

Creating a Common Curriculum for Interprofessional Learning: Strategic Development of Undergraduate Programs in Medicine and Health

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Abstract

There is a global call for strategic changes of professional programs in medicine and health care to respond to future health care needs. This paper will analyse and discuss the process and interaction within the Faculty of Health Sciences in a strategic initiative to re-design and develop the common interprofessional curriculum for professional health care programs at Linköping University

Introduction

There is a global call for strategic changes of professional programs in medicine and health care. The Lancet Commission report (Frenk et al 2010) lists a number of aspects that affect the conditions for sustainable health care globally. These global issues are; how to secure sustainable use of financial and personal resources, how to establish partnership models of healthcare delivery, how to improve patient safety, and how to establish effective teamwork and collaborative practice, all of which are part of the agenda for educational developers. Other issues are gaps and inequalities in health within and between countries, emerging infectious diseases, environmental and behavioral risk factors, the rapid demographic shift towards an aging population, and thus, an aging workforce in the healthcare system. Professional health care programs need to be adapted to meet these challenges in order to improve cooperation and security in health care. The authors argue that there is a need for a new professionalism and a new set of skills based criteria to classify the competence of health professionals. Competency-based curricula and interprofessional education have also been promoted globally by policy makers as a necessity to meet the demands of future health professionals (WHO 2012). While the shift to competency based learning outcomes through the Bologna process is well known for professional educators across Europe, interprofessional education (IPE) is still often not given specific attention in many programs for education of health professionals (Frenk, et al 2010).

Interprofessional education (IPE), has been defined as curricular activities in which students from different professional programs learn from, with and about each other (CAIPE, 1997; Thistlethwaite 2012). Since 1986, the Faculty of Health Sciences (FHS) at Linköping University, Sweden, has been working with a problem-based approach to learning and an interprofessional curriculum, as corner stones of the pedagogy. These innovations were a strategic response to a threat of being closed down when the numbers of medical schools in Sweden were to be reduced (Savage & Brommels 2007), and lead to a sustainable educational practice where all students are involved in recurrent interprofessional learning activities throughout their study programs.

The FHS is now responding strategically to new global challenges of the changing health care system, to institutional challenges in the shift to a new generation of teachers, and

increasing numbers of undergraduate students. A group of professional educators across the faculty was assigned as a task force to develop a new interprofessional curriculum common for all undergraduate programs, i.e. Biomedical Laboratory Science, Medical Biology, Medicine, Nursing, Occupational Therapy, Physiotherapy, and Speech and Language Pathology. The focus of this paper is to explore the change strategy and process of development in the work with the new curriculum.

Method

The work process builds on a theoretical model for interprofessional curriculum development (Lee et al 2013) emphasises four interrelated dimensions to consider in the process, i) future orientation of health practices, ii) knowledges, competencies, capabilities and practices, iii) teaching, learning and assessment approaches and practices, and iv) institutional delivery. These dimensions make up the structure and working process for the task force.

The first dimension addresses the ‘why’ question of education and concerns the necessity to connect the curriculum to the world of practice and the changing demands in the workplace of all health sectors. In this process, global health and educational reforms as well as local institutional conditions were taken into account. The second dimension concerns the ‘what’ question - what should be the content of the intended learning outcomes for interprofessional competence. What knowledges, capabilities and attributes are required of health care professionals? It is important here to consider the relational nature of competence - changes in health care services brings about changes in practices, identities and expertise of professionals (Lee et al 2013). These changes also bring consequences for what should be included in the curriculum and part of the education of health care professionals for the future. The task force considered and integrated existing intended IPL outcomes for all undergraduate programs on the local university level. We also identified and incorporated intended interprofessional learning outcomes in national course outlines for professional health care programs, and international competency based frameworks for interprofessional practice (IPEC 2011). IPEC suggests four competency domains; 1) Values/Ethics for interprofessional practice, 2) Roles/Responsibilities, 3) Interprofessional communication, and 4) Teams and Teamwork.

We elaborated and developed the framework to construct an interprofessional curriculum that would fit with the educational objectives for the professional health care programs at the FHS in Linköping. To adapt the framework for our purposes, competency-based learning objectives were formulated with progression over the course of the curriculum for each competency domain. This meant that learning objectives were formulated for joint curricular activities on initial, intermediate and final level of the undergraduate programs. We also identified a fifth domain of competence, Pedagogy and Learning that was added to the framework. We argue that this competency domain is a necessary condition for interprofessional competence, both in order to understand the learning and pedagogy needed for the team to learn with from and about each other. Equally important is competence of how to stage patients’ learning, including how to involve patients/clients in decisions about their own care. Finally, the framework was adapted through the addition of a system for assessment of interprofessional competence.

In the next phase of the curriculum development, the ‘how’ question, i.e. appropriate teaching, learning and assessment strategies were considered. The FHS have been working with problem based learning as a common approach to learning and teaching since the inauguration 1986. Pedagogical approaches that emphasise interaction between the learners

have been recommended for achieving interprofessional competencies (Dahlgren, 2009; Reeves et al 2012). After a review of the literature, our conclusion was that PBL remains a robust and suitable approach to IPE in Health Sciences degree courses.

The model for curriculum development (Lee et al 2013) emphasizes the importance of paying attention to the views of different stakeholders in the process, i.e. teachers, students, practitioners and graduates. As part of the strategy for developing pedagogical competence of the task force, and all teachers in the faculty, a series of three seminars were given by international educational experts visiting the faculty. The seminars had a dual function, they were open to all teachers in the faculty and the visiting experts also acted as critical friends to the working group. The seminars concerned learning and assessment in higher education in particular and perspectives on professional learning more generally.

During the year of development of the new curriculum, the Deans of the Faculty have been in close dialogue with the task force, and the work in progress has also continuously been presented in different forums to involve all stakeholders in the process. Some of these forums are the board for undergraduate education, the monthly faculty colloquium, the faculty board, and the student union. To involve all stakeholders in the process and decision, the final proposal for the new interprofessional curriculum has been sent out on referral. The Faculty board will collate the results of the referral round and discuss and incorporate the viewpoints from the stakeholders in the final decision about a revised interprofessional curriculum. This phase of the process corresponds to the fourth dimension of the curriculum development model, i.e. how to support institutional delivery, and how to integrate the local university structure and culture in the shaping of curriculum design and delivery.

Findings

In short, the proposed activities of the curriculum comprises of three periods of three weeks respectively, which build on one another progressively. The undergraduate students in the faculty will join together for interprofessional learning activities under three themes; I) Professionalism in Health Care during the initial level of the programs, II) Patient Centered Health Care at the intermediate level, and III) Professional Perspectives in Collaboration at the final level of the programs.

For assessment of the interprofessional learning outcomes, the students will keep a learning portfolio across the interprofessional activities where they will document evidence of learning and reflect on these in relationship to the actual course objectives. The learning portfolio will be assessed together with the assessment of the actual course where the interprofessional activity is included.

Discussion

We argue that one of the crucial points for the success of interprofessional education is the awareness of learners and teachers that interprofessional competence is not separate from the professional competence – it is two sides of the same coin. A crucial challenge is to develop pedagogically conscious teachers, who see PBL as a principle rather than a protocol or procedure. We believe that enhancing this awareness is necessary in order to maintain and improve the quality of the programs and their delivery.

From more than 25 years of experience of interprofessional education at the FHS, we know from student and teacher evaluations, that a common assumption is that interprofessional activities takes time from the professional learning. Faresjö et al (2007), however, showed in a national survey of the medical programs in Sweden, that the interprofessional learning did not jeopardise medical skills of the FHS students. Östergren et al (2009) confirmed these results in a comparison of national internship test results.

In our revision, the intention has been to emphasise the interprofessional education as an integrated part of the professional programs. Hence, the assessment of interprofessional competence will not be assessed separately, but integrated with the assessment of the professional learning. The interprofessional learning portfolio will be assessed together with the assessment of the actual course where the interprofessional activity is included.

Practical implications

The presentation will provide examples of how interprofessional education in health care can be organised and carried out in educational practice.

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