulted in more succinct descriptions of the cases.

Again, this single paragraph is insufficient to alter the initial statement. However it makes us realise that the concept of 'difficult clinical situations' might be more complex than initially thought. To learn from a clinical situation, one must recognize the learning potential, in this case it means recognising the difficulties of the situation. Therefore prior knowledge is needed to build on. Secondly, a learning curve can be described through this data. This reflection triggers the researchers to look for similar quotes in other articles.

Appendix II shows the references of the analysed papers.

Project timetable

June '14

- Definitive protocol submission

July '14 - Feb '15

- Literature search according to primary search string developed in protocol
- Selection and quality appraisal of articles
- Further testing and modifying of the coding sheet

March '15 - Aug '15

- Data extraction
- Analysis and synthesis of data to test the predefined statements
- Additional searches will be done in the light of emerging concepts or theories
- Further analysis and synthesis of data to build a comprehensive model or theory

Sept '15 - Dec '15

- Reporting and submitting for publication

Conflict of interest statement

No conflict of interest to declare for any member of the review group.

Plans for updating the review

Five years after publication of this review, a new search will be done (with the combined initial and additional search strategies) to inform us on the necessity of an update.

Review team expertise

- Gemma Cherry – psychologist, expertise in writing reviews
- Myriam Deveugele – psychologist, professor Communication in Healthcare
- Fien Mertens – GP, communication trainer for medical students
- Peter Pype (lead reviewer) – GP, communication trainer for medical students, PhD with focus on workplace learning in palliative care, has followed a two day course on Qualitative Evidence Synthesis with workshops on realist synthesis by Andrew Booth, SchARR, University of Sheffield
- Ann Stes – academic department of education, expertise in writing reviews
- Bart Van den Eynden – GP, professor in primary and palliative care
- Johan Wens – GP, professor in primary care, expertise in writing reviews

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Appendix I: Search syntax

Pubmed search syntax

- 1 "Learning"[MeSH] OR "Learning"
- 2 "Models, educational"[MeSH] OR "Models, educational"
- 3 "Problem-based learning"[MeSH] OR "Problem-based learning"
- 4 "Professional development"
- 5 "Workplace learning"
- 6 "Participatory learning"
- 7 "Shared learning"
- 8 "Collective learning"
- 9 "Community-based learning"
- 10 "Informal learning"
- 11 "Work-based learning"
- 12 "Team-based learning"
- 13 "Interprofessional learning"
- 14 "Practice-based learning"
- 15 "Open learning"
- 16 "Situated learning"
- 17 "Self-regulated learning"
- 18 "Action learning"
- 19 "Lifelong learning"
- 20 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16
OR 17 OR 18 OR 19

- 21 "Cooperative behavior"[MeSH] OR "Cooperative behavior"
- 22 "Interprofessional relations"[MeSH] OR "Interprofessional relations"
- 23 "Patient care team"[MeSH] OR "Patient care team"
- 24 "primary health care team"
- 25 "Peer collaboration"
- 26 "Community of practice"
- 27 "Collaborative practice"
- 28 Multi-profession* OR Multiprofession*
- 29 Multi-disciplin* OR Multidisciplin*
- 30 Inter-profession* OR Interprofession*
- 31 Inter-disciplin* OR Interdisciplin*
- 32 Teamw*
- 33 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28 OR 29 OR 30 OR 31 OR 32

- 34 "Primary health care"[MeSH] OR "Primary health care"
- 35 "Family practice"[MeSH] OR "Family practice"
- 36 "Health personnel"[MeSH] OR "Health personnel"
- 37 "Medical practice"
- 38 "Family care"
- 39 "Primary care practice"

- 40 "Family medicine"
- 41 34 OR 35 OR 36 OR 37 OR 38 OR 39 OR 40
- 42 20 AND 33 AND 41
- 43 42 + filter publication date (1/1/1990-31/12/2013)

ERIC (Proquest) search syntax

- 1 SU.EXACT.EXPLODE(" Learning") OR "learning"
- 2 "Active learning"
- 3 "Adult learning"
- 4 "Associative learning"
- 5 "Aural learning"
- 6 "Cooperative learning"
- 7 "Discovery learning"
- 8 "Experiential learning"
- 9 "Incidental learning"
- 10 "Intentional learning"
- 11 "Interference learning"
- 12 "Lifelong learning"
- 13 "Multisensory learning"
- 14 "Nonverbal learning"
- 15 "Observational learning"
- 16 "Prior learning"
- 17 "Problem based learning"
- 18 "Sequential learning"
- 19 "Serial learning"
- 20 "Transfer of training"
- 21 "Transformative learning"
- 22 "Verbal learning"
- 23 "Visual learning"
- 24 "Workplace learning"
- 25 SU.EXACT.EXPLODE("Learning experience") OR "Learning experience"
- 26 SU.EXACT("Learning strategies") OR "Learning strategies"
- 27 SU.EXACT.EXPLODE("Professional development") OR "Professional development"
- 28 "Learning at work"
- 29 "Participatory learning"
- 30 "Shared learning"
- 31 "Collective learning"
- 32 "Community-based learning"
- 33 "Informal learning"
- 34 "Work-based learning"
- 35 "Team-based learning"

- 36 "Interprofessional learning"
- 37 "Practice-based learning"
- 38 "Open learning"
- 39 "Situated learning"
- 40 "Self-regulated learning"
- 41 "Action learning"
- 42 "Learning in practice" OR "Learning at practice"
- 43 "Collaborative learning"
- 44 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 ... OR ... OR 42 OR 43
- 45 SU.EXACT("Cooperation") OR "cooperation"
- 46 SU.EXACT.EXPLODE("Interprofessional Relationship") OR "interprofessional relationship"
- 47 SU.EXACT.EXPLODE("Communities of Practice") OR "communit* of practice" OR "CoP*"
- 48 SU.EXACT.EXPLODE("Interdisciplinary Approach") OR "interdisciplinary approach"
- 49 SU.EXACT.EXPLODE("Teamwork") OR "teamwork" OR teamw*
- 50 "cooperative behavior*"
- 51 "compliant behavior*"
- 52 "collaboration*"
- 53 "peer collaboration"
- 54 "interprofessional practice" OR "inter-professional practice"
- 55 "interprofessional collaboration" OR "inter-professional collaboration"
- 56 "collaborative practice"
- 57 Multi-profession* OR multiprofession*
- 58 Multi-disciplin* OR multidisciplin*
- 59 Inter-profession* OR interprofession*
- 60 Inter-disciplin* OR interdisciplin*
- 61 "patient care team*"
- 62 "medical care team*"
- 63 "interdisciplinary health team*"
- 64 "healthcare team*" OR "health care team*"
- 65 "care team*"
- 66 "primary health care team*" OR "primary healthcare team*"
- 67 45 OR 46 OR 47 OR 48 OR 49 OR 50 OR... OR... OR 65 OR 66
- 68 SU.EXACT.EXPLODE("Primary Health Care") OR "primary health care" OR "primary healthcare"
- 69 "primary care"
- 70 SU.EXACT.EXPLODE("Family Practice(Medicine)") OR "family practice*"
- 71 "family care"
- 72 "medical practice"
- 73 "general practice*"
- 74 "primary care practice"
- 75 "family medicine"
- 76 SU.EXACT.EXPLODE("Health Personnel") OR "health personnel*"
- 77 "health care provider*" OR "healthcare provider*"

- 78 Fieldworker* OR "field worker"
- 79 SU.EXACT.EXPLODE("Caregivers") OR caregiver*

- 80 68 OR 69 OR 70 OR ... OR... OR 78 OR 79

- 81 44 AND 67 AND 80

- 82 81 + filter publication date (1/1/1990-31/12/2014)

Appendix II: Analysed papers for the pilot study

Sandra van der Dam, Jos M.G.A. Schols, Tinie J.M. Kardol, Bert C. Molewijk, Guy A.M. Widdershovend, Tineke A. Abma. (2013) The discovery of deliberation. From ambiguity to appreciation through the learning process of doing Moral Case Deliberation in Dutch elderly care. *Social Science & Medicine*, 83, 125-132.

Jennifer Morton. (2012) Transcultural healthcare immersion: A unique interprofessional experience poised to influence collaborative practice in cultural settings. *Work*, 41, 303–312. DOI 10.3233/WOR-2012-1297.