

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.

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

# 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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Murdoch C. Having interprofessional education during the undergraduate years is essential for building teamwork skills in general practice—the 'no' case. *J Prim Health Care.* 2014;6(4):333–335.

The one subject that was omitted from the menu was general practice, because the professors of the medical disciplines believed that the future general practitioner (GP) needed undergraduate experience of all their specialties, without actually experiencing general practice itself. We were advised that if we were that interested, we could use our holidays to visit our own GP, which I duly did. My two weeks with James McNeill of Ayr was an epiphany for me, because I entered and explored the edges of a fascinating and complex secret world that the experts had never ever known about.

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### Who decides the content of undergraduate medical education now?

Fast forward 50 years and the content of undergraduate medical education is still being decided by academics based in medical schools, albeit with more emphasis on educational methods. The question now before us is whether interprofessional education (IPE) should be part of the mix, and the claim is that having IPE during the undergraduate years is essential for building teamwork skills in general practice. I disagree with the sentiment, not because I think that IPE is a bad thing but that I think that other priorities have to be addressed to correct the imbalance that still exists, where the curriculum is still loaded in favour of traditional specialist disciplines to the neglect of general practice and person-centred medicine.

### IPE: What do we really mean?

IPE is defined as 'an intervention where the members of more than one health or social care profession, or both, learn interactively together,

for the explicit purpose of improving interprofessional collaboration or the health/wellbeing of patients/clients, or both.'<sup>1</sup>

At first sight this seems a good idea, with medical, nursing, pharmacy, dentistry, physiotherapy and social work students all learning together, getting to know each other and the faculty who teach them, leaving their 'silos' behind and producing a generically qualified health professional. This would at least be logical; but such is the intransigence and power of all these academic groups that, in practice, IPE is a small course, even where it has been adopted by medical, nursing and other professional faculties. In a comprehensive survey of 83 IPE programmes across 14 countries, researchers found that close to 60% of the activities occurred just once, and fewer than 30% offered students course credit.<sup>2</sup>

### Does it work?

There have been several systematic reviews of the effects of IPE, the most recent of which found six studies that evaluated the effects of IPE.<sup>1</sup> The plain language summary of this rather obfuscated review reports:

Four of these studies found that IPE improved some ways in how professionals worked together and the care they provided. It improved the working culture in an emergency department and patient satisfaction; decreased errors in an emergency department; improved the management of the care delivered to domestic violence victims; and improved the knowledge and skills of professionals providing care to mental health patients. Two of those four studies also found that IPE had little to no effect on other areas. Two other studies found that IPE had little to no effect at all. The studies evaluated different types of IPE and were not of high quality. It is, therefore, difficult to be certain about the effect of IPE and to understand the key features of IPE to train health and social care professionals to work together effectively.<sup>1</sup>

Despite this disappointing result, the authors were optimistic about the future of IPE. Their rather limp response to the question why, given this lack of effect, IPE is still 'flavour of the month' was: 'we would like to stress that the

absence of evidence of effect is not evidence of absence of effect'.<sup>1</sup>

### **When will we have a medical curriculum that reflects current medical practice?**

Those in favour of this motion that having IPE during the undergraduate years is essential for building teamwork skills in general practice hold the view despite a distinct lack of evidence that this laudable aim either has been, or even could be, achieved. This faith-based assertion is not uncommon in undergraduate medical education, as there is little evidence that many of the constituents of the curriculum contribute much to the ability of graduates to practise efficiently over their lifetime. I propose that this is yet another example of a pressure group using 'woolly thinking' to subdivide an already overcrowded undergraduate curriculum. A hundred years ago, Sir James McKenzie spelt out the issue very eloquently: 'Those of you whose lives are spent in the peaceful serenity of these academic groves little realise the struggles and difficulties that confront your pupils when they go out into the wilderness. After completing his education, the youthful doctor goes into the world convinced that he is equipped with that knowledge that will enable him to wrestle with disease in whatever stage or form it presents itself. He soon realises that this is little better than an illusion. The people who consult him complain of things he has never heard of, and disease presents itself under totally different aspects from what he had seen in his hospital training.'<sup>3</sup>

This imbalance still exists and the problem is a lack of understanding of people and their symptoms, not of understanding professional roles. As I pointed out in a review 30 years ago, we need intra-professional education by competent primary health care practitioners and educators, and a thorough grounding in normal human structure and function, clinical decision-making in community settings, and a whole shift away from the tertiary hospital as the centre of health care.<sup>4</sup>

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