Interprofessional education: experiences from the Ghent University undergraduate curriculum

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Ghent University
Faculty of Medicine and Health Sciences
located on the University Hospital campus
Faculty of Medicine and Health Sciences: programmes

1. Medicine
2. Dentistry
3. Biomedical sciences
4. Physical education and movement sciences
5. Rehabilitation sciences and Physiotherapy
6. Logopaedic and Audiological sciences
7. Medical-social sciences: Master of nursing and midwifery/ Health care management and policy/ Health education and Health promotion
Fundamental change undergraduate medical curriculum

- After negative assessment bij Accreditation Board
- Change: from fragmentated discipline-based curriculum towards an integrated patient- and problem-oriented curriculum
- Components:
  - Units
  - Lines
  - Studium Generale
# Third Year

<table>
<thead>
<tr>
<th></th>
<th>1st semester</th>
<th>2nd semester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research Methodology</td>
<td>Health and society II</td>
<td>Problems of Digestive Tract, Endocrine Systems and Nutrition</td>
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<tr>
<td></td>
<td>Infection and immunology</td>
<td>Problems of Ear, Nose, Throat, Neck, Skin and eyes</td>
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<td>Mechanisms of disease</td>
<td>Family Medicine and Primary Health Care</td>
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<tr>
<td></td>
<td>Diagnostic and Therapeutic Methods</td>
<td>Evaluation1</td>
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<tr>
<td></td>
<td>Christmas Holidays</td>
<td>Evaluation2</td>
</tr>
<tr>
<td></td>
<td>Intersemestrial Holidays</td>
<td>Summer Holidays and Resit</td>
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- Clinical and Communicative skills III
- Medical Decision Making and evidence based medicine I
- Projects: analysis and reporting of Research Data
- Exploration: Contextual Medicine and Family Medicine Studium generale
Why we initiated interprofessional education?

- Changing needs in society; demographic and epidemiological transitions
- Importance of Social Determinants of Health
- Opportunity: training programs for different health professions on campus
Interprofessional Community-Based Teaching

• BA 1: exploration in the health care system, clerkship family medicine
• BA 2: clerkship in a nursing home
• BA 2-3: exploration with a family
• BA 3: community oriented primary care
• MA 2: development of interprofessional care plan
• MA 2-3: (interprofessional) clerkships
Community Oriented Primary Care

Ghent 2002-2012

- Medical students
- Social paedagogic students
- Sociology students
- Health Promotion students
Cumulatie kansarmoede-criteria
Scores hoger dan anderhalve keer het stadsgemiddelde

P (Spreidingswaarde) > 1.5

1 criterium
2 criteria
3 criteria
4 criteria
5 criteria
Geen enkel criterium + Niet in aanmerking (Totale bevolking < 100)

Informatieverwerking C-Luma bvba
Community Health Centre:

- Family Physicians; nurses; dieticians; health promotors; dentists; social workers; …
- 6000 patients; 60 nationalities
- Capitation; no co-payment
- COPC-strategy
Visit to a family living in poverty
Process of data-collecting
Making a community diagnosis
Presentation to local stakeholders
COPC is an interprofessional TEAM-experience!
Logistics of interprofessional COPC-week

- **Community**
  - 84 inhabitants of the community
  - 252 caregivers
  - 10 community stakeholders

- **Supervision/organisation**
  - 12 tutors
  - 1 coordinator
  - 12 panel members
  - 3 assessors
A family physician should restrict his/her role to fighting diseases

Mean = 1.83
I learned a lot about the role of primary care providers

Mean = 3.91
Mean = 2.46

I do not see solutions for the problems of the inhabitants of this neighbourhood
The mean percentage of third-year students and master of social work (MSW) and master of social welfare studies students (2003-2007) agreeing or disagreeing with statements on a questionnaire evaluating the effects of the community-oriented primary care (COPC) exercise at Ghent University. The figure shows which percentage of the students agreed or disagreed with the statement “working with students of another discipline was an enriching experience.”
I got a feeling of powerlessness.

It was very interesting and fascinating to discuss the problems in the community from different points of view.

Two days are too short to make a good community diagnosis.

You realize that everybody had his/her own background and that his/her disease fits in a bigger global picture.

To get in touch with different disciplines in health care.

The interviews with the caregivers give you an idea of how hard working in a deprived area can be.

I got a feeling of powerlessness.
An Interdisciplinary Community Diagnosis Experience in an Undergraduate Medical Curriculum: Development at Ghent University

Bruno Art, MD, Leen De Roo, MA, Sara Willems, MA, PhD, and Jan De Maeseneer, MD, PhD

Abstract

Since 2002, the medical curriculum at Ghent University has incorporated a community diagnosis exercise, teaming medical students with master of social work and social welfare studies students. The course focuses on the interaction between the individual and the community in matters of health and health care.

During one week, small groups of students visit patients and their caregivers in six underserved urban neighborhoods, and they combine these experiences with public health data, to develop a community diagnosis. Local family physicians and social workers monitor sessions. The course requires students to design an intervention tackling one community health issue. At the end of the course, the students present their diagnoses and interventions to community workers and policy makers who provide feedback on the results.

In the authors’ experience, medical and social work students all value the joint learning experience. The occasional culture clash is an added value. The one-week course is very intensive for students, mentors, and cooperating organizations. Although students criticize time restraints, they feel that they reach the outlined objectives, and they rate the overall experience as very positive.

The authors find that this interdisciplinary, community-oriented exercise allows students to appreciate health problems as they occur in society, giving them insight into the interaction of the local community with health and health care agencies. Combining public health data with experiences originating from a patient encounter mimics real-life primary care situations. This campus–community collaboration contributes to the social accountability of the university.

Interprofessional development of a care plan for patients with:

- Multiple Sclerosis
- COPD
- Reumatoid Arthritis

A 3-days group experience
Learning from patient experiences
Students from nursing, medicine, management, health promotion
Experts feed-back on the proposed care pathway
Feed-back by the students: qualitative assessment

It is important to learn how other disciplines work and how we can cooperate.

Development of care plans focusing on prevention and goal-oriented care is important.

Organisation and logistics: room for improvement.
Critical analysis: interprofessional undergraduate education

- Continuity throughout the BA-MA years
- “Real life”: visits, patients in context, CHC and FM practices, stakeholders
- Network of Community Health Centers, linked to the Department
- Challenges:
  - Participation of disciplines
  - Continuity of staff
  - Complexity of the logistics
THEnet’s Evaluation Framework for Socially Accountable Health Professional Education
New curriculum Ghent University: COPC
Better payment for residents in Family Medicine

Social Accountability: workforce in Family Medicine

Global Medical Record: patient list
Impulseo-funding PHC
Better payment for residents in Family Medicine
Interprofessional Education for Integrated Primary Care Professionals

Position Paper EFPC, coordination Jan van Es Institute
Further information and contact

Start experimenting on a small scale, within your own reach

Cultural differences between the professions, each focusing on their own domain (silo)

Make better use of existing integrated settings for IPE (act as change agents)

l.vanamsterdam@jvei.nl
http://www.jvei.nl/international/

EFPC: www.euprimarycare.org
Some examples

**Cultural barriers**

*Kazachstan*: become ‘friends’ first

*Netherlands*: breaking down hierarchical barriers

*Albania*: experience interference or cooperation

**Successful examples:**

*Sweden*: broadening medical training FPs & other

*Netherlands*: house of multi-disciplinary practice

**Legal & financial barriers**

*Hungary*: practice nurse, 15 years experience in primary care = still illegal

*Italy*: FPs & nurses teams for chronic diseases, works fine, financing stopped = teams stopped

*Switzerland*: there must be a need for cooperation = too many patients, not enough doctors
Thank you