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# Does interprofessional education jeopardize medical skills?

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## Introduction

Working together between health care professionals to meet the increasingly complex patients' and clients' needs more effectively is more important today than ever before. However, health care organisations today also recognise the importance of interprofessional competence, which could be seen as an additional aspect in the professional compass. Life long learning and interprofessional skills have been found to be important domains in defining and assessing medical professional competence (Epstein & Hundert, 2002). Since the WHO report, "Learning together to work together for health" (WHO, 1988), IPE has been a rising policy objective of many governments worldwide. Different initiatives in this direction have started for example in United Kingdom by the National Health Services (NHS) and the Department of Health and by the government in Canada through "Health Canada". Interprofessional education (IPE) in the field of health sciences is now widely perceived as a potentially effective method for enhancing collaborative practice. Although IPE courses have started at many health faculties around the world a question is sometimes raised if such initiatives might threaten already overloaded biomedical curricula and also in the end diminish medical skills among our students. There is also still scant evidence of its effects on professional practice and health care outcomes (Barr et al., 2005).

As the only medical faculty among the six current in Sweden, Linköping University has for 20 years allocated at least 10 weeks of the curricula for IPE between educational programmes for: physicians, nurses, physiotherapists, occupational therapists, medical biologists etc, with the aim of achieving interprofessional competence (Areskog, 1994). Three steps of Interprofessional

education are defined in our curricula. The pedagogical approach for IPE as well as the entire curriculum is problem-based learning (PBL). In the first step (first semester), all new students from the health science programmes within the faculty participate in an obligatory 8 weeks common course labelled “Health, Ethics and Learning part I”. The course aims to be a platform and common value basis to establish the concepts of health and ethics as well as to introduce problem-based learning.

After about two and a half years, all students again participate in an integrated two-week course “Health, ethics and learning part II”, with a specific theme. The theme chosen is sexology and it is studied in mixed tutorial groups with at least one student from each program. The idea of choosing a theme like sexology is that this subject cuts across all programmes and possesses many aspects of health, ethics and learning. The aim of this second stage is to strengthen the students’ own professional identity through interaction and reflection together with other disciplines as a prerequisite to gain and increase interprofessional competence.

The third step is to reach collaborative interprofessional competences in clinical practice. For many of the programmes this is organised as a two week practise at a hospital training ward. The students form an interprofessional team with responsibility for caring of real patients under supervision. Actually, to our knowledge, the first initiative in the world of a student training ward of this kind started 1996 at the Faculty of Health Sciences at Linköping University (Wahlström et al., 1997). Other opportunities of interprofessional training and

practise are found in the local community, primary care and at educational and skills laboratories at the university hospital.

## Aim

The aim of this study was to analyse whether an extensive commitment to interprofessional education in the medical curriculum jeopardizes the traditional medical skills or gives an additional asset to the medical students.

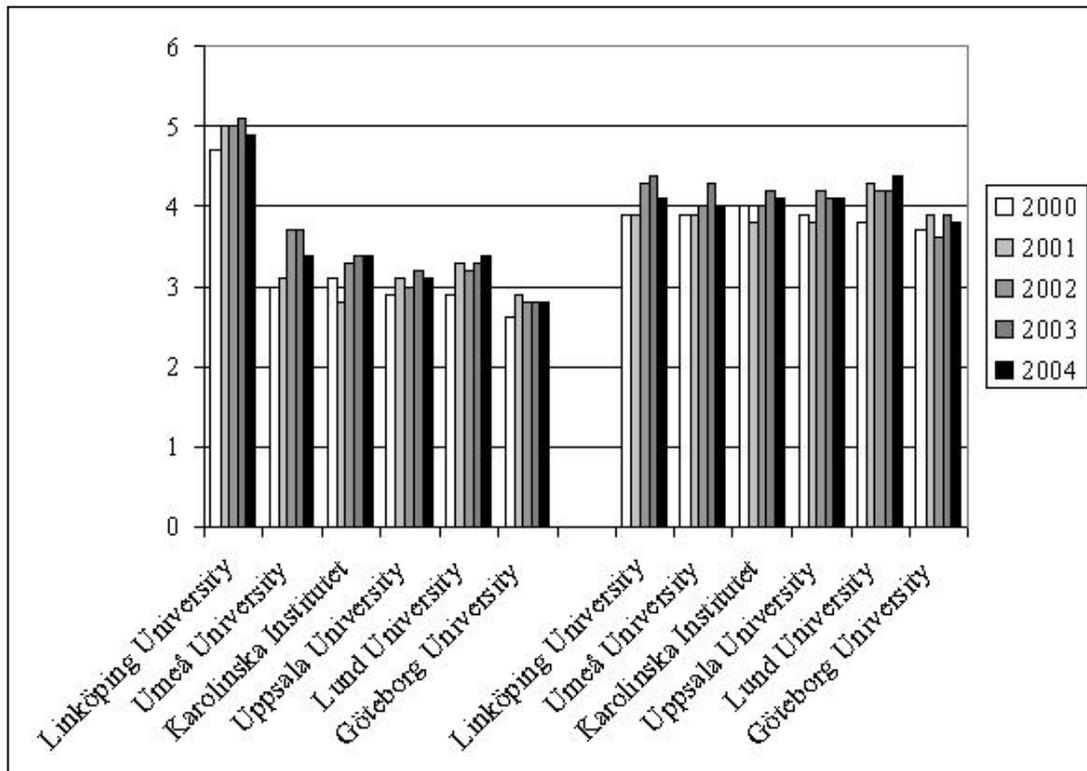
## Methods

The Swedish Medical Association has conducted national independent surveys annually (2000-2004) of all newly examined and registered medical doctors (approximately  $n = 700$  annually and in total  $N = 3\,534$  during this 5 year period) from all six medical faculties in Sweden. The survey focused on the extent to which respondents considered that their undergraduate education had developed their skills and abilities for their future medical specialisation. The response rate has been approximately 85% in each year. The following eight issues were raised in the surveys: co-operation with other professions/colleagues in health care, leadership, communication with patients, readiness for a life-long learning, interest in research, medical handling of acutely ill patients and practising preventive care.

## Results

The newly registered medical doctors educated at the Faculty of Health Sciences at Linköping University and exposed to IPE and PBL reported significantly

( $p < 0.0001$ ) more confidence that their undergraduate studies had given them interprofessional skills and abilities to co-operate with other professions than medical students from the other medical faculties in Sweden. These results have been solid and consistent for the last five years, as shown in **Figure 1**.



**Figure 1. Questions of Interprofessional competence and medical skills directed to all newly examined and registered doctors in Sweden during a 5 year period, data from the Swedish Medical Association.**

In contrast, there were no significant differences between Swedish medical faculties in the former students' confidence that their education had given them skills to medically handle acutely ill patients.

## Discussion

Findings from these national independent evaluations indicate that exposure to IPE in combination with PBL, as developed and implemented at the Faculty of Health Sciences at Linköping University, gives an additional asset (interprofessional competence) to our students, which does not seem to compete or interfere with their professional medical skills, expressed as confidence to medically handle acutely ill patients. The questions in the survey were based on the former medical students' perceptions and therefore first and foremost reflect their attitudes, and not actual clinical performance, which might be a limitation in this study. However, positive interprofessional attitudes expressed as confidence in ability to cooperate with other professions are important prerequisites for interprofessional action and practice.

We believe that defined courses (even early in the curricula), and student training wards can help undergraduate health sciences students gain interprofessional competence. In addition, problem-based learning that is based on student centred learning in small groups also appears to be effective. It is warranted in further research also to follow up interprofessional and other competences of other health professional groups exposed to interprofessional education.

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