

# Clinical inter-professional education activities: Students' perceptions of their experiences

Veronica Ntsiea<sup>1</sup>, Vaneshveri Naidoo<sup>1</sup>, Fasloen Adams<sup>2</sup>, Victor Mokokotlela<sup>3</sup>, Paula Barnard-Ashton<sup>4</sup>

1. Department of Physiotherapy, Faculty of Health Sciences, University of the Witwatersrand

2. Head of Department, Department of Occupational therapy, Faculty of Health Sciences, University of the Witwatersrand

3. Department of Family Medicine, Faculty of Health Sciences, University of the Witwatersrand

4. eFundanathi Department, School of therapeutic Sciences, Faculty of Health Sciences, University of the Witwatersrand

Correspondence: Veronica Ntsiea; Email: Veronica.Ntsiea@wits.ac.za

## Abstract

### Background and purpose

Students from different health disciplines should learn together during certain periods of their education to acquire skills necessary for solving the health problems. The Faculty of Health Sciences of University of the Witwatersrand created inter-professional education (IPE) activities for students to assess clinical IPE groups' perceptions of IPE experiences and to identify lessons learnt during IPE sessions.

### Methods

This was a qualitative study with review of the students' post IPE feedback forms. The students were granted 'protected time' of three full days over a period of two months to participate in IPE activities.

### Results

Students felt that knowledge about health team members was gained and that IPE groups should have more than one person from each field with the same level of clinical exposure. The students indicated the need to have regular IPE activities and if possible to incorporate this into clinical practice for them to experience it in daily clinical practice.

### Conclusion

Participating in the IPE activity made students gain appreciation and respect for other health professionals' roles and scope. When student groups are big, patient observations can be done as this does not compromise IPE learning outcomes. Group composition should be kept in mind to cater for the learning needs of all students. If it is not possible to meet the needs of all professions, smaller groups with professions applicable to case can be created.

**Keywords:** Inter-professional education, Inter-professional learning, Perceptions, Experiences

## Introduction

Students from different health disciplines should learn together during certain periods of their education<sup>1</sup>. This inter-professional education could result in team work which is required for a holistic approach to health of individuals and communities. According to the world health organization (WHO), inter-professional education is "when two or more professions learn about each other, from and with each other to enable effective collaboration and improve health outcomes"<sup>1</sup>. In this article the focus is primarily on inter-professional education (IPE) which is a formal process of imparting knowledge, values, skills and attitudes. Inter-professional learning (IPL) is knowledge gained through the informal processes and thus will occur during participation in the IPE activities.

Inter-professional education is believed to "prepare healthcare professionals to work in dynamic, challenging, contemporary health systems where mutual respect and collaborative care contribute to improving patient outcomes"<sup>2</sup>. Many institutions are beginning to incorporate IPE into their training. Teamwork<sup>3</sup> and effective communication is enhanced through IPE and practice<sup>4</sup>. Thus, IPE is acknowledged as an important aspect of healthcare education<sup>5</sup>, and may promote appreciation of each profession's role for the benefit of patients<sup>6</sup>. Inter-professional education also ensures that students understand the role and capacities of their profession within a team<sup>7</sup>.

Despite knowledge of benefits of IPE, education of health

professionals has not achieved the goal of having health professionals who work well in teams with a broader contextual understanding<sup>8</sup>. Academic institutions can improve this by ensuring their curricula equip entry-level professionals with necessary skills and competencies for holistic patient care. Research also found that students' attitudes towards IPE are barriers to the successful implementation of IPE<sup>9,10</sup>.

To reap the benefits of IPE, Faculty of Health Sciences of the University of the Witwatersrand created IPE activities. The aim of these activities was to allow students to learn from, with and about each other as per WHO,<sup>1</sup> thereby promoting inter-professional teamwork that was envisioned to be for the benefit of service delivery in the long run. Four IPE groups were created: a) Clinical group: Students from different professions were allocated patients to assess, discuss treatment and holistic management plans, and where possible manage patient as a team; b) Community group 1: Inter-professional groups of students visited institutions like old age homes and community health centers to undertake screening and render appropriate services; c) Community group 2: Students conducted community mapping and needs assessment activities in communities. This was followed by group discussions of potential intervention plans for identified needs with input from all represented professional groups; d) Disaster management group: Students got an opportunity to take part in disaster management involving different professions to learn the role that each professional can play in managing a disaster situation. This activity

highlighted the similarities in characteristics amongst different professions.

The aim of this study was therefore to assess clinical IPE group's perceptions of their experiences of IPE and to identify lessons learnt while participating in the programme. Four domains of interest for IPE activities were values, ethical consideration in patient care, roles and responsibilities of all professionals responsible for patient care, communication between team members and team work.

## Methods

### *Study design*

This was a qualitative study with data gathered from review of the students' post IPE feedback forms. The researchers briefed students about the proposed IPE activity and explained the process to be followed.

### *Study setting*

South Africa, Johannesburg, University of the Witwatersrand, Faculty of Health Sciences (2017). The faculty graduates approximately 1200 health professionals each year in the following fields: Medicine, Physiotherapy, Occupational therapy, Clinical associates, Pharmacy, Biokinetics, Dentistry, Nursing, and Oral Science. Speech and Audiology students who are located in the Faculty of Humanities attended the IPE activities in the Faculty of Health Sciences.

### *Sampling*

All 4<sup>th</sup> year students of undergraduate programmes that have clinical education were invited to participate in the IPE programme: Physiotherapy, Occupational therapy, Pharmacy, Dentistry, Nursing, Medicine (Graduate entry medical programme), Clinical associates (2<sup>nd</sup> year), Biokinetics (3<sup>rd</sup> year), Oral hygiene (2<sup>nd</sup> year); Speech and Audiology (3<sup>rd</sup> and 4<sup>th</sup> year).

### *Data collection*

Students were granted 'protected time' of three full days over a period of two months to participate in IPE. The same clinical IPE activity was repeated three times with three groups of 149, 83 and 139 students. Sessions were facilitated by members of the faculty who were briefed during the IPE facilitation workshop.

Due to large number of students involved, livestreaming was used. Assessments were streamed from the hospital (casualty, wards and physiotherapy department) to the eZone (on university campus) where students watched patient assessment done by a small group of seven to ten students remotely. A day before IPE activity, one of the researchers assessed the patients and got their consent to participate in the livestreaming which indicated that there will be other students watching in another room and that the session is just projected and not recorded. The clinical IPE session working procedure is presented in APPENDIX A. There were 11 groups of between 8 and 12 students with at least one facilitator per group during each of the three IPE sessions. Facilitators were five MSc students (Physiotherapy); one occupational therapy clinical educator, one lecturer from the following degree programmes: biokinetics, clinical associates, pharmacy, physiotherapy and occupational therapy.

Departments which could not send facilitators had one available to be contacted telephonically in case students had questions about their degree programme that facilitators and researchers could not answer. The IPE activity was conducted

within the international classification of functioning, disability and health framework.<sup>11</sup>

Immediately after the IPE session students were invited to complete evaluation forms that comprised three open-ended questions about their experiences of the IPE session. Completion of feedback forms was voluntary and anonymous. The questions asked were as follows:

Please write your reflections under the following:  
Describe - Choose one part of the learning experience and write about what happened; Analyse - Explain what the learning experience means; Evaluate - Show how successful the learning experience was (how did it affect you); What did you learn from this session?

### *Data Analysis*

The data was subjected to thematic analysis, to identify common categories and themes that emerged from the students' responses. Categories were developed using words, phrases, and statements that reflected common phenomena. Similar items were grouped to develop codes and categorised. Inductive coding was used to allow research findings to emerge from frequent, dominant significant themes.<sup>12</sup>

### *Trustworthiness*

Credibility was ensured by giving a detailed description of the data collection and analysis process. Two co-coders not involved in the IPE sessions reviewed codes thus contributing to the credibility of the study. Transferability was ensured by providing a thick description of the study methods and findings. Each process and decision trail of this study was reported in detail for dependability. Researchers' own biases and assumptions were dealt with through peer evaluation of the codes and categories to ensure confirmability.

### *Ethical considerations*

Ethics approval to conduct the study was granted by University of the Witwatersrand Human Research and Ethics Committee (M170380). Participation in the study was voluntary. Informed consent by students was implied when a participant completed the activity feedback sheet. Patient participation in the livestreaming was also voluntary. A day before IPE activity, one of the researchers assessed the patients and got their consent to participate in the livestreaming which indicated that there would be other students watching in another room and that the session is just projected and not recorded. Patients were made aware that they could withdraw from participation in the livestreaming at any time without consequences.

### *Results*

The number of students per degree programme who participated in the clinical IPE activity are presented in TABLE 1. Three hundred and eight (73,5%) of the 419 students allocated to clinical IPE activity attended. The students' perceptions and experiences of the clinical IPE activity are presented as two themes with categories for each theme.

#### Theme 1: Logistics related matters

Venue and group composition, choice of patient, watching evaluation vs participating in evaluation, method of IPE, and timing of session.

#### Theme 2: Lessons learned

Clarification of roles, teamwork and hierarchy, and interaction with patient and colleagues.

**Table 1 Students who participated in the clinical IPE activity**

Degree	Study year	Expected n	Attended n	% Attendance
Medicine <sup>a</sup>	4	247	202	81.8
Clinical Medical Practice	2	25	11	44.0
Dental Science	4	13	6	46.2
Pharmacy	4	15	11	73.3
Occupational Therapy	4	30	22	73.3
Physiotherapy	4	21	18	85.7
Biokinetics	3	28	13	46.4
Speech-Language Pathology	3 & 4	7	6	85.7
Audiology Nursing	3	29	17	58.6
Oral Health Sciences	2	4	2	50.0
TOTAL		419	308	73.5

<sup>a</sup>Second year graduate entry medical programme

### Logistics related matters

#### a) Venue and group composition

They were happy with the venue set up for small groups in tutorial rooms and big group in the eZone (with big screen and sound system) for livestreaming.

*“it was good to be given patient information in small groups and having a “teleconference” to further assess the patient”; “The eZone interaction was really interesting and an informative session”; “It was good to witness clinical education without space constraints.”*

Students were also happy with the way the small group sessions were facilitated. Students who were the only professional in their field felt it was a very big responsibility. They suggested that groups should be balanced with more than one person from each field.

*“It was very productive. It could be more integrated, there was only one physio and one occupational therapist in our group and the rest were GEMP students”*

They also reported that the proportion of medical students to the rest of the students was not balanced and thus the students tend to dominate because of their numbers.

*“Medical students did dominate at times because of their numbers but tried to be more inclusive to other professions.”*

Not all team members thought they had a significant role and also felt that other professionals who work with patients such as social workers and psychologists must be included in the IPE team.

*“The dentist in the group felt a bit left out”; “... students were willing to bring forth ideas even for those who admitted having little knowledge about neuro patients.”; “it could have been more successful if all the other students from other professions like psychology and social work were here.”*

#### b) Choice of patient

Some students felt having a ‘real’ patient and not just a paper patient was beneficial, however others suggested a paper patient or simulated patient would have worked better. They felt that a paper or simulated patient could accommodate all professionals by having all medical conditions that would require input from all including dentists and pharmacists.

Some students felt that using a ‘real’ patient was too invasive and stressful for the patient with more than seven people surrounding them throughout the evaluation.

Livestreaming was found to be very beneficial as a big group was able to learn on actual patients without infringing on patient’s privacy.

*“Session was good because it means that students get to experience what an actual consultation and assessment is like and learn on actual patients without being in the actual space. i.e. not standing around the bed – privacy issues”*

They indicated that this can also be a way to learn from experts across the world by including them in the livestreaming session.

A need to include a medical condition that was covered by all professions represented in the IPE session was highlighted. Medical students had not done neurology yet. Medical students who commented on this thought it would have been more beneficial choosing cases that had been dealt with during their lectures, or if this was held later in their degree when they have covered neurology or have final year medical students who would have knowledge of more medical conditions.

*“Maybe the final year medics should be involved instead of 4<sup>th</sup> year as they have more clinical skills and knowledge.”*

#### c) Watching evaluation vs participating in evaluation

Students indicated that they would prefer to be in the group that did patient assessment and not the one that had to watch on the screen. They suggested that each group should be given an opportunity to evaluate their own patient and discuss amongst themselves for them to learn more from direct interaction with the patient.

*“I felt that the group that had an opportunity to assess the patient learned more than us watching in the eZone”*

#### d) Method of IPE

Some students indicated that they would benefit more if the IPE activity was implemented more regularly in the clinical facilities.

*“At each hospital, students from the different disciplines that are placed at that hospital (either for clinical practice or*



*shadowing) should meet for a session at the hospital, assess a patient together and then discuss patient management...more interactive and less logistical issues of time and place"*

Some indicated that it would be better to end the session with summary of the whole activity.

*"I think a panel of experts could summarise the care of the patient relevant to their field. This panel could be made up of all health care professionals."*

#### e) *Timing of the session*

Having IPE activity very close to the examination week was not desirable as it affects attendance and participation even for those who attend.

*"the timing in the year was horrible because of examinations... would have appreciated this earlier in our block and not 10 days before our block test"*

Students felt they lacked clinical skills and knowledge to deal with the cases presented and felt it would be better to do in final year.

*"We had patients with neurological issues and GEMP 2 students who were in the group have not done neurosciences block. The experience would have been better if we knew our role in the treatment of these patients"*

Medical students felt allied health professionals were further in their degrees (mostly final year students) and thus, they did not feel like 'equals' when assessing and discussing the cases.

*"I felt like fish out of water, the 4<sup>th</sup> year medical students are nowhere near the level of the 4<sup>th</sup> year physiotherapy and Occupational therapy students. They already have such "maturity" when dealing with patients, and that is what I learned"*

### **Lessons learned by the students**

#### a) *Clarification of roles*

The students felt that having cases analysed in an IPE setting was very informative because roles of each profession were clarified.

*"I learned more about how different medical (health) professionals perform their examinations. It gave me insight into what an OT actually does and how best to work in synergy"; "Helped me to understand the role of Biokineticist"; "I learned about a clinical associate and their role"*

#### b) *Teamwork and hierarchy*

Some participants felt that hierarchy still exists between health care professions. Others felt this session broke down hierarchy because the main focus was on the benefits of teamwork and holistic patient treatment.

*"This was an amazing experience. I felt like 'medical hierarchy' was broken down in respect of all professions sharing a common goal"*

*"I will now read everybody's notes and speak to other professionals treating the patient."*

It was also highlighted that some students were not willing to learn from others.

*"Some students were unwilling to participate and did not want to learn from others."*

However, despite these, students indicated that it was an opportunity to learn more about different professions and their treatment approaches which indicated that each professional has a role to play at various stages of patient care.

*"We had serious down to earth conversations about what we each do"*

Some students indicated that they had learnt when to refer and to whom, the importance of communication and respect between all team members, as well as the importance of the holistic patient care.

*"It enabled me to identify why referrals are so important. Treatment does not end with prescriptions and being discharged."*

#### c) *Interaction with patient and colleagues*

Knowledge gain in the following was highlighted: importance of biopsychosocial approach, how to be a better healthcare professional, need to improve explanation to patients, patience when working in a team, importance of asking for help, listening to the patient, knowing own area and own limitations, confidence in own abilities, and having confidence to speak to other disciplines.

*"It was successful....the journey a patient goes through from doctor to therapists and back to community"; "I have learnt that rehabilitation staff members interact with patients on a personal level"; "I learned to be patient and to be able to listen to other professions"; "I have learned to 'ask if you don't know"; "not to underestimate my capabilities because I realised that I am capable of working in a team"; "The learning experience helped in realizing that patients should not merely be treated as objects but member of family."*

### **Discussion**

Gaining knowledge about health team members was the main outcome of the IPE and students felt that this was achieved. This is important because this may lead to improved communication and teamwork and thus improve competencies.<sup>13</sup> Being exposed to other professionals and understanding their role and being able to assess and discuss treatment plans with entire team improved students' confidence in functioning as a team and communicating.<sup>14</sup> Having IPE activities where team members can gain knowledge about each another's roles no matter how small the activity, should be encouraged as this can improve patient care because of the chances of improved teamwork.<sup>15</sup>

Students in this study suggested that groups should be balanced with more than one person from each field and should have students at the same level of clinical exposure (all students in the group should either be senior or junior). Some suggested that all professionals should be included in the group. This was not possible because of the nature of degrees with some degrees such as medicine having more students than degrees such as oral hygiene or speech therapy. Group size, composition and type of case for discussion is difficult to manage in a way that will suit all professionals. In a study by Lairamore et al,<sup>15</sup> IPE groups with students from numerous health professions discussing broad case scenarios were moderately effective however, a smaller grouping of professions with targeted cases was more effective at influencing student perceptions of the need for teamwork. Thus, when planning IPE activities focus should be on creating groups with professionals required for specific learning experience for all students to experience shared learning. Thus, it may not always be necessary to include all professionals in the activity. However, not being able to contribute equally as team members during an IPE session as was the case in this activity, may reduce confidence, interest and participation of some team members and thus should be guarded against by having activities which create a platform for all team members to participate meaningfully.

Some students felt that the group who had an opportunity to assess patients during IPE activities learned more than those who observed, however, they were assured that this would not affect learning. This was supported by Reime et al's study findings that observers and participants had similar results in three of six predefined IPE learning outcomes.<sup>16</sup> Thus, given the large student groups, observations can be made without compromising the IPE outcomes.

Students indicated the need to have regular IPE activities and if possible to incorporate this into clinical practice for them to experience it in daily clinical practice. Importance of regular IPE sessions was also highlighted by Mellor et al.<sup>17</sup> This will result in inter-professional practice.<sup>18</sup>

### Limitations of the study

Final year allied health professions were in the same group with fourth year medical students who still had two more years of clinical education. This limited participation of medical students when doing objective patient assessment. Lesson learned from this is that if we have senior and junior students, roles of each professional group to be specified before patient assessment. Some groups did not have students from all degree programmes. Lesson learned from this is that each group should have students from all degree programmes and if not possible, the sessions to be wrapped up with experts' input about the role of each profession including areas where there is an overlap between professions to avoid duplication of services. Two of the sessions were close to test weeks and thus attendance was poor. Test and examination timetable for all student groups should be taken into consideration when creating IPE programme.

### Conclusion

Participating in the IPE activity made students gain respect for other professionals' roles and scope. When student groups are big, patient observations can be done as this does not compromise IPE learning outcomes. Group composition should be kept in mind when selecting an IPE case for discussion to cater for learning needs of all students by including as many professions as possible per group. If it is not possible to meet the needs of all professions, smaller groups with professions applicable to case can be created. This study gives an idea of factors to take into consideration when designing IPE programmes, especially for a big group of students.

### Acknowledgements

Heidi van Zyl and Abraham Munemo for serving as coders. Facilitators: Aviwe Mgobozi, Razeeya Khan, Jared Bales, Samantha Leeferink, Takondwa Bakuwa, Clare Cresswell, Temitope Ojelade, Grace Mukoka, Juliana Freeme, Cindy lee du Randt, Ronel Roos, and Lyndsey Milcarek.

### References

1. World Health Organization. Framework for action on interprofessional education and collaborative practice. 2010 [cited 2018 June 20]. [www.who.int/hrh/resources/framework\\_action/en/](http://www.who.int/hrh/resources/framework_action/en/).
2. Olenick M, Allen LR. Faculty intent to engage in interprofessional education. *J Multidiscip Healthc*. 2013; 6:149-161. Published 2013 Apr 19. <https://doi.org/10.2147/JMDH.S38499>.
3. Morphet J, Hood K, Cant R, Baulch J, Gilbee A, Sandry K. Teaching teamwork: an evaluation of an interprofessional training ward placement for health care students. *Adv Med Educ Pract*. 2014; 5, 197–204. <https://doi.org/10.2147/AMEP.S61189>.
4. Gray B, Macrae N. Building a sustainable academic-community

partnership: Focus on fall prevention. *Work*. 2012; 41, 261–267. <https://doi.org/10.3233/WOR-2012-1294>.

5. Aguilar A, Stupans I, Scutter S, King S. Exploring how Australian occupational therapists and physiotherapists understand each other's professional values: implications for interprofessional education and practice. *J Interprof Care*. 2014; 28(1), 15–22. <https://doi.org/10.3109/13561820.2013.820689>.
6. Fernandes AR, Palombella A, Salfi J, Wainman B. Dissecting through barriers: A mixed-methods study on the effect of interprofessional education in a dissection course with healthcare professional students. *Anat Sci Educ*. 2015;8 (4):305-316. <https://doi.org/10.1002/ase.1517>.
7. Brewer ML, Stewart-Wynne EG. An Australian hospital-based student training ward delivering safe, client-centred care while developing students' interprofessional practice capabilities. *J Interprof Care*. 2013; 27(6), 482–488. <https://doi.org/10.3109/13561820.2013.811639>.
8. Frenk J, Bhutta ZA, Chen et al. Education of Health Professionals for the 21st Century: A Global Independent Commission; Kistnasamy, Patrick Barry; Pablos-Mendez, Ariel. Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *Lancet*. 2010; 376 (9756):1923-1958. [http://dx.doi.org/10.1016/S0140-6736\(10\)61854-5](http://dx.doi.org/10.1016/S0140-6736(10)61854-5).
9. Curran VR, Sharpe D, Forristall J. Attitudes of health sciences faculty members towards interprofessional teamwork and education. *Med Educ*. 2007; 41(9):892-6. <https://doi.org/10.1111/j.1365-2923.2007.02823.x>.
10. Hertweck ML, Hawkins SR, Bednarek ML, Goreczny AJ, Schreiber JL, Sterrett SE. Attitudes toward interprofessional education: comparing physician assistant and other health care professions students. *J Physician Assist Educ*. 2012; 23(2):8-15. <https://doi.org/10.1097/01367895-201223020-00003>. PMID: 22827145.
11. World Health Organization. International classification of functioning, disability and health: ICF: short version, Short version. Geneva: World Health Organization. 2001 [cited 2018 June 18]. <http://www.who.int/iris/handle/10665/42417>.
12. Thomas DR. A general inductive approach for analysing qualitative evaluation data. *Am J Eval*. 2006; 27(2):237-246. <https://doi.org/10.1177/1098214005283748>.
13. Nørgaard B, Draborg E, Vestergaard E, Odgaard E, Jensen DC, Sørensen J. Interprofessional clinical training improves self-efficacy of health care students. *Med Teach*. 2013 Jun; 35(6):e1235-42. <https://doi.org/10.3109/0142159X.2012.746452>.
14. Milne J, Greenfield D, Braithwaite J. An ethnographic investigation of junior doctors' 60 capacities to practice interprofessionally in three teaching hospitals. *J Interprof Care*. 2015; 29(4), 347–353. <https://doi.org/10.3109/13561820.2015.1004039>.
15. Lairamore C, Morris D, Schichtl R, George-Paschal L, Martens H, Maragakis A, Garnica M, Jones B, Grantham M, Bruenger A. Impact of team composition on student perceptions of interprofessional teamwork: A 6-year cohort study. *J Interprof Care*. 2018; 32(2):143-150. <https://doi.org/10.1080/13561820.2017.1366895>.
16. Reime MH, Johnsgaard T, Kvam FI, Aarflot M, Engeberg JM, Breivik M, Brattebø G. Learning by viewing versus learning by doing: A comparative study of observer and participant experiences during an interprofessional simulation training. *J Interprof Care*. 2017; 31(1):51-58. <https://doi.org/10.1080/13561820.2016.1233390>.
17. Buckley S, Hensman M, Thomas S, Dudley R, Nevin G, Coleman J. Developing interprofessional simulation in the undergraduate setting: experience with five different professional groups. *J Interprof Care*. 2012; 26(5):362-9. <https://doi.org/10.3109/13561820.2012.685993>.
18. Mellor R, Cottrell N, Moran M. "Just working in a team was a great experience..." - Student perspectives on the learning experiences of an interprofessional education program. *J Interprof Care*. 2013; 27(4):292-7. <https://doi.org/10.3109/13561820.2013.769093>.

## Appendix A: Clinical IPE session working procedure

Students in 11 working groups with each profession represented in the group. The groups in separate room with dedicated facilitator to oversee entire activity. For patient livestreaming – all groups meet in the eZone where they all watch one of the groups assessing a patient in the hospital and all have an opportunity to give input and ask questions before going back to their small groups for discussion. This was done three times (casualty patient, ward patient and patient in rehabilitation stage)

Ice breaker: Each student to pick another profession and explain their role (e.g. an Occupational therapy student to explain the role of a Clinical associate – a clinical associate student to indicate whether the information is correct or not)

Election of a student team leader and a scribe: a different chair and scribe after every break

Activity:

- Each student to say what they understand by IPE
- Case presentation by facilitator (sharing patient information based on assessment conducted by researcher the previous day – subjective including medication and summary of functional ability)
- Group discussion to plan assessment (what the group members think should be assessed to come up with patient diagnosis, including investigations that will be required to confirm diagnosis and the role of each professional in managing this patient: including dentist (can be prevention), social worker/psychologist)
- One group with at least one health professional from each of the represented professions as well as a facilitator works in the hospital to assess a patient (subjective and objective) and entire assessment session livestreamed to the eZone for the rest of the clinical IPE students and facilitators
- Students and facilitators in the eZone ask questions and comment during livestreaming when given an opportunity to do so by student leader
- Students back in their small groups (different venues) for small group discussions with each profession represented
- Small group discussion: Summarise assessment findings; Deciding on diagnosis (indicating whether they agree with diagnosis given in medical record or if they have an alternative diagnosis) – justifying the decision including discussion of what needs to be done to confirm diagnosis; Management plan: the role of each profession and what can be done together
- Discussion of differences in treatment goals and treatment approaches based on various stages of patient recovery and how the role of each profession changes throughout the stages of care
- All to indicate if they have learned something new about the role of other professionals in managing the patient discussed.
- Each member to explain the role of at least one profession other than theirs in managing the patient (include the role of Social worker and/or Psychologist, Speech therapist, Pharmacist, Dental...): Student leader and facilitator to make sure this is covered
- To also discuss similarities (overlaps) between different professionals
- Discussion of how the patient is likely to be affected post discharge (possible participation restrictions – home and community including return to work/business [income generation] etc) and how these will be prevented or managed (including discharge plans and outpatient visits) and the role of the team in all of these
- Possible complications and how to prevent them (if applicable): role of the team including all stakeholders (e.g. porter, family, employer)
- Students to share specific treatment ideas (using visuals and demonstrations)

IPE Evaluation (completion of the forms) and wrap up (Students and facilitators)