

Having interprofessional education during the undergraduate years is essential for building teamwork skills in general practice

YES

'A team is a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable'.¹

Interprofessional teamwork in general practice leads to better utilisation of skill sets, enhances workflow, economic sustainability and improves patient satisfaction, with a common aim to reduce duplication, delay, discontinuity and mistakes. The need for collaborative teamwork, first promulgated in the Alma-Ata Declaration, endorsed in the Ottawa Charter, now features in New Zealand's 'Better, Sooner, More Convenient' government policy. Teamwork is needed when 'no one health care provider can meet all the complex needs of a patient and his/her family'² and this is particularly the case in long-term condition care.

Modern general practice is uniquely placed to provide the 'medical/clinical home' for rapidly increasing numbers of such complex patients. However, coordination of care is multifaceted and primary care teams are evolving at a variable rate to embrace the 'deep' teamwork necessary to provide best patient care. Deep teamwork

involves shared vision, valued skills, tested trust and input from patient and whānau (family) into shared decision-making.

Working in teams is not easy, and can initially seem counterintuitive and unnecessarily time consuming. However, team skills can be learned, and similar to sports teams, they improve with practice. Thus, the ability to work in a health care team is an essential clinical skill; yet for the most part the different disciplines have minimal education contact during training. Apart from social interaction as friends, students in different health professional programmes see each other 'on the wards', but not within the classroom or in the general practice setting. Other than personal health care experience, they learn about other disciplines from the media—be it TV, YouTube, film or writing. How accurate is that?

Today's successful entrants to the health professions are overwhelmingly of 'Generation Y', and inherently 'competitive'. Although credited with espousing collaborative technologies, such as Facebook, they are paradoxically not as collaborative as we think. A study of employees in large US companies, found that 'Gen Y' workers do not use collaborative technologies, choosing instead 'to work within their roles and corporate hierarchy... in a race to prove their worth ...or lose their job'.³

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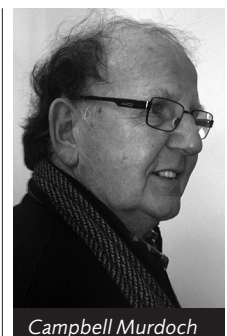
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While evidence can help inform best practice, it needs to be placed in context. There may be no evidence available or applicable for a specific patient with his or her own set of conditions, capabilities, beliefs, expectations and social circumstances. There are areas of uncertainty, ethics and aspects of care for which there is no one right answer. General practice is an art as well as a science. Quality of care also lies with the nature of the clinical relationship, with communication and with truly informed decision-making. The **BACK TO BACK** section stimulates debate, with two professionals presenting their opposing views regarding a clinical, ethical or political issue.



Eileen McKinlay



Campbell Murdoch

BACK TO BACK this issue:

These factors, compounded with the current highly competitive selection processes for health professional degrees, often result (unsurprisingly) in students undertaking their training with individual needs and wants to the fore. Learning to work in collaborative health care teams focused on best possible patient care requires explicit appreciative learning, reflective and experiential practice; these core skills are best established early on and then embedded throughout training. For senior undergraduate students to be 'practice ready' on graduation, they need knowledge about the principles of good teamwork, to have experienced interprofessional collaborative working, and to have been part of a well-functioning health care team.²

It is too late to start learning teamwork skills as graduates, when clinical responsibility and patient care stakes are high. For any complex clinical skill, practice for novices is best done in a safe learning environment, and teamwork is no exception

Interprofessional education (IPE) during undergraduate years enhances development of teamwork skills. This occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care.⁴ This is not students of different disciplines sitting alongside each other in class with no interaction, learning from a teacher of one discipline. Instead, it is education (including clinical workplace learning), where interaction and synergy between disciplines is expected.

IPE is increasingly an education requirement. The Liaison Committee for Medical Education (representing The Association of American Medical Colleges and the American Medical Association) now require that medical training programmes:

Provide several examples of required experiences where medical students are brought together with students or practitioners from other health professions, to learn to function collaboratively on health

care teams, with the goal of providing coordinated services to patients.⁵

In New Zealand (NZ), there have been a number of innovative interprofessional undergraduate initiatives. Horsburgh and Lamdin initiated an interprofessional course on Māori health,⁶ then ran an interprofessional quality improvement class.⁷ Boyd and Horne initiated the Wellsford general practice interprofessional attachment.⁸ Jones, Horne, McCallin and others established the National Centre for Interprofessional Education and Collaborative Practice. McKimm, Sheehan and others have undertaken interprofessional hospital-based clinical attachments.^{9,10}

At the University of Otago Wellington, we have introduced two forms of undergraduate IPE: the first, a 10-hour, 'embedded-type' programme now undertaken with dietetics, medicine, physiotherapy and radiation therapy students; the second, a five-week 'immersion-type' programme in Tairāwhiti, involving dietetic, dental, medical, nursing, physiotherapy and pharmacy students. The Tairāwhiti programme sits alongside a sister programme in Whakatane.

All such programmes are well received and students show positive changes in their attitudes to the value of teamwork and confidence in working with other disciplines. To date, NZ general practices involved have not only provided valuable experiential IPE learning for students, but have also noted benefits to their own teamworking.

Student attitudes to teamwork change positively as a result of good quality IPE, but there are challenges in demonstrating translation of this training into more effective collaborative clinical practice. Evidence is only now forming, with longitudinal studies post-registration difficult to establish, and the elimination of confounding factors nigh on impossible. However, the Canadian Interprofessional Health Collaborative interprofessional practice competencies (embedded in IPE curricula), including communication and patient/client/family/community-centred care, role clarification, team functioning, interprofessional conflict resolution and collaborative leadership, can be tracked to competencies in recognised high-performing teams.

It is too late to start learning teamwork skills as graduates, when clinical responsibility and patient care stakes are high. For any complex clinical skill, practice for novices is best done in a safe learning environment, and teamwork is no exception. By starting this skill acquisition early in training, new graduates can 'hit the ground running', with teamwork skills already well developed. While some things are difficult to change (competitive entry, personality traits), the provision of IPE components throughout the training period normalises the need for continued teamwork skill development and embeds IPE as an expected and valued part of education and practice.

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A full reference list is available on request to the corresponding author.

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NO

Deciding the mix of undergraduate medical education

When I graduated in medicine (Glasgow 1960–66), it was felt that six years of undergraduate study, followed by an internship in each of medicine and surgery, was able to fit the graduate for a career in general practice. The revealed wisdom then was that the first building bricks were physics, chemistry, zoology and botany, followed by 15 months of anatomy, physiology and

biochemistry, with a huge barrier examination two-thirds of the way through the third year. Those who survived were deemed fit to enter the clinical phase and, in each of the next seven terms, there was a mix of clinical teaching in a hospital ward in medicine and surgery, and lectures on the principles of pathology, bacteriology, materia medica, medical jurisprudence and public health. In the last year, obstetrics and gynaecology and paediatrics were allowed into the clinical mix and we were obliged to have intensive clinical studies in medicine and surgery. Some other specialties were also allowed, such as psychology; psychiatry; mental deficiency; ear, nose and throat; ophthalmology; dermatology; and even venereal diseases.

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