Learning together in medical and nursing training: aspirations and activity

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Context Policy documents about service innovation, education priorities and professional development exhort professions to learn together and work collaboratively. However, the literature suggests that the existence of shared learning in medical and nursing pre-qualifying education is patchy.

Aim This paper does not claim to be research. It sets out to reflect on the trends and tensions in key policy directions, relating these to aspirations and a mapping of current intiatives in the sphere of medical and nursing pre-qualifying education.

Approach A limited national information gathering exercise was conducted during the planning phase of seminars hosted by the Centre for the Advancement of Interprofessional Education (CAIPE) in 1996 and 1997. This involved directly contacting all medical schools and departments of nursing and midwifery in geographical proximity, or with an institutional relationship. Information was sought on current or planned activity in shared learning, defined as medical and nursing students and/or working together.

Emerging themes There were a few examples of shared learning identified by the mapping exercise. The paper discusses these and draws on the consensus that emerged from the seminars on objectives and topics for shared learning. It concludes with a discussion of what makes for success or failure in such ventures with suggestions for future educational policy development.

Keywords *Education, medical; education, nursing; educational measurement; Great Britain; policy making, education; professional competence.

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Introduction: the policy context of interprofessional learning

Within the wider policy context of the NHS and community care reforms over the last 10 years, governments of both political complexions have urged the development of seamless and integrated care through more effective professional coordination.[1–4] Delivering the clinical effectiveness agenda in acute and primary care requires the development of professional knowledge which ensures all staff are trained to work in multiprofessional teams.[2] This needs to be implemented 'through more opportunities for multidisciplinary learning, continuous education'.[3] Regional Education Development Groups and consortia for non-medical education are now required to promote the development of shared learning at both pre- and post-basic levels, and will actively seek to involve users and carers in the planning and delivery of education and training for health professionals.[5]

As well as these policy imperatives, the theme of interprofessional learning has been emphasized in independent reviews of care for particular client groups, such as the mentally ill[6] and the disabled,[7] and in consultations led by professional bodies.[8] With the exception of the Schofield report,[9] most of the above papers focus on post-qualifying education in order to promote coordinated and coherent care delivery by professionals, care sectors and agencies. The Schofield report uses similar language, but departs from the above approach by advocating a generic and multi-skilled workforce, flexibility between professional groups and employer-led occupational standards for training. It made radical recommendations for a new generic carer to replace nurses and for a common

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foundation programme for all future health care professionals including doctors. Thus although the language and rhetoric is similar in promoting multidisciplinary learning, it conceals a different set of assumptions and beliefs about health care and professional practice, which emphasizes employer-led occupational standards and reflects pressures for professional deregulation. This scrutiny and challenge to the professions stems from calls for accountability for decisions and practice from the public, politicians and managers. Thus on the one hand, the policy rhetoric calls for partnership, multidisciplinary team work and holism, while the reality of practice indicates professional groups jostling over shifting boundaries and autonomy.

The importance of preserving the distinctiveness of medicine and nursing while at the same time acknowledging and valuing their interdependence is vital if the health service is to deliver effective and coordinated care to patients and their families. This view is encapsulated in statements from both medical and nursing professional bodies. The General Medical Council in *Tomorrow's Doctors*[10] expects new graduates to communicate and collaborate effectively with other health professionals and to be effective members of health care teams. A nurse[11] should have 'effective teamwork skills' to participate 'in a multiprofessional approach to care'. This paper addresses the extent to which current curricula in nursing and medical training programmes are delivering interprofessional education and some of the factors which are perceived to promote or constrain development. This is discussed within the context of seminars organized under the umbrella of CAIPE in 1996 and 1997.

Definitions

Apparently simple exhortations for increased initiatives in interprofessional education, conceal some conceptual confusion and loose use of terms. Leathard[12] differentiated between 'multidisciplinary' (many) and 'interprofessional' (between). The former describes received learning, that is, a mixed professional group attending the same lecture with common content and the latter indicates interactive learning, when two or more professions learn together with the object of cultivating collaborative practice through comparative content.[13] Thus the purpose of interprofessional education is to develop, modify and maintain the knowledge, attitudes and skills needed for interprofessional decision making, problem solving and collaboration, which form a major part of the interprofessional competencies defined by Barr[14] and which are required to meet the health and social care needs of patients and carers. The terms 'interprofessional education' and 'shared learning' tend to be used interchangeably in the literature. While interprofessional education is a broader term, which includes learning at pre- and post-qualifying levels, shared learning is arguably a preferred term in pre-qualifying education at a stage before professional status can be claimed. Shared learning is the term used in this paper.

Mapping initiatives in medical and nursing pre-qualifying education

It was clear from the literature that the extent to which shared learning is in place in qualifying courses in health and social care is limited[15,16] and the involvement of medicine rare, even at post-qualifying level.[17] Although there are some celebrated and sustained examples overseas of shared learning in undergraduate education (including medicine), for example at Linkoping in Sweden,[18] within the UK literature little is reported. Exceptions include the 1-day workshop for students from nursing, medicine and the therapy professions in Southampton[19] and the work carried out in Bristol that looked at attitudes, identity and the retention of stereotypes before and after shared learning.[20,21] However, both of these were short-lived initiatives which folded once the champions moved on and the funding ceased. Further, the evaluations were limited, because they were small-scale innovations that were not able to consider the impact of the education on changes in practice.

In order to plan for seminars to promote shared learning within nursing and medicine, we began by drawing a map of current activity in shared learning between nursing and medical students in pre-qualifying courses. The authors carried out this work in their roles as joint Chairs of the seminars. In carrying out this enquiry regarding current provision, which was unfunded and therefore limited in scope, both drew on their respective professional and academic networks as well as knowledge of the interprofessional education and research arena. In the early part of 1996 we wrote to the 25 medical schools (personal letters were sent by L.S. to the curriculum development facilitators and to the professors of general practice, where applicable) to enquire about activity and interest in interprofessional education/shared learning defined as 'medical and nursing students studying and/or working together'. Professors of general practice were approached, as they have traditionally played a lead role in curriculum innovation in medical schools. At the same time a telephone enquiry was undertaken of 37 departments of

nursing and midwifery (F.R.). These were selected on the basis of an institutional association with or reasonable geographical proximity to a medical school which would enable students to work together. An appropriate respondent was defined as a key player in the organization with an overview of curriculum development, for example, head of school, director of studies or head of curriculum studies. They were asked if their organization was involved in any undergraduate development of shared learning between nursing and medicine and if so who was leading the change.

The only claims we make from this enquiry is that it provided a systematic base on which to plan the seminars. In this respect we found only three examples of shared learning, advanced plans in four organizations and two lapsed pilots, one of which was the initiative in Bristol referred to above. However, a further 11 institutions had plans.

The seminars

CAIPE hosted two linked seminars in 1996 with pairs of medical and nursing educators from the same or nearby institutions, with a follow-up in 1997. It was decided to restrict the field to nursing and medicine at this stage, to maintain the focus and therefore the usefulness of the work. We sent personal invitations to the nurse and medical educator pairs who were reported to be leading the shared learning initiatives, and to the key players in organizations with definite plans. Table 1 shows the objectives of the seminars. There were participants from 23 different universities, and among these, 12 organizations were represented by at least one nurse and a medical colleague. Other invited participants included representatives from the General Medical Council, National Boards for England, Scotland and Northern Ireland, the National Health Service Executive (NHSE) and two medical school deans. The consensus reached at the meetings for the objectives and potential topics for shared learning is shown in Table 2.

Table 1 Seminar objectives

- To clarify the learning outcomes for each professional group to be achieved through shared learning
- To consider models of innovation and good practice in shared learning
- To discuss methods of implementation and strategies to overcome difficulties
- To discuss and support future developments through a network

Table 2 Consensus reached at the 1996 seminars

Consensus on objectives of shared learning between medical and nursing students
- To improve patient care
- To improve understanding of professional roles
- To foster trust and enhance interprofessional working relationships
- To maximize use of resources
- To improve communication

Consensus agreement on shared learning topics
- Epidemiology/population health/health promotion
- Health care ethics
- Critical appraisal skills
- Clinical skills
- Decision making and care planning, particularly in palliative and intensive care, care of older people, children and those with chronic illness.

During the year following the 1996 seminars, we aimed to share progress with the 'front runners' and to work with this core group to provide a catalyst for other developments. Through the consideration of a variety of models and approaches, we sought to continue the development of effective and efficient approaches to shared learning at the undergraduate level, and to further develop and continue supporting the network.

Issues arising at the follow-up seminar

Although we did not repeat the survey, participants from 10 organizations at the 1997 seminar reported innovations in shared learning which had been implemented in their programmes. The number of fully implemented shared learning activities had more than trebled, from three to 10 (modules/skills workshops), and more still were in the planning stage. The nature of the activity focused around five themes: shared skills development; interpersonal/communication skills; primary care/health promotion; foundation sciences, and palliative/elderly care (Table 3).

The second seminar was organized as a round table. Participants reported on the development of new activities, focusing on the aims, progress, key issues and critical success and constraining factors. The role and challenges for deans and leaders of educational institutions were discussed in terms of creating the right climate for change and the requirements for management support of curriculum innovation. Methods of preparing teachers from both disciplines for joint assessment were discussed, following contributions. A report of a team objective structured clinical examination (TOSCE) was presented as one method of assessment which had been used to assess the learning

Table 3 Reported activities in shared learning in medicine and nursing, 1996/97

Multidisciplinary skills laboratories	St Bartholomew's School of Nursing and Midwifery and the Schools of Medicine;* University of Liverpool, University of Aberdeen
Interpersonal/ communication skills	United Medical and Dental Schools and the Nightingale Institute, King's College London
Primary care/ health promotion	St George's Hospital Medical School and Kingston University;* St Bartholomew's Medical School and City University;* Universities of Newcastle and Northumbria
Foundation sciences, e.g. basic medical sciences and social sciences	University of Nottingham; University of Birmingham
Palliative care/ elderly care	University of Southampton; University of Nottingham

*Shared learning initiatives reported in 1996 and 1997

Table 4 Strategic and curriculum challenges for interprofessional education identified by seminar participants

Strategic challenges
- Organizational commitment to strategic leadership and development for curriculum change
- Moving from pilots to mainstream activity, from options to core components of both curricula
- moving from the activity in 'softer' areas of health care, e.g. primary care, into acute and high technology medicine and surgery

Curriculum challenges
- Finding space and time for shared learning within two curricula
- Meeting needs of contrasting perspectives, terminology/language and levels of experience
- Balancing numbers of students when dealing with widely varying cohorts
- Defining learning outcomes appropriate to students with varying academic attainment
- Focusing on clinical skills, problem-oriented learning and team accountability for care delivery

outcomes of medical and nursing students after completion of a shared module on primary care.

Concluding discussion

Some important issues and questions in terms of strategic and curriculum challenges were highlighted in the seminars, Table 4. These suggest the importance of leadership and commitment to the organizational change necessary to implement and sustain shared learning in the curriculum. Without resources, time and organizational capacity, the well-rehearsed curriculum barriers to interprofessional learning, such as different academic levels of students, the contrasting perspectives and priorities of teachers and the separate funding streams for education, will not be addressed.

It is not surprising that, in such uncharted waters, the seminars left many questions unanswered. However, there were some clear messages emerging in terms of identifying strategies to implement change, such as identifying champions in the organization, influencing the opinion formers and policy makers and finding the strategic connections to loosen the separation between funding streams for education. More work also needs to be done on defining outcomes and long-term benefits for patient care and agreement on core interprofessional competencies and educational method. The curriculum issues, such as the definition of interprofessional competence, mechanisms for awarding academic credit for shared learning and the appropriate assessment methods, need to be addressed in follow-up work, which will seek to develop some principles in terms of identifying the strands, sequence, progression, methods and assessment of outcome for interprofessional learning.

The evidence from the mapping exercise and the seminars is that there are isolated activities of shared learning in medical and nursing curricula, (although we are aware that, since writing this paper, new ventures have been started) which experience shows may have a tendency to lapse as the champions move on or the project funding ceases. The mismatch between what happens in practice and the policy rhetoric unfortu-

nately appears to be reinforced by our system of separate organizations for professional accreditation, funding and educational commissioning. The small initiatives and enthusiasm cited here are unlikely to be sustained unless there is rapid action to tackle the structural, financial and attitudinal constraints. Without powerful and coordinated leadership on this issue at strategic level, shared learning in pre-qualifying education will remain a hobby-horse for some and an expendable luxury for others.

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