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Letters to the editor

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The Interprofessional HIV/AIDS Prevention and Care course, offered by the College of Health Disciplines, University of British Columbia, Vancouver, Canada, has been available to nursing, dietetics, medicine, pharmaceutical sciences and social work students since 1997. In 2003 and 2004, a problem-based learning (PBL) approach was integrated using Corbin & Strauss's (1992) chronic illness trajectory model. PBL patient scenarios were designed using five stages from the model: pre-trajectory, trajectory-onset, stable, unstable, and downward and dying. Incremental patient scenario 'snapshots' were discussed and analysed during five facilitated sessions, in small groups of two to five students from the different healthcare professions. Tutorials and lectures were also used to encourage large-group discussions and provide content relevant to the PBL scenarios.

In 2003, 22 students (six nursing, one dietetics, six medicine, five pharmaceutical sciences, and four social work) and in 2004, 25 students (six nursing, five dietetic, four medicine, six pharmaceutical sciences and four social work) completed a course evaluation. Specific PBL components were evaluated and students also rated their overall interprofessional learning experiences using a four-point Likert scale of 1 (strongly disagree), 2 (disagree), 3 (agree) and 4 (strongly agree). The course evaluation return rate was 100% ($n = 22$) in 2003 and 2004 ($n = 25$).

Student evaluations of specific PBL components in 2003 were: scenario reality 3.6 (SD 0.6), appropriateness of PBL group size 3.59 (SD 0.50), PBL group identification of learning needs and sharing of information 3.64 (SD 0.49), and facilitator effectiveness 3.59 (SD 0.50). Comparatively, in 2004 student approval ratings increased slightly for scenario reality 3.68 (SD 0.48) and appropriateness of the group size 3.72 (SD 0.54). However, there were decreases in the ratings of identified group learning needs and sharing of information 3.36 (SD 0.81) and facilitator effectiveness 3.28 (SD 0.68). The same faculty members facilitated the PBL sessions in both 2003 and 2004; however, the student evaluations did not support our hypothesis that facilitator effectiveness would increase with experience, and in turn that would increase group efficacy. Students showed strong agreement in both 2003 and 2004 that interprofessional learning would help them become better healthcare professionals 3.91 (SD 0.29) and 3.96 (SD 0.20); had increased their understanding of clinical problems 3.91 (SD 0.29) and 3.80 (SD 0.41); and enhanced their ability to manage clinical problems 3.86 (SD 0.35) and 3.76 (SD 0.44). The inclusion of PBL was premised on the expectation that it would contribute significantly to these aspects of interprofessional learning. However, all components of PBL were rated lower than students' evaluation of their interprofessional learning.

Overall student evaluations of the PBL component of the course were positive. The use of Corbin and Strauss's illness trajectory model provided an effective framework to guide both students and faculty in the PBL scenarios. However, many pedagogical challenges accompanied the integration of PBL. We strongly recommend PBL group rules and roles be established from the outset, and that formal student and faculty support is available to assist with the unique challenges inherent to PBL and IPE. Furthermore, the increased financial cost associated with the large number of faculty required to facilitate PBL small-group sessions should be considered when deciding to adapt this approach.

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Simulated patients and the development of procedural and operative skills

The paper by Ker *et al.* (2005) fills an important gap in the literature on simulated patients. The paper reviews the relatively limited literature and draws on the authors' experiences of the Dundee Simulated Patient Bank.

Readers may be interested in an additional role to which we put our simulated patients—the development and assessment of procedural skills (Kneebone *et al.*, 2002a; Kneebone *et al.*, 2003; Nestel *et al.*, 2003a, b). By linking simple (e.g. suture pad, urinary catheterisation, venepuncture) or more complex (e.g. carotid endarterectomy, virtual reality endoscopy) models with actors we aim to create an authentic simulation that uses all relevant senses (e.g. audio, visual, tactile) in realistic settings (Kneebone *et al.*, 2002b; Kneebone & Nestel, 2005; Kneebone *et al.*, 2005). These simulations provide learners with an opportunity to integrate technical, communication and other professional skills essential for effective practice with real patients.

Depending on the nature of the procedural skill, simulated patients undergo various levels of training. Performance depends on characterization of role as well as knowledge of key aspects of the procedure so that the simulated patient can respond appropriately (e.g. time taken for local anaesthetic to work, relief from successful urinary catheterization). In some procedures, the simulated patient cannot see the clinician conducting the procedure so performance cues for the simulated patient are provided by a concealed audiolink from an observer.

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