

Royal Society of Medicine

Valedictory Lecture

**Medicine and the Making of
Interprofessional Education**

A Celebration

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President

**The General Practice with Primary Health Care Section
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with

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In memory of Dr John Cohen

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“Medicine – (is) – a very powerful instrument of social welfare. Doctors are members of a social service in which they are learning to co-operate more and more fully with others – clergy, teachers, health visitors and social workers of all kinds.”

Sir Henry Brackenbury
Chairman of the BMA Council,
1927-1934

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I am indebted to John Horder, John McMullen and Margaret Thwaites for sharing their living history during many absorbing discussions.

Introduction

Interprofessional education is a distillation of the investment made by the participating professions – medicine, nursing, allied health, social work and others - each instilling its values, knowledge and skills accompanied by its preferred learning methods during a continuous process of negotiation and accommodation. This paper focuses on the contribution made in the UK by medicine - showcasing general practice as befits the occasion.

It distinguishes between three phases:

- the **pioneering phase** from 1966 to 1999 during which doctors led many of the early ‘initiatives’;
- the **promotional phase** from 2000 to 2009 during which medicine sometimes seemed disconcerted;
- the **prospective phase** entering uncharted waters.

The Pioneering Phase

Interprofessional education took root in the UK during the late 1960s, driven by developments in primary and community care. Teamwork became the cornerstone for effective collaboration as primary care centres were established, but no panacea. Relationships between professions which may have worked well enough at arms length became fraught at close quarters. Jefferys (1965), confirmed later by Bruce (1980), found most GPs enthusiastic about the work of the district nurses, but critical of health visitors whose role some failed to understand. Others understood well enough, but felt that the advice given by the health visitors was at best unnecessary and at worst ill-conceived to the point of being harmful. These *women* stood accused, according to Dingwall (1978), of being interfering, even officious and impertinent towards patients, giving medical advice, often incorrect or in conflict with the GP's treatment, and undermining *his* authority with *his* patients.

As for social workers, GPs regarded them as relatively junior employees of the local authority, whose main functions were to find home helps, sort out financial problems and rescue battered babies. Neither GPs nor health visitors thought that social workers were trustworthy. They were hard to contact and slow to take action, did not offer a 24 hour service or remain long in the same post, never made time to discuss individual cases and never provided feedback (Jefferys, 1965).

Comments about GPs were scarcely less critical. According to the health visitors and social workers, they were difficult to contact, did not understand the work of other agencies and withheld information of importance. Better co-operation between professions could not be achieved without major changes in both attitudes and working arrangements, but change was uncomfortable and threatening (Bruce, 1980).

Retired GPs who recall those days assure me that relations with their colleagues from other professions were invariably cordial and constructive, but there is evidence that doctors can sometimes be blissfully unaware of the stress which colleagues from other professions are experiencing (Baggs et al., 1999; Reeves et al., 2008; Rosenstein, 2002).

The same tensions were rehearsed during numerous workshops and conferences convened to help resolve the problems. The first, according to Horder (1974), was a two day symposium on "Family Health Care: the Team" convened in London in 1966 by Kuenssberg (1967) and sponsored, amongst others, by the Royal College of General Practitioners (RCGP).

The RCGP with the health visitors and social work training bodies then recommended "regional arrangements" for interdisciplinary meetings. The 'Windsor Group' discussed co-operation and conflict in community care (Bennet et al., 1972) and convened a two-day seminar where GPs and social workers concluded that one of the most emotive issues was the extent and nature of future relations between their respective professions following the creation of social services departments in the wake of the Seebohm Report (1969). Freeing social workers from medical control had, according to delegates, led to problems, but improving working relations would need also to include health visitors, whose role was seen to overlap with those of both GPs and social

workers (Martin & Mond, 1971).

That debate prompted a five-day seminar at Cumberland Lodge in Windsor Great Park where recently qualified practitioners from the three professions explored each other's roles and identities, dissipated prejudices and acknowledged stresses in their working relations. GPs had reportedly failed to understand that health visitors had become independent practitioners with skills in preventive medicine, which in some ways went beyond their own. Neither GPs nor health visitors had yet accepted social workers' claims to their own specialist field. Many GPs preferred to pass social problems to health visitors when referrals to social services departments reportedly led to rejection, rationing or delay. The core knowledge and skills of each profession, said delegates, had to command the respect of each of the others before liaison could be effective, and services become flexible and responsive. The roles of all three professions had broadened. Increasing overlap between them argued for common studies during pre-qualifying education.

A national conference held at Middlesex Polytechnic (now Middlesex University) in 1984 was a landmark. It was organised by Michael Carmi (general practice), Valerie Packer (nursing) and Ann Loxley (social work) who had been running interprofessional short courses jointly for some time. Delegates backed a proposal to establish a permanent central organisation to support and co-ordinate interprofessional learning (Carmi, 1991). Further conferences followed leading to the founding in 1987 of the Centre for the Advancement of Interprofessional Education in Primary Health and Community Care (as CAIPE was then known) (Horder, 2003).

John Horder, who had recently retired from general practice and completed his term of office as President of the RCGP, agreed, despite a recent health crisis, to take the lead, becoming CAIPE's first Chairman¹, then President and now affectionately known as its 'Founding Father'. The accompanying title of 'Founding Mother' has yet to be bestowed. There are two deserving candidates: Ann Loxley, John's stalwart supporter and occasional sparring partner as Honorary Secretary of CAIPE in its early days; and Elizabeth, his wife, whose calming words of reassurance saw John (and me) through many testing times.

Concurrently in Scotland, Ken Calman, then Professor of Clinical Oncology at the Glasgow Medical School, was the driving force behind 'Interact', a rolling programme of conferences for interprofessional activists moving from city to city. The interprofessional movement owes much to his support throughout his long and distinguished career in medicine and academe, notably his proposals as Chief Medical Officer for England for "practice professional development plans" in primary care which put teamwork and interprofessional education at their heart (Department of Health, 1998).

Back in London, Patrick and Marilyn Pietroni were pioneering interprofessional education with the Marylebone Centre Trust. Jungian analyst and Freudian psychotherapist respectively, they introduced psychodynamic insights to cultivate a

¹ He was succeeded by Sir Michael Drury and then Ian Cameron before the baton passed to other professions.

holistic understanding of interprofessional education and practice within which the complementary therapies were assured of a place (Pietroni & Pietroni, 1996).

Applying Jung's theory of archetypes, Patrick saw the doctor as 'the hero-warrior god', the nurse as 'the great mother' and the social worker as 'the scapegoat', a role inherited from the medieval witch via the midwife who had successfully escaped such stigma. A fourth archetype was 'the trickster', like Hermes and Mercury bearing Caduceus' staff as they carried messages between God and man. Slippery and cunning, the trickster for Patrick resembled not medicine but psychotherapy.

If some of us struggled to distinguish between archetypes and stereotypes, which interprofessional learning existed to challenge, we joined in the fun when participants at one workshop were invited to caricature themselves and others. The social work students saw themselves as Guardian readers into health foods; medical students as beer drinking, rugby players; and nursing student as caring but unimaginative. The medical students saw social work students as left wing, self-opinionated but intellectual, driving deux chevaux; nursing students as having chips on their shoulders; and themselves as naïve and (agreeing with the others) arrogant (Pietroni, 1996).

The Trust launched the Journal of Interprofessional Care in 1992, with Patrick as its first editor, and destined to become the dedicated channel for national and later international exchange of scholarship in interprofessional education, practice and research. It was also instrumental in bringing interprofessional education into universities, mounting the first interprofessional masters' programme, validated by the University of Westminster. The programme adapted the Tavistock model of inter-personal, group and organisational experience as a 'Pride and Prejudice' module to simulate working life in health and social care.

The seeds of university-based interprofessional education were also being sown at Exeter where Denis Pereira Gray, then Head of the Postgraduate Medical Education, with Rita Goble from occupational therapy, instigated postgraduate and masters programmes to secure firmer academic and research foundations for non-graduate entrants to nursing, social work and the allied health professions, with an interprofessional twist (Pereira Gray et al, 1993; Goble, 1994).

Shared learning between health and social care professions during pre-registration studies was developing in parallel but minus medicine and interprofessional learning (Mortimer, 1979). It was the 1980s before the first examples were reported, in Bristol, where medicine where medical students shared modules with nursing and social work students (Carpenter, 1995; Carpenter & Hewstone, 1996).

Numerous initiatives were bringing together newly qualified practitioners, one by John Hasler in Oxford (Hasler & Klinger, 1976) and by Oliver Samuel in London (Samuel & Dodge, 1981), while Bob Jones was running "novice days" in Exeter (Jones, 1986).

GPs were also writing teamwork texts – John Hasler (Hasler, 1976, John Horder (Butrym & Horder, 1983) Bob Jones (Jones, 1986), Peter Pritchard (Pritchard & Pritchard, 1992), Mike Pringle, (Pringle, 1993) and Glyn Elwyn (Elwyn & Smail, 1999).

By the 1980s interprofessional education was no longer preoccupied with introspection about problematic relationships; it was more positive, more outward looking, more intent on exploring how the professions together could be more effective in improving services and promoting healthier life styles. Problematic relationships could be dealt with if and when they broke surface.

Paul Thomas was blazing the trail in Liverpool where he led a five-year primary health care development programme during which facilitators worked with their fellow GPs and nurses to break down isolation between practices, to promote the employment of practice nurses and to encourage a reorientation from one-off treatment of disease to participation in health (Thomas, 1994). Amongst a plethora of activities, mentors were designated to support the rapidly growing number of practice nurses, but the initiative which I especially relished was the one where interviewers discussing healthy life styles with patients in the waiting room dispensed daffodils in exchange for cigarettes!

Nationwide, Deryck Lambert was injecting much the same energy into health promotion in primary care during a travelling circus of workshops mounted by the Health Education Authority (Lambert, 1988). 'Triads' were invited from the same primary health care team, each of which selected a health promotion priority to translate into a training strategy during the workshop and implement 'back at the ranch', reporting progress during a recall day.

There is one more GP whom I must include, the late John Cohen who, as President of this Section for 1995/96, promoted the interprofessional cause here in the RSM before I came on the scene. With his predecessor, Michael Ashley Miller, John drafted proposals for an RSM Primary Health Care Forum and organized two interprofessional conferences on teamwork (one with the RCN involving Lynn Young). He was concurrently my Head of Department at the University of Westminster. We talked often, but he never mentioned the RSM, still less his efforts to plant the interprofessional flag in this august institution. The little that I have achieved, I dedicate to him.

The Promotional Phase

The turn of the Century was a watershed. Interprofessional education was no longer marginal; it was entering the mainstream of professional education. No longer confined to post-experience studies, it was being embedded in pre-registration programmes. No longer dealing in penny numbers; it was catering for student intakes counted in thousands. No longer bottom-up; it was top-down. No longer practice-driven, it was responding to a raft of modernisation policies (Department of Health, 2000a&b, 2001, 2004, 2006). No longer passing fashion, it was here to stay.

The challenges were many.

Stakeholders thrashed out their differences and pressed competing claims for inclusion in crowded curricula; claims ranging from health promotion to service improvement, to patient safety, to multi-tasking, each with different implications for interprofessional curricula.

Successful joint planning depended upon resolving status differentials. Courses for nursing, social work and the allied health professions were often in the new universities; for medicine, dentistry and pharmacy in the old. Differences in history, ethos and culture militated against partnership. While much of the drive behind interprofessional education was generated within the new universities accustomed to working with local employers and responding to government policy, the old universities were more precious and more protective - difficult, but by no means impossible. Angela and I are proud to be associated with two of the success stories: Angela with the partnership between Leicester, De Montfort and Northampton universities; me between St. George's Medical School and Kingston University.

Presentation was also problematic. 'Common learning' had become the catchphrase commended by government and adopted by employing agencies with the best of intentions to convey togetherness and solidarity, but unhelpful from a professional perspective when construed as dumbing down, denying difference or detracting from uncommon learning. The case for a foundation of common learning was incontrovertible to establish shared values and ethics, within the same political and organisational context, but unhelpful when it failed to take into account differential application to practice.

Doctors were by no means alone in fearing that interprofessional education was being driven too far too fast, without waiting for pilot projects to report (Barr, 2007; Miller et al., 2006) or evidence to be assembled (Barr et al., 2005; Hammick et al., 2007).

General practice was seeing the lead which it once gave slip away as the new universities and a new generation of teachers from health sciences took over, whilst teaching teamwork, by which GPs rightly set much store, seemed less in vogue (Barr et al., 2005; Miller et al., 2002).

All of which makes unequivocal backing today for interprofessional education by leading medical institutions the more remarkable. Why?

One explanation is support from the medical education associations.

- SCOPME - the Standing Committee on Postgraduate Medical and Dental Education
- AMEE - the Association for Medical Education in Europe
- ASME, the Association for Medical Education
- MEDVED, the Medical, Dentistry and Veterinary Subject Centre of the Higher Education Academy

SCOPME came out in favour over more than a decade ago, albeit concluding that there was no one right way to achieve effective "multiprofessional learning and working". Autonomy, in a climate of equity and mutual respect would enable practitioners to develop their own way (SCOPME, 1997).

AMEE was more up-front as Ron Harden invited us to join him on his magical mystery tour in search of interprofessional education (Harden, 1999, 3, 8-9). AMEE's

commitment has been consistently reinforced at its conferences, in articles in *Medical Teacher*, occasional papers (Hammick et al., 2007) and in its *Practical Guide for Medical Teaching* (Barr, 2009).

ASME has long-supported interprofessional education (Freeth, 2007) with unswerving leadership from Frank Smith.

MEDVED has implanted interprofessional teaching and learning in medical education, in partnership with other Higher Education Academy subject centres.

A second explanation may be the impact of the RCGP. Name after name on its 'roll of honour' has backed the interprofessional cause – Ekke Kuenssberg, John Horder, Denis Pereira Gray, John Hasler, Deryk Lambert, Michael Drury and Mike Pringle – reinforced in its *Journal* and occasional papers, by the Prince of Wales Fellowship Scheme (Billingham et al., 1999) and, most recently, its plans for the GP Foundation to advance education and professional standing for practice managers, nurses and physician assistants.

A third explanation may be messages gravitating upwards from medical teachers and students, notably Sir Graeme Catto when concurrently as President of the GMC energising interprofessional education at King's College London, messages endorsed by Sir Liam Donaldson (the Chief Medical Officer) who asserted that some medical schools had successfully introduced learning across professions (Department of Health, 2004).

But I doubt whether we should have witnessed such dramatic endorsement of the interprofessional cause by medicine had it not been for the Kennedy Inquiry into the untoward death of children undergoing cardiac surgery at the Bristol Royal Infirmary.

In Sir Ian Kennedy's own words:

"The story – is not an account of bad people. Nor is it an account of people who did not care – (but) — many failed to communicate with each other, and to work effectively together for the good of the patients. There was a lack of leadership and teamwork. — (in) – a hospital where there was a club culture which hindered a multiprofessional approach to reviewing care."

(Kennedy, 2001, 3-10)

Kennedy was shocking, challenging but strangely reassuring: shocking in its indictment; challenging in exposing the relative neglect of hospitals in UK interprofessional education; reassuring in reasserting the centrality of patient safety and quality of care in interprofessional learning and working to which all parties could subscribe without reservation..

The RCP, the BMA and the GMC have all now thrown their weight behind interprofessional education, invoking interprofessional education to realise their longstanding ambitions for interprofessional teamwork.

From the Royal College of Physicians:

“Multidisciplinary healthcare teams are the indivisible units for delivery of quality health services. – But overall doctors have not spent sufficient time learning from other members of the health care team. – we recommend that the GMC – and medical schools explore ways of strengthening common learning to enable better interprofessional education and training.”

(RCP, 2005, 3.6, 3.19, 3.24)

From the British Medical Association:

“Emerging evidence suggests that interprofessional education can, in favourable circumstances and in different ways, contribute to improving collaborative practice”, although further research is needed. Effective team-working, collaboration and communication across professional boundaries are vital and interprofessional education a means to those ends. Such education focused not only on the subject matter, but also on the way in which practitioners worked together, taking in account appreciation of different ways of working, and the strengths of a diverse workforce.”

(BMA, 2006)

From the General Medical Council, tomorrow's doctor will:

- *Understand and respect the roles and experience of health and social care professionals in the context of working and learning as a multiprofessional team*
- *Understand the contribution that effective interprofessional teamwork makes to the delivery of safe and quality care*
- *Work with colleagues in every way that best secures the interest of patients*

(GMC, 2009, 22)

Medical schools *must*, asserts the GMC, ensure that their students work and learn from other health and social care professionals and students (GMC, 2009, 102).

The Prospective Phase

Implementing that requirement cries out for monitoring, especially how visiting panels to Medical Schools appraise progress and feed back.

Partnerships between medical schools and others need to be revisited and revised, under gathering clouds of cuts in public expenditure which threaten but challenge interprofessional education as never before.

At which point I hand over to Angela Lennox to foreshadow some of the opportunities and challenges ahead for education and practice as a government policy adviser and an interprofessional exponent, but above all as a practising GP.

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