COUNCIL OF HEADS OF MEDICAL SCHOOLS
AND DEANS OF UK FACULTIES OF MEDICINE

CHMS Position Paper: Interprofessional Education[1]

Introduction
The Term "Interprofessional Education" is usually used to mean two or more professions learning together (especially about each other's roles) by interacting with each other. "Multiprofessional education" is sometimes used synonymously with this, but to some people the term simply implies more than one profession learning a particular subject area together. We think that it is interprofessional education as defined above which has to be considered. "Interprofessional Education" can also become confused with the possibility of individuals changing careers between the different health professions. We think it is better to keep the two issues entirely distinct and only learning together/interacting is discussed here.

Interprofessional education (IPE) is broader than health and there are significant current initiatives in law, engineering and science. In the military it is commonplace for different specialisms and ranks to train together while retaining their individual specialty and leadership roles in the team. In the health sector there have been some notable examples of interprofessional learning, but few have been evaluated. Recent literature reviews (Tope 1999, Hammick 2000) whilst generally supportive of interprofessional education, conclude that there is a confusion in nomenclature, lack of clarity in the learning objectives, and no evidence for its effectiveness when delivered at the undergraduate level. The outcomes and metrics by which IPE might be judged are also inadequately conceptualised. Are we seeking simply more harmonious working relationships in teams or are we after better patient outcomes, greater NHS efficiency, or all of these?

Within the health sector IPE is seen as a crucial element of the modernization agenda leading not only to shared learning but also to new kinds of working and new kinds of professional roles, through novel combinations of tasks and responsibilities. There are probably IPE opportunities in all bilateral relationships between professions, for example, physiotherapy/occupational therapy, or mental health nursing/social work, or psychiatry/clinical psychology.

The Department of Health in England currently funds four leading edge sites for common learning and there are many other universities that are developing curricula to encompass an element of IPE. In this context where does CHMS stand on IPE? On the one hand, do we think that the importance of producing fit for purpose doctors, capable of working effectively in teams is so pressing that, even without established research evidence, medicine must be a player in IPE – not only for medicine's sake but also for the sake of healthcare UK? Or, on the other hand, do we consider that the student intake to Medical Schools is so different intellectually to that of other health professions, that the opportunities for IPE (even if proven by research) are outweighed by potential losses? Are doctors so fundamentally different from other health professionals that we would be justified in standing aside from IPE? A position between these extremes might recognise the wisdom of

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pursuing IPE opportunities cautiously to continue to ensure the technical competence of doctors of the future.

The CHMS Position

1. CHMS supports the principle of interprofessional education and supports the introduction of common learning programmes to parts of the course on the clear understanding that the integrity and quality of uni-professional medical training is protected. Common learning programmes should be introduced in a measured way and evaluated before commitments to major changes to uni-professional programmes are planned.
2. CHMS considers that interprofessional education may have a particular role to play in areas such as communication skills; physical handling of patients; key clinical skills (e.g. temperature taking, blood pressure, monitoring the unconscious); simulated ward/clinical settings; ethics; fostering an understanding by every student of the roles of members of different professions in the health and social care team, with a view to ensuring that such teams work more effectively.
3. CHMS wishes to ensure that the introduction of interprofessional education does not damage the research mission of medical schools, by adding further to the burdens on clinical academics. Though teaching a particular topic by IPE should not in theory take longer than by uni-professional means (and there may be longer term efficiency gains), the transition to IPE delivery will require the time, effort and commitment of clinical academics.
4. CHMS would expect that medical schools would be full partners in planning all IPE developments involving their students to ensure a reasonable expectation that the medical student experience is enhanced from each new exposure to IPE.
5. There must be a full evaluation of student feedback followed, if necessary, by action to replace less successful sessions with alternatives that contribute positively to the education of medical students. Continuation of unsuccessful educational experiences for any reason is contrary to the philosophy of quality enhancement in education. New IPE courses will quickly have to develop a positive evidence base to be continued.
6. Any changes need to maintain or improve the quality of doctors emerging from schools. This includes the acknowledgement that medical students should continue to receive a scientific education as well as a medical training in the course of their undergraduate studies. There are practical timetabling issues if time is to be made for inter-professional training while protecting scientific education.
7. Any changes need to be consonant with the GMC’s *Tomorrow’s Doctors 2002* to ensure regulatory approval.
8. The process must be vigorously researched. Outcomes should range from immediate goals such as greater student satisfaction, to longer-term research examining improvements in team work and health gain to the populations served. Once this is achieved the presence or absence of clear evidence of benefit should be expected to prompt a re-evaluation of IPE in medical schools, taking into account the experience of educators and students.
9. Changes to medical curricula need to be made with the approval of those answerable to the GMC; usually the Head of School. Recent radical changes in all UK medical curricula are still bedding in; further changes require careful consideration.

10. CHMS believes that it is inappropriate to declare that a given percentage of the medical curriculum should be delivered by IPE. Such percentages will differ from school to school and will depend not only on the curriculum objectives and strategies of the medical school, but also on the views and curricula of partners in other health professions. It is more appropriate to identify the curriculum content of the common learning programme first then set aside the appropriate amount of time.
11. CHMS recognises that individual schools will have to deal with issues such as geography/different numbers of students in each discipline/timetabling/accommodation etc. Solutions, their practacabilities and viability will vary from school to school.
12. A robust method for assessing learning outcomes for different professions from a single common learning programme experience has not yet been achieved. Though it is true that no form of educational assessment is perfect, the added complication with IPE is the wide range of different levels at which the common learning content is usually taught to different professions from advanced diploma nurses to graduate-entry medical students. Research on assessment is as necessary as research on outcomes.
13. In general, because of the greater scientific literacy of medical students at entry to the course, it is inappropriate to teach the basic sciences in an IPE format. However, we welcome the influx of AHP graduates to medical courses, and the particular perspectives they bring.

This position paper was agreed by the full CHMS Council at its meeting on 14 February 2003.

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CHMS Basic Medical Education and Admissions Subcommittee