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Practitioner perspective

How much interprofessional education did I receive in my medical training?

Melissa Johnson MBChB
Southport and Ormskirk Hospital NHS Trust, Southport, UK

A recent graduate looks back and reflects on the interprofessional education she received in her medical training and offers suggestions for improvement.

Having just completed my Foundation Year One (FY1) training, I am taking a look back and reflecting on the interprofessional education (IPE) that I received during my five years of medical school and my first year of Foundation training. I also want to consider how important IPE is for today's and tomorrow's doctors.

The Centre for the Advancement of Interprofessional Education (CAIPE) provides the accepted definition of IPE: 'Interprofessional Education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care'.[1] The definition goes on to consider IPE to 'include all such learning in academic and work based settings before and after qualification, adopting an inclusive view of the term professional'.[1]

The General Medical Council (GMC) sets out a list of guidelines for teamworking, in their influential document: *Good Medical Practice* (Box 1).[2] An extract relevant to IPE states that all doctors should 'respect the skills and contributions of your colleagues and communicate effectively with colleagues within and outside the team'. The GMC, however, does not state how or where these objectives should be achieved.

Experience of IPE in my medical curriculum

My first experience of IPE during medical school was sharing aspects of our first-year course with dental students. We had separate clinical skills sessions but all our formal teaching was done together. However, our problem-based learning (PBL) sessions were held separately. This led to segregation between the medics and the dentists. We were physically in the same lecture theatre, but we did not actually learn with each other.

Some interprofessional awareness was developed during the first year in our PBL sessions because most of the scenarios had another professional involved and each week we were set a learning objective to research

Box 1 Good medical practice GMC[2]

Good medical practice: working in teams

Most doctors work in teams with colleagues from other professions. Working in teams does not change your personal accountability for your professional conduct and the care you provide. When working in a team, you should act as a positive role model and try to motivate and inspire your colleagues.

You must:

- respect the skills and contributions of your colleagues
- communicate effectively with colleagues within and outside the team
- make sure that your patients and colleagues understand your role and responsibilities in the team, and who is responsible for each aspect of patient care
- participate in regular reviews and audit of the standards and performance of the team, taking steps to remedy any deficiencies
- support colleagues who have problems with performance, conduct or health.

the role of that professional. This gave us an opportunity to find out some basic background to other healthcare professionals' training and job function.

During placements throughout the second, third and fourth years, IPE occurred without being explicitly taught. In the second year, one of the nurse specialists working on the surgical admissions unit was very keen to teach us and regularly set up teaching sessions. These sessions were very useful and taught us a lot about history taking and basic assessment tools. These are methods that I now use in my everyday practice and I learnt about them interprofessionally, but this learning was opportunistic rather than planned.

During my third year, I spent a day shadowing a midwife both in hospital and out in the community. I learnt a lot about what midwives do and how mother and baby are followed up in the community after birth. I even learnt how to hold a baby correctly! Not only did this teach me things for my future practice, but it also gave me an insight into how midwives work, and what their responsibilities and worries are. This was invaluable to me when working in obstetrics and gynaecology as an FY1 doctor.

During fourth-year placements, specialist nurses were again keen to teach us and I felt that these sessions were useful. I think it is important to point out that a few of my contemporaries did not like being taught by other healthcare professionals, expressing concerns that we were learning things at a level that was too basic for us as future doctors. Some students were quite rude to specialist nurses who had taken time out to come and teach us.

I think this situation illustrates the point that IPE can only work if, as healthcare professionals, we all hold the view that what we are aiming for is patient-centred care. In our medical school interviews as prospective medical students we all answer the question 'why do you want to be a doctor?' with the cliché answer of 'because I want to help patients'. Students that go on to hold this belief will enter into the spirit of IPE and benefit from it. They will treat each different healthcare professional with respect and communicate well in order 'to help patients' because the patient is the focus of their care. Doctors that do not quite believe in the cliché, those perhaps that just like the kudos of the title 'doctor', will put up walls to other healthcare professionals, close the lines of communication, then IPE cannot work and, in my view, quality of care will suffer.

During my fifth year I did a placement with the anaesthetic department at a children's hospital and was taught how to cannulate children by the operating department assistants. During another placement in the fifth year I spent time with the ultrasonographers in gynaecology clinics, they taught me how to start to interpret ultrasound scans. As well as learning from these healthcare professionals, I was concurrently learning about them by observing them at work.

IPE in my Foundation year training

As part of our Foundation Programme curriculum we had a teaching session on the role of occupational therapists, physiotherapists and the speech and language therapy team. A member of each team talked to us about their role and how we could help them. This was a good way of giving us all a small insight into their jobs. This session came in the last few weeks of our FY1 year and would have been much more useful if it had been provided earlier.

Throughout my FY1 year, I started to better understand the value of each individual healthcare professional and how they each played an important role in the patient's overall care. I came to realise how important the pharmacists on the ward were to the junior doctors and also to the consultants when they joined us on ward rounds. Palliative care nurses became a vital source of analgesic advice for me when trying to get a patient's symptoms under control. Dieticians were very helpful in monitoring patients' nutritional status and giving advice regarding feeds and nutritional support.

Obstacles to interprofessionality

Not every situation I encountered resulted in perfect interprofessional learning. One day I asked a dietician to explain re-feeding syndrome to me. She was very uncomfortable being asked to do this and repeatedly said 'you'll know better than me'. I was genuinely surprised that she thought I would know more about her specialist subject than she did. I had a similar experience with a physiotherapist who was delighted when he taught me something new on my orthopaedic placement. Why did he think I would know more about physiotherapy than he did? This misperception of what junior doctors know and need to know is something that needs to be addressed.

The physiotherapists and occupational therapists seemed to have developed a culture in which they never communicated with the junior doctors about the progress of their patients. They only ever updated the nursing staff. I discovered in the last month of my FY1 year that physiotherapy and occupational therapy notes were documented in a separate folder on the ward, but this had not been communicated to me for

11 months. Communication is so important in the delivery of care, and lack of communication like this, probably due to a perceived hierarchy, is what leads to mistakes and unnecessary delays, for example, patients not being discharged promptly. IPE at its best provides opportunities to help change the view of a perceived hierarchy with doctors at the top to a genuine team approach where the patients are the focus of multidisciplinary expert care.

One of the least effective experiences of IPE was when I attended a 'SAVES' course, which was an extension to a basic life support course. Nursing students from years 1–3 and final year medical students were taught together for the first time. There were several problems with this approach relating to the different levels of practical knowledge within the nursing cohort and between the nursing and medical cohorts. The session may have worked better if it had been run with final-year nursing students and final-year medics, but I still feel it would be difficult to run the session at a level that was appropriate for both sets of students.

Reflection

The question this situation raised for me, on reflection, was should different health professionals have integrated teaching sessions from the start of their training? You could argue that this would lead to a more natural integration between health professionals after qualification, leading to better communication and thus a better quality of care for patients. However, I feel this is an idealistic view and practically the curricula for all the different health professionals means that there is not enough common ground for groups to meet together with similar background knowledge.

From my experience of medical education and working as a junior doctor I feel that IPE is something that cannot and should not be taught in the classroom. First, I feel that it is impractical to learn with other healthcare professionals as the difference in curriculum content creates difficulties for shared understanding. Learning from and about the role of other health professionals is something that is really valuable to a trainee doctor. However, appreciating what those jobs entail only occurs fully through shadowing those individuals and seeing exactly what skills they contribute to the well-being of patients.

I believe that as part of their training medical students should shadow a number of health professionals and that this aspect of their training should be compulsory and assessed, perhaps by a short reflection following each shadowing session. This would provide a much more meaningful and valuable interprofessional education that would benefit medical students on their journey towards providing high-quality care in interprofessional health teams.

REFERENCES

1 Centre for Advancement of Interprofessional Education, 2002. www.caipe.org.uk/about-us/defining-ipe (accessed 31 January 2012).
2 General Medical Council. *Good Medical Practice*. www.gmc-uk.org/guidance/good_medical_practice.asp (accessed 31 January 2012).

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ADDRESS FOR CORRESPONDENCE

Dr Melissa Johnson, Merseyside Deanery, Southport and Ormskirk Hospital NHS Trust, Southport and Formby District General Hospital, Town Lane, Kew, Southport PR8 6PN, UK. Email: melissajohnson@nhs.net

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