COMMENTARIES

Longitudinal integrated clerkships are ok, but do they prepare students for reality?

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Current competency-based medical education (CBME) models are configured to prepare students for uni-professional clinical practice rather than the more complex multi-professional workplaces that characterise modern health care. This partly explains why medical and other healthcare graduates are often perceived as ill-prepared for the complex challenges of collaborative practise in clinical workplaces.1 Repeatedly, adverse event reports attribute healthcare failings to poor communication and coordination between health professionals.2,3 It is becoming increasingly clear that the perceived ‘soft’ competencies of interprofessional communication and collaboration need to be foregrounded as core skills for all healthcare students.4 Yet despite growing evidence that interprofessional placements (IPPs) enhance graduates’ preparedness for collaborative practice,5 most undergraduate programmes are designed to prepare students for individual rather than collective (or collaborative) competence.6 Moreover, the integrative design of CBME programmes is typically intended to ensure disciplinary coherence within curriculums rather than harmonisation between the curriculums of the different health professions who as graduates will be tasked with providing collaborative health care. We argue that longitudinal integrated clerkships (LICS), as described by Hense et al.,7 represent an example of a uni-professional integration innovation. Whilst we agree that LICS are an important innovation in preparing undergraduates for medical practice, we also argue that LICS as currently configured represent a missed opportunity for learning how to navigate one’s place in the workplace reality of interprofessional practice. If the purpose of CBME is to prepare people for present and future clinical worlds, we contend that LICS should where possible be developed into what we term longitudinal integrated and interprofessional clerkships (LIICS).

Since the advent of situated learning in the 1990s, clinical education is often conceptualised as a process of professional identity formation through participation in clinical communities of practice.8,9 Lave and Wenger’s original description of situated learning through legitimate peripheral participation in communities of practice was based on studies of apprentices in uni-professional communities in West Africa.10 Later, recognising that identity development is realised in terms of accountability to multiple groups and institutions over time, Wenger coined the term ‘landscapes of practice’ to describe the many interpersonal and organisational spaces in which identity formation occurs.11 We argue that LICS as currently configured are about socialisation into uni-professional clinical communities of practice rather than the more representative interprofessional ‘landscapes of practice’ prevalent in most clinical workplaces. In addition to placing students in uni-professional LICS in medical disciplines, we argue that students should be also be assigned to interprofessional clinical services such as sexual health clinics or stroke units that could offer LIIC experiences. Where possible, opportunities to work with students from other professions should be optimised, as this creates an environment of relatively equitable status, conducive to greater collaborative engagement.12 For example, students can work in interprofessional teams during patient focused case conferences to...
develop joint assessment and management plans. Such LIIC placements could and should incorporate all the essential elements of LICS, including continuing relationships with staff and patients and direct involvement in patient care but should also be jointly supervised and mentored by health professionals from a variety of professions.

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Professional socialisation is not just about negotiation of one’s legitimacy in established clinical communities or teams. It is also about performing one’s identity in the context of the many ad hoc interprofessional groupings that assemble and disassemble every day to address tasks such as discharge planning, resuscitation or cancer therapy. Students need to be prepared to work with other professionals in the context of brief and unplanned joint tasks or projects. Using the tenets of activity theory, Engeström and others have described this form of rapid assembly and disassembly teamwork as knotworking.13 If each professional is conceptualised as a thread within the knot, their position and contribution shift depending on the nature of the knot, that is the issue at hand. Once the knot is unworked, people disperse and work with other people to unwork other knots, or indeed may be involved in unworking several knots with different teams or sub-teams simultaneously. Therefore, effective knotworking, and collaborative practice, requires an ability to listen, negotiate, share leadership and coordinate activity between people of very different backgrounds, roles and knowledge. We argue that knotworking is an essential competence for new graduates of all health professions and that LIICS could offer many opportunities for learning how to be an effective knotworking participant. For example, a common practice in primary care LICS is for medical students to follow their patients across the interface into secondary care. This is a largely passive observational and uni-professional experience. We suggest that following patients could be developed into a knotworking LIIC opportunity if medical students were to take on a patient advocacy role when patients are referred to secondary care or to other primary care professionals such as physiotherapists and speech and language therapists. Patient advocacy would provide medical students with a meaningful and collaborative role in the knotworking relations that ensue.11

**To meaningfully assess student readiness for collaborative practice, a more systematic, holistic and capability-focused approach is required**

We believe that uni-professional clinical education is no longer sufficient preparation for graduate practice. We recommend that current LIC models could be adapted to become LIICS that incorporate interprofessional clinical education. Whilst we know that LICS as currently configured align well with the values of medical educators and fit with current models of CBME, we feel that LICS are sufficiently mature as an educational design to take the next logical step towards authentic clinical experience, that is becoming longitudinal, integrated and interprofessional.

**LICS are sufficiently mature as an educational design to take the next logical step towards authentic clinical experience**

We recognise the challenges to establishing LIICS. Current CBME assessment approaches privilege uni-professional knowledge over collaborative working abilities. Whilst assessment may drive learning, it can also anchor learning if utilised optimally. To meaningfully assess student readiness for collaborative practice, a more systematic, holistic and capability-focused approach is required.14 Hense et al7 argue that LICS are more likely to be sustained if assessment tools are developed to capture student capabilities acquired through patient contact and interdisciplinary collaboration. Formative approaches such as deliberately seeking evaluations of student performance from patients, as well as from staff and students from different professional disciplines, should be combined with more formal summative feedback approaches using standardised instruments. In this way, continuity of care aspects of LICS can be combined with the collaborative practice attributes of IPP to achieve meaningful LIIC experiences.

**Students need to be prepared to work with other professionals in the context of brief and unplanned joint tasks or projects**

References

1. Thompson S, Metcalfe K, Boncey K, et al. Interprofessional education in geriatric medicine: towards best practice. A controlled
Can the arts and humanities bring the patient's voice centre stage in medical education?

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‘Where is the patient’s voice in medical education?’ ask Gabrielle Brand and colleagues in their paper published in this issue of Medical Education.1 The answer to this question depends on the type of patient voice that you are referring to. On the one hand, there is the voice of the patient receiving health care, subject to the hierarchies of power in the patient-clinician context,2 often unwell and unlikely to be strategically focused on the educational needs of students. On the other hand, there is the voice to which this paper refers, patients as ‘co-designers’ of medical education, involved at the level of purposeful planning of student learning.1

Using the participatory action research (PAR) approach,3 hierarchies are levelled as researchers become co-participants and participants become co-researchers in what is now a community of collaborators working towards the common goal of designing a series of educational outcomes for students. The outcomes here are a series of themed portraits, depicting patients and family members affected by mental illness, which serve as triggers for guided student discussion. In addition to being an exercise in patient-centred medical education, this study is a reminder of the power of the arts and humanities and the potential they hold for enriching the curricula of clinical training.

Perhaps the term ‘patient-centred medical education’ should receive more attention. After all, the practice of medicine has come some way to adopt the principles of patient-centred consulting4—the paternalistic style that dominated the earlier part of the 20th century has given way to the concept of a partnership between doctor and patient, a focus on the patient perspective.4 Is medical education falling behind clinical practice in this regard? Educators could be doing more to actively involve patients in the conception, planning and delivery of medical education. There are moves in this direction, certainly, but as outlined in the Vancouver statement, ‘involvement is often limited to a specific population of patients rather than reflecting the diversity of lived experiences, is fragmented and not embedded in the educational institution, and lacks appropriate infrastructure and sustained leadership and resources’.5 Patients are less influenced by institutional culture and sector norms—they are...