

Faculty Development – Interprofessional education

Definitions

Most healthcare education (particularly in the pre-registration university or classroom setting) is uni-professional, in which students learn together as a single group, e.g. nurses, doctors, dentists, midwives, allied health professionals or social workers, and do not learn with or alongside other professional groups. While the uni-professional context is an important arena in which learners develop knowledge, skills and behaviours relating to their own and other professional groups, it does not achieve the additional outcomes of interprofessional education.

Interprofessional education and interprofessional learning

The literature uses a number of terms interchangeably and sometimes inconsistently, which can be somewhat unhelpful. Much of the original literature referred to interprofessional education (IPE), and certainly CAIPE (the UK Centre for the Advancement of Interprofessional Education), which was highly influential in highlighting, researching into and taking forward the IPE agenda, prefers the term IPE. In this module, we will use interprofessional education (IPE) and interprofessional learning (IPL) interchangeably according to the definitions below. We use both terms here to emphasise the informal as well as formal nature of much IPL activity, particularly in the clinical context. Keep in mind that when using the terms, you may need to clarify specifically what is being discussed.

CAIPE's definition of IPE is the most widely used:

'IPE occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care... and includes all such learning in academic and work-based settings before and after qualification, adopting an inclusive view of 'professional'.' (2006)

As Freeth (2007, p. 2) notes, IPE is primarily concerned with students or professionals actively learning together. The learning is based on an exchange of knowledge, understanding, attitudes or skills with an explicit aim of improving collaboration and healthcare outcomes.

IPL links closely to the concept and practices of the interprofessional delivery of health and social care where there is interaction among professionals that goes beyond having members of different professions sharing an environment together (Headrick et al., 1998), and interdisciplinary health and social care where professionals work collaboratively to improve health outcomes (World Health Organization, 1988). This helps to support the delivery of effective integrated care across primary, secondary and tertiary services involving a range of client groups, implying shared assessments, clinical records, care and client goal setting with patient/client, community and family at the centre (Boyd and Horne, 2008, p. 5).

Multiprofessional education (MPE) – sometimes called shared learning or common learning – is where one or more students or professionals learn alongside one another. The learning may be around acquisition of a clinical skill or knowledge, learners may occupy the same physical space and use the same learning materials, but the difference between MPE and IPL is that MPE does not have an overt agenda and activities are not aimed at sharing practice and improving patient/client care, although this might happen serendipitously.

Boyd and Horne note that multidisciplinary healthcare is provided by ‘a collection of health professionals who independently contribute their particular expertise in parallel to each other, with minimal interdisciplinary communication’ (2008, p. 5).

Teamworking can be defined as ‘a considered action carried out by two or more individuals jointly, concurrently or sequentially. It implies common agreed goals, clear awareness of and respect for others’ roles and functions’ (Boyd and Horne, 2008, p. 5).

CAIPE note that effective implementation of the principles of IPE ‘calls for collaboration amongst government departments, employing authorities, statutory and regulatory bodies, universities and colleges, professional associations and users and carers’ (2006).

Collaboration is ‘an interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of healthcare providers to synergistically influence the ways client/patient care and broader community health services are provided’ (Way et al., 2002, p. 3).

Background and policy context

As early as 1988, the World Health Organization (WHO) highlighted that if health professionals learned together, and learned to collaborate as students, they would be more likely to work together effectively in clinical or work-based teams. The international trend still continues, and a WHO paper fully endorsing IPE to support collaborative clinical practice is due to be published soon.

There is overwhelming evidence that a failure of health and social care professionals to work together and communicate with each other can have tragic consequences for individuals (Quinney, 2006, p. 13; Laming Report, 2003). Despite the lack of robust ‘evidence’ that IPE contributes to more effective collaborative practice and improved patient and client outcomes, there are clear policy drives from government to encourage collaborative practice and partnership working.

Finch (2000) set out the important features that interprofessional collaborations should try to embrace. ‘The NHS wants students to be prepared for interprofessional working in any or all of the following senses:

- to ‘know about’ the roles of other professional groups
- to be able to ‘work with’ other professionals, in the context of a team where each member has a clearly defined role
- to be able to ‘substitute for’ roles traditionally played by other professionals, when circumstances suggest that this would be more effective
- to provide flexibility in career routes: ‘moving across’.

Respondents replying to a General Medical Council (GMC) consultation on the strategic options for medical undergraduate education felt that ‘interprofessionalism was an important area in medical education, but it was more likely to be embedded into medical practice through experience. (However) there is concern that poorly designed interprofessional learning could harm collaborative interactions and polarise attitudes’ (GMC, 2006).

Drivers for interprofessional learning

The main driver behind the development and implementation of interprofessional learning (IPL) was to help improve health and social care services. This was in the wake of shifting service delivery patterns (including more care in the community, shorter in-patient stays and changes in professional roles) and a response to some high-profile cases in which vulnerable people (often children and young people) 'fell through the net' (Colwell Report, 1974; Laming Report, 2003).

Barr (2005, p. 13) sums up the reasons why IPL has developed as follows:

- to modify negative attitudes and perceptions (Carpenter, 1995)
- to remedy failures in trust and communication between professions (Carpenter, 1995)
- to reinforce collaborative competence (Barr, 1998)
- to secure collaboration:
 - to implement policies (Department of Health, 2001)
 - to improve services (Wilcock and Headrick, 2000)
 - to effect change (Engel, 2001)
- to cope with the problems that exceed the capacity of any one profession (Casto and Julia, 1994)
- to enhance job satisfaction and ease stress (Barr et al., 1998; McGrath, 1991)
- to create a more flexible workforce (Department of Health, 2000)
- to counter reductionism and fragmentation as professions proliferate in response to technological advance (Gyamarti, 1986)
- to integrate specialist and holistic care (Gyamarti, 1986).

Economic drivers also support collaboration and partnership working. Faresjo suggests that 'the working together of healthcare professionals to meet the increasingly complex patients' and clients' needs most effectively is more important today than ever before. This is especially so in rural and remote areas around the world, where available healthcare resources are often quite sparse. In such cases, is it essential that health and social professionals work together in order to supply sufficient care within available resources' (2006, p. 1).

Learning theory

The rationale for interprofessional learning (IPL) is not only underpinned by service demands around teamworking, shared knowledge, professional development and collaboration, but also by learning theories. Freeth (2007, pp. 4/5) cites Jarvis's (1983) work on motivation and adult learning theory, which focuses on effective learning happening in the gap (or 'disjuncture') between what someone thinks they know and what they think they need to know. Freeth notes that 'slightly unfamiliar contexts, such as IPE, create disjuncture, revealing learning needs and motivating learners to close the gap'. In addition, skilfully facilitated and planned IPL can utilise 'constructive friction', creative conflict and the learning 'edge' to promote change, stimulate debate and discussion, and promote professional and personal development (Freeth, 2007, p. 5).

Another learning theory that underpins IPL is the 'contact hypothesis' (Allport, 1954), which suggests that attitudes towards diverse groups will improve with contact with that group, where there is equal status, focus on difference as well as similarities, the perception that members are 'typical' of their professional group, and opportunity to experience successful working together' (Taylor et al., 2008).

Positive experiences of working and learning in mixed groups validates this hypothesis, but as Carpenter and Hewstone (1995) suggest, this is not always so easy to manage in practice. Media and other professional stereotypes, difficulties in timetabling (particularly in clinical or other work-based placements), apportioning costs, finding appropriately skilled (and credible) facilitators, finding common, meaningful assessments and ensuring the professionals graduate against their own professional standards all seem to conspire against the implementation of IPL activities.

Principles of interprofessional learning

In 2001, CAIPE identified seven principles 'to guide the provision and commissioning of interprofessional education (IPE) and to assist in its development and evaluation';

CAIPE's vision is that when IPE works well, it:

- improves the quality of care
- focuses on the needs of service users and carers
- involves service users and carers
- encourages professions to learn with, from and about each other
- respects the integrity and contribution of each profession
- enhances practice within professions
- increases professional satisfaction.

The principles 'draw on the IPE literature, evidence base and the experience of CAIPE members, underpinned by values common to all healthcare professionals including a commitment to equal opportunities and positive regard for difference, diversity and individuality' (CAIPE, 2006).

Let us consider this in a little more depth.

- Improves the quality of care
Interprofessional learning (IPL) underpins the reality of the complexity of healthcare. Single professions or individual professionals working in isolation do not have 'the expertise to respond adequately and effectively to the complexity of many service user's needs' to ensure that care is safe, seamless and holistic; and of a high standard.
- Focuses on the needs of service users and carers
IPL puts the needs and 'interests of service users and carers at the centre of learning and practice';
- Involves service users and carers
Through active participation and involvement in 'planning, delivering, assessing and evaluating' IPL, service users and carers help 'to ensure that services meet the needs for whom they are designed';
- Encourages professions to learn with, from and about each other
This is one of the core distinguishing features of IPL.
- Respects the integrity and contribution of each profession
Participants in IPL are seen as equal learners, even though there may be differentials in power, position or status in the workplace.
- Enhances practice within professions
'Each profession gains a deeper understanding of its own practice and how it can complement and reinforce that of others. This is endorsed when the IPE carries credit towards professional awards and counts towards career progression';
- Increases professional satisfaction
This is achieved primarily through mutual support and guidance, discussion about roles and responsibilities, and collaborative

practice.

(Quotes above are from CAIPE, 2006.)

One of the issues about the difference between IPL and multiprofessional education, is that effective IPL overcomes some of the potential for resentment that shared learning might engender in its participants. Multiprofessional learning should not always be seen as a sub-set or step towards IPL, particularly when the learning involves students from diverse professional groups.

There are many examples of common learning or shared learning as well as programmes or learning interventions aimed more specifically at enshrining the IPL principles described above. Many of these are at pre-registration level, particularly in the early or foundation years where much of the basic science or communications skills learning might be shared learning. Sometimes this is with the specific aim of encouraging students to work together and learn about one another's practice, but often it is to provide students with a common foundation or baseline level of learning so as to provide them with a range of options at the next stage of learning.

Making clinical teaching interprofessional

It is important that course and curriculum design takes account of interprofessional education (IPE). IPE needs to be embedded in the curriculum rather than seen as an ‘add on’, which may be easy to cut when budgets are tight. It is not always easy, however, to champion IPE across different professions, departments and organisations, so let us consider some of the practical ideas that teachers might introduce into day-to-day teaching to promote and raise awareness of IPE.

Freeth suggests that typical successful choices in which to include IPE activities are:

- ‘clinical and service-based quality improvement initiatives where the embedded model is already well-developed at post-qualification level
- multi-professional student teams shadowing real teams or providing supervised care
- curriculum strands that address patient groups whose needs can only be met through interprofessional or interagency collaboration
- patient-safety initiatives’ (2007, p. 7).

Other ideas might include the following.

- Introduction of a new clinical protocol, approach or technique.
- Case conferences (these are often multi-disciplinary, but more emphasis could be placed on learning from other professionals).
- Bringing learners from different professions together in structured formal sessions around specific topics, or inviting learners from other professions to sessions which traditionally have been for single professions. Teaching modes might include lectures, seminars, tutorials, case studies/scenarios or problem-based learning.
- Involving learners from different professions to work together in clinical situations (such as the clinic, consulting room, theatre, ward, community, home visits) to learn together and share experiences and perspectives on patient care or understanding of situations.
- Promoting informal IPE, while providing opportunities for discussion, sharing of knowledge and learning from other professions.

Clinical skills acquisition lends itself well to interprofessional working, particularly in the latter years of the undergraduate course or in postgraduate contexts, such as anaesthetics, operating theatres, clinics or day centres. Guided by the principle ‘learning from one another’, rather than ‘with one another’, the learning uses a range of interprofessional clinical scenarios often using high-fidelity manikins.

Such scenarios can be led by an interprofessional team, co-ordinated by an interprofessional skills teacher. In focusing on learning as a team to address patient care, participants can develop mutual respect and appreciation of the difficulties each may face when dealing with the acutely sick patient.

Finally, you may wish to think about how you could embed raising awareness around interprofessional issues in your day-to-day work with trainees. Simply asking questions relating to how trainees work with and might learn from other professionals emphasises that you (as a role model) take the views of other professionals seriously.

This can be done as part of routine enquiry about a patient's progress – 'So what did the physiotherapist have to say about Mr Smith's progress over the last two days?' or 'Let's look at the notes, I see that the night nurses wrote... How do you think we should deal with this new information?' Or you might want to informally or formally involve other professionals in discussions about patient care, management or discharge.

Examples of initiatives in interprofessional education

The table below provides examples of some interprofessional education initiatives in various teaching and learning contexts.

Example	Teaching and learning context	Reference
Incorporation of an interprofessional learning strand into 10 health and social care professional organisations	Undergraduate health and social care students	Barrett G, Greenwood R and Ross K (2003) Integrating interprofessional education into 10 health and social care programmes. <i>Journal of Interprofessional Care</i> . 17(3 August): 293–301.
Implementation and evaluation of a shared learning programme	Final-year medical and social work students	Carpenter J and Hewstone M (1996) Shared learning for doctors and social workers: evaluation of a programme. <i>British Journal of Social Work</i> . 26: 239–57.
Pilot programme in interprofessional education (IPE) delivered and evaluated to assess whether there is value in learning together and the outcomes of different types of IPE	Pre-registration house officers, pharmacists and student nurses	Kilminster S, Hale C, Lascelles M, Morris P, Roberts T, Stark P, Sowter J and Thistlethwaite J (2004) Learning for real life: patient-focused interprofessional workshops offer added value. <i>Medical Education</i> . 38: 717–26.
Using community-based studies of disabled children and their families to provide an interprofessional learning (IPL) exercise for medical and nursing students	Medical and paediatric nursing students	Street KN, Eaton N, Clarke B, Ellis M, Young PM, Hunt L and Emond A (2007) Child disability case studies: an interprofessional learning opportunity for medical students and paediatric nursing students. <i>Medical Education</i> . 41: 771–80.
An attempt to highlight the issues of professional stereotypes within the context of mental health and subsequent implementation and evaluation of an IPE	Community mental health teams, including social workers, mental health nurses and psychiatrists	Barnes D, Carpenter J and Dickinson C (2000) Interprofessional education for community mental health: attitudes to community care and professional stereotypes.

programme to address some of these issues		Social Work Education. 19: 565–83.
The development and delivery of a programme for health professional students in which they learn the principles of collaborative learning and teamworking skills in rural healthcare placements	Medical and nursing students on rural healthcare placements	McNair R, Brown R, Stone N and Sims J (2001) Rural interprofessional education: promoting teamwork in primary health care education and practice. Australian Journal of Rural Health. 9(Suppl.): 19–26.
Development and piloting of a two-day workshop in interprofessional team building	Faculty and students from nine health programmes at the University of British Columbia	Gilbert JHV, Camp RD, Cole CD, Bruce C, Fielding DW and Stanton SJ (2000) Preparing students for interprofessional teamwork in health care. Journal of Interprofessional Care. 14(3): 223–35.
Development of a strategy for interprofessional collaboration using case studies that focus on collaboration between physicians and nurse practitioners in delivering healthcare to the community	Nurse practitioners and family physicians	Way DO, Busing N and Jones L (2002) Implementing Strategies: collaboration in primary care – family doctors and nurse practitioners delivering shared care. Ontario College of Family Physicians, Toronto.

The role of the teacher

The teacher is instrumental in ensuring that interprofessional learning (IPL) is effective at many levels: at the level of the curriculum (its design and balance of activities); timetabling; allocation of resources; consideration of power relationships between different professional and academic groups; and selection of appropriate activities for IPL. Once higher-level decisions have been made to implement IPL activities, the teacher is also responsible for what goes on in the learning environment itself – the micro-culture of the ‘classroom’.

Thinking point

- Do you think that teachers of IPL need special skills and training? Or is it simply facilitation ‘plus’?

Susanne Marie Lindquist and Scott Reeves’s paper (2007) focuses on the facilitator’s role with a view to enhancing our empirical understanding of this area.

- The study aimed to provide some insight into the role of facilitating interprofessional learning and explore some of the elements that lead to successful facilitation of IPL.
- Results suggested that facilitators felt that in order to be effective, they needed to be able to ‘display a range of attributes including enthusiasm, humour and empathy’.
- The facilitators often felt that although enjoyable, the role was challenging, but they valued the opportunity to develop their techniques and the follow-up debriefings were also very useful.
- The study indicated that support of IPL facilitators by way of meetings and debrief sessions is valuable in the implementation of IPL in the workplace.

Marcel Deon considers the educational theory underpinning IPL and how this can be used to structure learning and develop meaningful activities. He suggests experiential and co-operative learning as two axes that can be used to plan, design and evaluate IPL activities.

- Examine several techniques for enabling the successful implementation of IPL in health professions.
- Challenge students with interesting and complex learning tasks which are representative of their working environments to enable them to transfer this learning to their work.
- The learning task or situation needs to be structured to reflect the ‘five elements of best-practice cooperative learning’, which include face-to-face and small group teaching, development of interpersonal skills and accountability for one’s own learning.

- Use of the experiential learning framework together with ‘planning, doing, observing and reflecting’ is important in the development of the learning tasks.

Deon suggests that using the above techniques will allow the successful implementation of interprofessional education.

Thinking point

- How do you think these ideas could be used in your own teaching? Does this add to your understanding of how IPL works in the classroom?

Here are some guidelines for classroom management of interprofessional groups.

- Encourage ‘learning from’ rather than ‘learning with’ one another.
- Make sure you have an adequate, diverse and equal mix of professionals.
- Ensure the majority of a session has relevance to all participants.
- Utilise the skills, knowledge and expertise of all the participants through carefully selected activities.
- Do not let one group dominate discussion and ideas.
- Challenge stereotyping and negative views.

Assessment

Consideration of assessment of interprofessional learning (IPL) raises a number of questions.

First, should we assess IPL at all? Is it assessable? And if we do decide that we can, and we should, then:

- how can IPL be assessed equitably, reliably and with validity?
- how can we develop assessments that work across different courses and professional groups and that tie in with different learning outcomes and assessment patterns?
- what should be in these assessments, what form should they take and where in the curricula should they be situated?
- who assesses IPL?
- should these be discipline-based teachers or do we need specialist IPL teachers?

With all these questions, it is unsurprising that, although there are many IPL initiatives in terms of learning activities, there has been little written about assessment – it presents one of the more difficult challenges.

Freeth (2007, p. 21) suggests that the key concept underpinning assessment of IPL is that of ‘constructive alignment’ (Biggs and Tang, 2007), in which all aspects of the curriculum: learning outcomes, educational or learning objectives, course design, teaching and learning activities, assessment and evaluation, are aligned so that there is a clear relationship between all aspects. Morison and Stewart (2005) pointed out the need to develop and use agreed interprofessional education (IPE) standards or learning outcomes as the basis for developing relevant assessments. So, the consequence of this is that if we teach IPL, we should teach according to agreed learning outcomes and we should also assess it overtly. We know that for many learners, assessment drives learning and what is assessed in the formal curriculum is more highly valued.

Assessment needs to reflect the approach and learning interventions that are in place, and teachers need to think carefully about what is actually being assessed. Many of the issues in IPL concern attitudes, beliefs and teamworking, always more difficult to assess than content or skills… but there is an emerging literature around this in healthcare professions’ education.

Thinking point

- The e-learning module [Workplace-based assessment](#) provides more information on common assessments used in medical education. Many of these (such as multi-source feedback) involve other health professionals assessing doctors. How do you think this shift reflects interprofessional education? Is it IPE or something else?

What are the implications (if any) for different health professionals assessing one another? How could you better prepare for these assessments?

Evaluation

In this section, we think about the final part of the plan, do, reflect, review cycle (D’Eon, 2004), and about evaluation. How do we know that interprofessional learning (IPL) works? And how can we measure its effectiveness?

When we think about evaluation generally, the first point is to return to what we set out to do originally, what were our learning outcomes, broad curriculum aims or goals? This type of evaluation considers how well a course or learning intervention ‘does what it says on the tin’. One issue for IPL is that although the activities may be carried out interprofessionally, there may not be an explicit articulation of IPL goals, aims or learning outcomes. And we cannot evaluate what isn’t stated. This raises the question of how to embed IPL into course design and the fabric of a written, formal and stated curriculum when IPL is often pushed into the informal and even the hidden curriculum.

Another form of evaluation takes a wider view and looks at the impact of learning on the learners’ experience, or even more widely on service. The drivers for introducing IPL into the curriculum include improving collaboration and teamworking in practice, improving interprofessional communications and understanding, and ultimately improving patient care. So evaluation here would be looking at more long-term implications and impact of IPL activities. Of course, the further the learning intervention is from the changes seen (in time, geography or professional development), the harder it is to attribute the change to a specific learning intervention or approach.

Communities of practice

The community of practice (CoP) concept has been largely attributed to Etienne Wenger, but it is not a new idea. In fact, Wenger argues that it has been around since human beings chose to group together and form societies. Wenger's definition of a CoP is "a model of situational learning, based on collaboration among peers, where individuals work to a common purpose, defined by knowledge rather than task"; (Wenger, 1996). Wenger's work on the development of the CoP illustrates how learning occurs through a social network and the importance of this.

In simpler terms, a community of practice can be described as a group of people who work together to achieve a common goal. The process of working together and sharing knowledge and resources can lead to an enriched learning experience as people are exposed to new ways of thinking and problem solving.

In the clinical workplace, a CoP could be a healthcare team assigned to a particular patient. That team has been charged with the task of providing appropriate healthcare management and could include in its membership: specialists, consultants, surgeons, nurses, medical students, nursing students, healthcare assistants and administrative staff. Each brings to the CoP their own set of skills and knowledge, and through consultation, discussion and general interaction with one another provide a substantial body of knowledge and skills on which they can all draw.

A community of practice has specific criteria which makes it so. There are differences between a CoP and, say, an informal network or committee. Communities of practice share three specific domains.

1. Knowledge – a common body of knowledge within the community.
2. Community – commitment to forming a group for networking.
3. Shared practice – sharing of ideas, resources and strategies.

The table in the Teachers's toolkit, distinctions between communities of practice and other structures (Wenger et al., 2002), defines some of the groups that exist in a work environment.

Thinking point

- Can you think of examples in your own environment and how they differ from each other?

Distinctions between communities of practice and other structures

The learning that comes from being involved in a community of practice (CoP) is often not formalised and usually unacknowledged by the workplace as a legitimate way of learning. However, the concept that learning is a social phenomenon (Wenger) leads to informal learning experiences which occur at all levels within a work environment. New knowledge allows people to act as change agents for their professions as they find new ways of doing things and have the opportunity to challenge practices, which ensures that best practice is incorporated into the workplace on an ongoing basis. If the working environment allows and encourages this type of learning experience, 'opportunities for professional and practice development are greatly increased' (Andrew et al., 2008).

So how does it work in the real world? Legitimate peripheral participation (LPP) is a term to describe a phenomenon whereby students are likely to learn more by being involved in the task in some small way. For example, in a clinical environment, instead of being a mere observer the student becomes involved in the consultation by way of being assigned a specific task, such as taking a history or asking the family some questions to ascertain exactly what happened to the patient before they were admitted, and so on. This distinguishes LPP from the notion of learning by apprenticeship, as it assumes that students learn from a variety of people rather than the traditional master–apprentice model.

In the clinical environment there are many examples of LPP in action and often they are not recognised as learning experiences. Recognition of LPP as a valid learning experience and perhaps a conscious effort to establish roles within the boundaries of LPP could lead to an enriched learning experience for both learner and professional, as well as providing a pathway for establishing professional identity and fully fledged membership to the CoP.

In an article on learning how to be a nurse through LPP, Spouse (1998) found that her 'findings demonstrated the importance of a close and facilitative relationship which consequently enabled students to engage in activities contributing to their professional development... students were more likely to interact with other personnel working in the clinical environment and to become successful autonomous learners' (Spouse, 1998).

STRUCTURE (How clear are the boundaries?)	What's the purpose?	Who belongs?	What holds them together?	How long do they last?
Communities of Practice (Fuzzy)	To create, expand and exchange knowledge and to develop individual capabilities	Self-selection based on expertise or passion for a topic	Passion, commitment, and identification with the group and its expertise	Evolve and end organically (last as long as there is relevance to the topic and value and interest in learning together)
Formal Departments (Clear)	To deliver a product or service	Everyone who reports to the group's manager	Job requirements and common goals	Intended to be permanent (but last until the next reorganisation)
Operational Teams (Clear)	To take care of an ongoing operation or process	Membership assigned by management	Shared responsibility for the operation	Intended to be ongoing (but last as long as the operation is needed)
Project Teams (Clear)	To accomplish a specified task	People who have a direct role in accomplishing the task	The project's goals and milestones	Predetermined ending (when the project has been completed)
Communities of Interest (Fuzzy)	To be informed	Whoever is interested	Access to information and sense of likemindedness	Evolve and end organically
Informal Networks (Undefined)	To received and pass on information, to know who is who	Friends and business acquaintances, friends of friends	Mutual need and relationships	Never really start or end (exist as long as people keep in touch or remember each other)

Interprofessional teamworking

In the field of healthcare work, effective collaboration and interaction can have direct ramifications for patient care. For example, the Victoria Climbié inquiry (Department of Health, 2003) and the Bristol inquiry (Department of Health, 2001a) both indicated the need to move towards collaborative teamwork, and the need for a review of professional education and training in the UK (Humphris and Hean, 2004).

The modernisation of healthcare in recent years has initiated a move towards a team-based model of healthcare delivery (Baker et al., 2006; Wagner, 2004). Poor teamwork skills in healthcare have been found to be a contributing cause of negative incidents in patient care, while effective teamwork has been linked to more positive patient outcomes (Grumbach and Bodenheimer, 2004; Runicman et al., 1993).

Effective interprofessional teamworking

- Effective healthcare requires co-ordinate and concerted efforts from individuals from various disciplines and a system of delivery (Wagner, 2004).
- Effective care requires the concerted and co-ordinated activities of multiple people and disciplines.
- Teamwork can contribute to job satisfaction.
- Teamwork can assist in the development and promotion of interprofessional communication (Opie, 1997).

Challenges associated with interprofessional team working

- A clear understanding of one's professional identity, likely role within a team and the ideas about related health professionals are tested and developed (Wagner, 2004).
- The perceptions of one's own professional identity and others' assumption about the professional identities of other groups may not align.
- There is an expectation that in professional settings a grouping of individuals will have the capabilities required to adjust their own practice to bring about a particular patient outcome (Barrie, 2004).
- Invalid assumptions may lead to breakdown in communication and teamwork, and constitute a barrier in effective patient care (Barrie, 2004).
- Research suggests that students rated their communication and teamwork skills positively, and were favourably inclined towards interprofessional learning, but held negative opinions about interprofessional interaction (Pollard et al., 2004).

Interprofessional team cohesiveness

- A study assessing the cohesiveness of a multidisciplinary operating theatre (OT) found that nurses tended to view the team as being a unitary entity, while the surgeons and anaesthetists perceived the team as being made up of several sub-teams (Undre et al., 2006)

- Interprofessional teamwork and communication within this case was deemed by the OT health professionals to be acceptable, with room for improvement.
- Undre et al.'s (2006) findings suggest that OT health professionals are not required to view themselves as a unitary body, in order to achieve acceptable levels of teamwork. However, this does not mean that shared understanding is not desired or encouraged, as this can lead to a barrier to the efficacy of interprofessional healthcare teams.

Group dynamics and interprofessional education

- Pollard et al. (2004) examined attitudes towards collaborative learning both prior to and after gaining a qualification in a health science. They found that older students and those with prior experience in health or social care were more likely to hold negative attitudes towards interprofessional teamworking.
- Tunstall–Pedoe et al., (2003) had similar findings of negative attitudes in medical students who shared a foundation programme for medicine, radiography and nursing (perhaps due to archetypal stereotyping?).
- Pollard et al. (2004) suggest that this negativity to IPE is rooted in the older and more experienced students, thus indicating that interprofessional interventions should perhaps be implemented at several levels during the education process.

Professional identities

In their journey towards becoming healthcare professionals, students develop a range of beliefs and attitudes about the professions for which they are preparing themselves. They develop an understanding about the boundaries of their profession, and the ways in which they may interact with others as part of an interprofessional healthcare team. These sets of beliefs, attitudes and understanding about their roles, within the context of work, generally refer to their 'professional identity' (Adams et al., 2006; Lingard et al., 2002).

Professional identity formation:

- can be framed within the context of social identity
- is a systematic way of evaluating, identifying and organising the perception of self (Erikson, 1968)
- concerns group interactions in the workplace and relates to how people compare and differentiate themselves from other professional groups
- helps students to gain a realistic view of the profession
- consists of exploring the available alternatives and committing to some choices and goals; students are seen as active participants in the formation of their professional identity (Niemi, 1997).

Social identity theory suggests that the attitudes and behaviours of members of one professional healthcare group towards another are governed by the strength and relevance of the members' social identity (Tajfel and Turner, 2001; Turner, 1999).

Healthcare teams have been described as the centre of both the clinical education of new healthcare professionals and patient care (Lingard et al., 2002). The discourse that team members engage in (the verbal and non-verbal communication that they engage in during the course of both activities) is a key way in which new health professionals are socialised into teams (Sinclair, 1997; Haber and Lingard, 2001). During early participation, they obtain gradual responsibility and supervised involvement within the field, developing an overview of their profession, and an understanding of professional goals, values and limitations.

Challenges associated with professional identity formation

- When confronted by contradictory and ambiguous situations and experiences, individuals engage in self-reflection and questioning of the personal view; identity is reshaped as a result (Niemi, 1997).
- Professional identity is constructed through discourse between individuals, and identities are continually being constructed and altered (Bleakley, 2004).
- Power processes in team-based work are processes of meaning and identity formation (Bleakley, 2004). These induce the team members to consent to dominant organisational views even if these pose potential disadvantages (Dooreward and Brouns, 2003).

Challenges and constraints

It is clear from the wide range of literature available on interprofessional learning (IPL) that the potential benefits are great, not only to patients and clients, but also to learners, educators and other stakeholders. It would seem that the workplace, including the clinical environment, would be an appropriate place to bring learners together in interprofessional groups or teams. After all, they are working together collaboratively and so learning together would seem logical. But is it so easy?

Thinking point

- What do you think some of the difficulties might be in introducing IPL into the workplace?

There are many challenges to teachers, clinicians and practitioners, and to educational managers and planners. Although interprofessional education (IPE) has been strongly advocated as improving interprofessional communication and integrated services and there is a growing body of evidence of its effectiveness in some contexts, there remain significant questions concerning its implementation. These questions include the management of interprofessional learning and logistics, the preparation of teachers and mentors in the workplace, the mix of disciplines and transferability of learning, and resistance from established hierarchical uni-professional training programmes (EIPEN, 2008).

Headrick et al. (1998, p. 773) list a number of barriers to interprofessional collaboration and education:

- differences in history and culture
- historical intraprofessional and interprofessional rivalries
- differences in language and jargon
- differences in schedules and professional routines
- varying levels of preparation, qualifications and status
- differences in requirements, regulations and norms of professional education
- fears of diluted professional identity
- differences in accountability, payment and rewards
- concerns regarding clinical responsibility.

Finch (2000) highlights some of the issues for higher education providers, specifically that 'universities and colleges are eager to work with the health service but require greater clarity about health service objectives' and that 'different types of education provision are required, depending on which of the four versions of interprofessional learning is being advocated' (2000, p. 1138).

Although the paper is positive in suggesting that IPL is a ‘good thing’, she cites a number of barriers to shared learning (and IPL) at the pre-registration stage, including:

- timetabling
- different requirements from professional bodies
- universities not necessarily providing programmes for all the professions
- different entry requirements and lengths of programme.

Finch makes a strong case that IPL must reflect real working practices, not just those happening now, but in perhaps five or 10 years hence – as these are the lead-in times for developing new programmes and new schools.

In clinical and professional learning contexts, Soklaridis et al. note the importance for future doctors to learn from non-doctor role models and teachers, and that IPL may well involve challenging differential power relations and differences (the ‘us and them’) between health professions (2007). Carpenter and Hewstone (1996) evaluated a course for student doctors and social workers based on shared learning. They highlight the potential for power differentials with a number of participants feeling that their learning was compromised, but for different reasons. Mandy et al. (2004) examined whether interprofessional education had any effect on professional stereotype held by first-year undergraduate physiotherapy and podiatry students. One of their findings was that early implementation of interprofessional education appears to reinforce stereotypes, this might be based on deep-rooted psychology, and if this is the case, undoing the stereotypes that exist within professional groups is more complicated than previously thought.

To sum up

This module has introduced some of the key principles and ideas around interprofessional education in light of an emerging body of literature. We have also considered some of the challenges for clinical teachers. Interprofessional education (IPE) is an area of teaching and learning that many teachers feel intuitively 'should work', but it needs careful planning. If teachers are going to implement IPE in their everyday practice, then it is helpful to keep in mind that effective IPE is good educational practice 'with a twist', the twist being the active involvement of two or more groups of professionals in learning 'from, with and about' one another.

- Always consider whether a session can be run as an interprofessional session and whether this will add value.
- Introduce questioning to stimulate awareness of your trainees about how they might learn from or appreciate the role of other professionals.
- Plan the session carefully so as to encourage participation from all groups.
- Deal with issues as and when they arise, keeping aware of potential for negative stereotyping or exclusion of groups.

Congratulations

You have now reached the end of the module. Provided you have entered something into your log you can now print your certificate. To generate your certificate please go to 'my area' and click on 'complete' in the course status column. Please note, you will not be able to print your certificate unless you have entered something in your 'reflections area'.

Please now take a moment to evaluate the course and enter your comments below.

Further Information

This module was written by Judy McKimm, Clinical Education Programme Director, University of Auckland, and Visiting Professor, University of Bedfordshire, and Dulcie Jane Brake, Clinical Education Programme Administrator at the Centre for Medical and Health Sciences, University of Auckland. The module relates to areas 2 and 3 of the Professional Development Framework for Supervisors in the London Deanery.

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Course Glossary

Learning Activities

Select one or more of the activities below to develop your understanding and application of interprofessional education.

If you are registered on the site, you can write up your reflections in the ‘reflections area’. Click on the ‘my area’ link at the top of the page to access your personal pages. Please note you must be logged in to do this.

Activity 1

Think about your own educational experiences. List the times you have been involved in interprofessional education and which professional groups have been involved.

Considering some of the findings from the papers described in the module, can you identify some of the positive and less positive aspects of IPE as a learner, for example stereotyping, dominance of some professionals over the group, or some groups or individuals being directly or indirectly excluded from the learning process.

Activity 2

List some of the issues and challenges that may have to be addressed if IPE is going to be introduced in your clinical teaching context. This may be at undergraduate or postgraduate levels or in the clinical training context.

What similarities and differences have you thought about?

Freeth suggests that IPE may be more relevant and meaningful to post-registration learners such as trainees than to undergraduate students (2008, pp. 14–15). What are your thoughts on this?

Activity 3

Identify a learning event that normally includes only one professional group. Using the learning and examples from the module, plan how you can involve other professionals in the learning, identify specifically what value each of the groups will get from the session and how learners will learn from, about and with one another.

Once you have carried the session out, think carefully about what worked well and what you might improve.