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1

Interprofessional Education as an Emerging Concept

Hugh Barr

Introduction

Interprofessional education (IPE) in the UK originated in innumerable discrete ‘initiatives’ unbeknown to each other in diverse fields of practice. The Centre for the Advancement of Interprofessional Education (CAIPE) opened up channels for communication within and between those fields, complemented later by the Higher Education Academy. The World Health Organization (WHO) including UK initiatives in its global review, while the *Journal of Interprofessional Care*, launched in and for the UK, became the conduit for exchange between national and international developments.

The CAIPE defined IPE, enunciated principles, formulated outcomes and set standards in search of coherence, consensus and consistency, overtaken by a government-led agenda for ‘common learning’ initially to promote collaborative practice, but increasingly to develop a more flexible workforce to assist in modernising health and social care services. These twin objectives carried different implications for inter-professional content and learning methods, differences which remain ill-understood and ill-addressed.

Introducing Interprofessional Education

IPE began in the UK during the 1960s. Early ‘initiatives’ were invariably local, small-scale, isolated, ephemeral and work based in primary or community care. Their instigators were driven on the one hand by

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belief in teamworking as the means to respond more fully and more effectively to the needs of patients and clients,¹ on the other by growing awareness of the need to resolve tensions between professions practising in close proximity for the first time. Teamwork, as it became apparent, was no panacea. Opportunities had to be created where members could learn about each other's values, knowledge, skills, roles and responsibilities, and reconcile differences, either during team meetings or time out such as awaydays. Many of these initiatives were in primary care, others in fields such as learning disabilities, mental illness, elder care or palliative care where learning together often focused also on shared understanding and ownership of progressive models of care and joint action to implement them. Each initiative was learned by trial and error with few, if any, opportunities to compare experience within the same field, let alone across fields, but with uncanny similarities (Barr 2007a).

IPE in child protection started later. It was driven by reports from successive enquiries into the abuse and sometimes death of children from 1972 onwards (Hallett and Birchall 1992) calling for 'joint training' to improve communications and trust between professions variously responsible for their education, health and wellbeing. The emphasis was less on teamwork, more on networking, establishing machinery for effective collaboration between agencies as much as professions. Exchange of experience between IPE in child protection and in primary and community care was conspicuous by its absence for many years.

So long as IPE was work based, it remained largely hidden. If and when initiatives were recorded, reports were usually for local consumption, few surviving the passage of time or finding their way into publications. IPE was, however, also taking hold in universities and colleges where it was more visible. Most of those initiatives were at the post-registration stage, typically recruiting experienced practitioners from a range of professions on to part-time courses to enhance theoretical and evidence-based understanding of specialist practice with a particular patient group or in a particular field. Fewer were during pre-registration studies. Indeed, it is sometimes unclear from the sketchy reports surviving which of these were intra-professional, for example between branches of nursing or social work, and which were interprofessional as understood in this book. Some of the teachers pioneering these initiatives reported their experience within their respective fields through papers presented at conferences and in journals, less often between fields.

Much of the credit for drawing IPE initiatives together in the UK goes to the CAIPE² launched in 1987. CAIPE focused initially on IPE in and

for primary care, but soon extended its scope to cover a wider spectrum for community based and later hospital-based care. Its services included provision of advice and information; responses to numerous enquiries; consultancies; reports; bulletins; workshops; and conferences. It was complemented from 1992 onwards by the *Journal of Interprofessional Care*³ which was more wide-ranging from the outset, covering collaborative education, practice and research within and across fields of practice in the UK and, from 1997, worldwide. No less committed than CAIPE to interprofessional learning for interprofessional practice, the Journal responded also to the need to establish IPE as a disciplined activity, grounded in scholarship and worthy of a place in academe.

Debating Differences

As debates about IPE came into the open, differences in perception became more apparent within and between stakeholders: service users; pressure groups; employing agencies; professional associations; regulatory bodies; trade unions; universities and their teachers; and government departments.

Objectives

Some invoked IPE to resolve ignorance, misunderstanding and tension between practitioners from different professions, others to enhance teamwork skills, yet others to improve services, revitalise communities, remodel the workforce, or reform professional education.

Participants

Some thought that IPE should include a limited number of professions to address particular needs, opportunities or difficulties in working relationships, others that it should include the maximum practicable number.

Dosage

Some believed that a periodic IPE ‘innoculation’ was enough to produce a collaborative worker, others that it would only be effective if ‘treatment’ was sustained and pervasive.

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Stage

Some held that IPE should begin on day one of pre-registration studies, continuing throughout and beyond, others that students needed time to find their respective professional identities and to put experience under their belts before being exposed to it.

Location

Some asserted that pre-registration IPE was more effective on placement, others that university and work based interprofessional learning were complementary and mutually reinforcing.

Integration

Some preferred to keep IPE on the margins of professional programmes as extra mural activities or on placement, others to weave it into the fabric of professional education programmes.

Content

Some contended that common curricula were sufficient, others holding that comparative curricula were essential for participants to explore differences as well as similarities in their values, skills and knowledge, roles and responsibilities.

Method

Some opted for one learning method, others for a repertoire on which teachers could call to address different objectives and respond to different learning needs and styles.

Planning

Some listed subjects for interprofessional teaching and learning, others preferred outcome-driven programme planning based on competencies or capabilities.

Adopting Definitions

The need for consensus about IPE became more pressing as it took on a different complexion in ever more fields of practice, prompting CAIPE

to adopt the following definition and commend it to its members and more widely:

Occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care.

(CAIPE 1997)

Alive to the need to distinguish between IPE and many other occasions when health and social care professions learnt together for other reasons, it drew a distinction between IPE and multiprofessional education (MPE) defined as

Occasions when two or more professions learn side by side for whatever reason.

(CAIPE 1997)

Defined thus, IPE is a subset of MPE with permeable boundaries. It may grow within MPE in response to changes in policy or practice, or students' needs and expectations, but it may also become subsumed within MPE when its distinctive qualities are insufficiently valued and protected, especially in the face of budgetary cuts when interactive learning in small groups may seem too costly.

Enunciating Principles

Encouraged by the positive reception that these definitions had received, CAIPE took steps to reinforce them by enunciating the following principles (Box 1.1).

Box 1.1 Effective IPE

1. Works to improve the quality of care;
2. Focuses on the needs of service users and carers;
3. Involves service users and carers;
4. Encourages professions to learn with, from and about each other;
5. Respects the integrity of each profession;
6. Enhances practice within professions;
7. Increases professional satisfaction.

(CAIPE 2001)

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The first of these principles is a reminder that IPE is not only grounded in practice, but also works for its improvement. The second and especially the third come through strongly in many current IPE initiatives in response to the momentum behind user-led care in UK health and social policy. The fourth reiterates the definition. The fifth and sixth are timely reminders of the need for IPE to be planned and delivered in ways that preserve and protect each profession within the wider professional family. The seventh responds to the need to cultivate mutual support to alleviate occupational stress and find fulfilment in co-working.

Classifying Learning Methods

Working with CAIPE, I distinguished between six learning methods frequently found in IPE (Box 1.2):

Box 1.2 Learning Methods in IPE

- Exchange-based learning;
e.g. appreciative enquiry, debates, games and case studies
- Action-based learning;
e.g. problem-based learning, collaborative enquiry and continuous quality improvement
- Practice based learning;
e.g. training wards and co-placements
- Simulation-based learning;
e.g. role play and experiential groups
- Observation-based learning;
e.g. joint visits and shadowing
- Received learning;
e.g. lectures.

(Barr 2002)

These methods are neither exhaustive nor mutually exclusive. Experienced teachers ‘mix and match’ them in response to different learning needs, to ring the changes and to hold the interest of their students. Received or didactic learning may be the least relevant given the stress put on interaction, but still has a place. E learning and blended learning have gained ground more recently and merit inclusion although they may be treated more appropriately as media rather than methods.

Further illumination came from the Interprofessional Education Joint Evaluation Team (JET)⁴ which adopted and developed the following analysis of the characteristics of adult learning by Brookfield (1986) adding its own observations in italics:

- The adult learner is a self-directed, autonomous learner. The outcome of the learning is more likely to be positive if the learner chooses the direction, content and methods. *This poses immediate challenges for IPE. Participants may need to explore whether their perceived learning needs and desired outcomes are in harmony and whether their preferred approaches to learning coincide. Mismatches may lead to negotiation and provide excellent opportunities for collaborative learning.*
- Teachers and facilitators need to respect adult learners' needs, personalities and learning preferences. *In IPE, participants and facilitators from different professions need to accept and celebrate the diversity in the group and learn from it.*
- The experience of the learner is paramount. Life experience is both the substrata for learning and defines the particular learning needs of the individual. *Lived professional experiences, and their influence on professional attitudes and behaviour, provide bases for interprofessional exchange as participants compare perspectives and experience and sometimes challenge each other.*
- Active learning is at the heart of adult learning. *This applies especially to professional and interprofessional learning. Passive acquisition of knowledge translates poorly into practice. Active learning implies change, which may only occur if previously held attitudes and beliefs are open to challenge in a safe, supportive and co-operative learning environment.*
- Learning has to be relevant. *IPE may be instigated in response to the perceived needs of the team, the organisation, the professions or the overall service delivery system. Effective learning, however, depends upon demonstrating relevance to each participant individually.*
- Pressure to learn needs to be internalized before the participant will be motivated to learn. *Again, this is a powerful reminder that IPE, albeit designed for groups is in the final analysis, for individuals.*
- The learner needs to be ready and receptive. This may result from a degree of discomfiture, where dissonance between the desired knowledge or skill and their current state is sufficient to prompt motivation to learn and change. *Effective IPE generates such discomfort but in a supportive environment.*

(Barr et al. 2005: 96–97)

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Responding to JET from the United States, Clarke (2006) commended interprofessional learning that was cooperative, collaborative and socially generated during exchange between the participants. It was associated with professional judgement and recognition of the social construction of knowledge within professions. Citing Kolb (1984), he saw experiential learning as a conflict-filled process out of which the development of insight, understanding and skills comes. Each profession, he said, had its cognitive or normative map derived from the process of professionalisation. IPE entailed the decentring of knowledge (Dahlgren 2006) to become aware of points of view other than one's own.

Formulating Outcomes

Given that many professional education programmes had adopted competency-based outcomes, there was a compelling argument for IPE to do likewise to facilitate its integration. Many formulations can be found in the literature, some of which were taken into account in drafting the following.

The competent practitioner will be able to do the following (Box 1.3):

Box 1.3 The Competent Practitioner

- Contribute to knowledge and development of others;
- Enable practitioners and agencies to work collaboratively to improve the effectiveness of services;
- Develop, sustain and evaluate collaborative approaches to achieve objectives;
- Contribute to the joint planning, implementation, monitoring and review of care interventions;
- Coordinate an interdisciplinary team to meet individuals' assessed needs;
- Provide assessment services on individuals' needs so that others can take action;
- Evaluate the outcome of another practitioner's assessment and care planning process.

(Barr 1998)

Some teachers questioned reliance on competency-based outcomes which they found myopic, mechanistic and reductionist, including

IPE-activists at Sheffield Hallam University who formulated instead a capability framework (Chapter 4), comprising outcomes that addressed students' ongoing learning, development and professional maturation in a working world subject to constant change and new demands.

The interprofessional team member, they said (Box 1.4):

Box 1.4 The Interprofessional Team Member

The interprofessional team member:

- is able to lead and participate in the interprofessional team and wider inter-agency work, to ensure a responsive and integrated approach to care/service management that is focused on the needs of the patient/client;
- implements an integrated assessment and plan of care/service in partnership with the patient/client, remaining responsive to the dynamics of care/service requirements;
- consistently communicates sensitively in a responsive and responsible manner, demonstrating effective interpersonal skills in the context of patient/client focused care;
- shares uniprofessional knowledge with the team in ways that contribute to and enhance service provision;
- provides a co-mentoring role to peers of own and other professions, in order to enhance service provision and personal and professional development.

(CUILU, 2004)

Checking Standards

CAIPE framed the following questions to assist in conducting internal and external checks on standards in an IPE initiative (Box 1.5):

Box 1.5 Checking Standards

- Do the aims as stated promote collaboration?
- How do the objectives contribute to collaboration?
- Do the aims and objectives contribute to improving the quality of care?
- Are aims and objectives compatible?
- How is IPE built into the programme?
- Is the programme informed by a theoretical rationale?

Box 1.5 (Continued)

- Is the programme evidence-based?
- Is the programme informed by interprofessional values?
- Does comparative learning complement common learning?
- Are learning methods interactive?
- Is small group learning included?
- Will numbers from the participant professions be reasonably balanced?
- Are all the professions represented in planning and teaching?
- Are service users and carers involved?
- Will the interprofessional learning be assessed?
- Will it count towards qualification?
- How will the programme be evaluated?
- Will findings be evaluated?

(Barr 2003)

Challenging the Emerging Orthodoxy

These efforts to instil order into IPE were appreciated by many university teachers, but countered by commentators and researchers intent upon promoting alternative terminology and definitions (see, for example, Pirrie *et al.* 1998). Cooper and her colleagues (2004) found the packaging too tidy, commending complexity theory to provide IPE with a realistic foundation to prepare students to work in complex systems by prioritising development of skills that promoted survival and adaptation. Pressure to force IPE into 'a linear straitjacket' had to be resisted and predetermined statements of outcome set aside. Nothing could have been further removed from the challenge to the emergent IPE orthodoxy from government to which we now turn.

Embracing Government's Agenda

If 1997 marked the beginning of the road towards a unified IPE movement in the UK, it was also the year when the incoming Labour government dedicated itself to the modernisation of health and social care. From the outset, it put professional education at the heart of its strategy. Training and education (in that order) would give staff a clear understanding of how their own roles fitted with others to

provide patients with integrated care. Emphasis, in the first instance, was on continuing professional development (Secretary of State for Health 1997), government judging perhaps that this would deliver change faster and encounter less resistance than attempts to reform pre-registration studies hedged about by conventions, regulations and vested interests.

But a more radical proposal followed in the NHS Plan (Secretary of State for Health 2000) in which government asserted the importance of collaboration between the NHS, higher education providers and regulatory bodies to make basic as well as post-basic education more flexible. It called for a core curriculum, comprising joint training in communication skills and in NHS principles and organisation, to promote partnerships at all levels to ensure a seamless service of patient-centred care. A new common foundation programme would give everyone working in the NHS the skills and knowledge to respond effectively to patients' individual needs, helping to give front-line staff the opportunity to think and work differently, to solve old problems in new ways and to deliver the improvements set out in the NHS Plan (Department of Health 2001). Cultivating collaboration was still on the agenda, but the salient message had become, to coin a phrase, 'educational engineering' where shared programmes would motivate and prepare students to become agents of change. Nor was that all; by 2004 government was advocating common learning to generate a more flexible workforce to further the modernisation of services, confidently asserting that attitudes were changing with 'a significant appetite for developing new roles in the services' (Department of Health 2004).

Anticipating this state of affairs, Finch (2000, cited by Barr 2002) argued that universities must understand IPE before they could embrace it. Definitions were unclear and objectives several.

Was the object for students:

1. To know about the roles of other professions?
2. To be able to work with those others?
3. To be able to substitute for those others?
4. To find flexible career pathways?

With the passage of time, Finch's four objectives boil down to two:

- Learning together to improve collaborative practice.
- Learning together to build a more flexible workforce.

Implementing IPE Nationally

Implementation of each was facilitated by a different set of central organisations, the first led by the Quality Assurance Agency for Higher Education in England (QAA) and the second by Skills for Health. Insofar as both drew up frameworks and established systems for common learning, they were on the same track, but with different emphases. The QAA, and the bodies working with it, concentrated on improving collaboration between professions, based on mutual respect for identities and boundaries, seeking by common consent, to carry educational and professional interests with it. Skills for Health, whilst making passing reference to collaborative practice, concentrated on modernising the workforce in response to policy and management imperatives, less beholden than the QAA to educational and professional sensitivities.

The QAA established a series of working groups in partnership with regulatory bodies and professional associations to agree benchmarking statements to determine standards for pre-registration courses for nursing and the allied health professions (QAA 2001), social work (QAA 2000) and medicine (QAA 2002) drawn together later in a statement of common purpose (QAA 2006). The consensus achieved was remarkable and indicative of underlying moves amongst professional associations to draw closer and to find common ground, but stopping short of a formulation that might have set standards for IPE in the way that CAIPE and others had formulated. The conspicuous omission was comparative learning, the exploration of differences on which informed collaborative practice would depend to make intelligent call on the distinctive contribution of each profession. Earlier QAA work (QAA 1999) on multidisciplinary programmes was pregnant with implications for IPE, but was not brought forward. The QAA statements nevertheless proved helpful to inform the design and content of pre-registration IPE, and judgements by QAA panels reviewing IPE embedded in professional programmes. They were reinforced by the Higher Education Academy, three of whose subject centres⁵ did much to promote and develop interprofessional teaching and learning, reinforced by those of the Centres for Excellence in Teaching and Learning (CETLs) which focused directly or indirectly on interprofessional learning.

'Skills for Health'⁶ works with and through Strategic Health Authorities (SHAs). It has published some 60 sets of National Occupational Standards and National Workforce Competencies, based on employers' expectations for good practice in specific areas and client domains

intended, amongst other purposes, to inform educational programmes and curriculum design. It has developed a Knowledge and Skills Framework within which to include them, building in ladders for career progression. It has taken steps to modernise qualifications in the healthcare sector to make them more relevant to practice and more flexible with additional points for entry and exit, secure their standards and introduce new awards such as the Foundation Degree to provide broad-based and unrestricted entry into healthcare employment. Most recently, it has put forward proposals entitled 'Equip' to standardise the monitoring of educational provision funded by SHAs on which decision, at the time of writing, had yet to be taken by government. Much of this work has been commissioned from independent consultants introducing rigour and a measure of detachment, but at the price of continuity and ongoing engagement with consultees. The imperative driving this plethora of reforms is implementation of government's workforce strategy to modernise health and social care services based upon the application of principles of human resources management where professional identities, roles and demarcations are subservient. Whilst making reference to learning for collaborative practice, it seems to be secondary to workforce reform in many Skills for Health statements.⁷

'Creating an Interprofessional Workforce' (CIPW 2007) was a three year project funded by the Department of Health to promote and develop an interprofessional culture within the health and social care workforce. Its objective was clearly to advance the modernisation agenda in association with SHAs, with whom close working relationships were established from the outset, but also with CAIPE, with whom collaboration grew closer as the project progressed. Marrying interprofessional and workforce agendas in its title, CIPW embraced both seemingly without difficulty. It succeeded, where CAIPE had failed, in engaging SHA's and NHS Trusts and other employing interests, whilst benefiting from the goodwill that CAIPE enjoyed in many universities and amongst their teachers. Given longer, with resources for follow up, CIPW might have done more to reconcile the two agendas.

Implementing IPE Locally

The road to reconciliation remained where it had always been – locally – where partnerships were established to develop 'common learning sites'. In each, responsibility for pre-registration IPE rested with one

or more universities, a number of employing agencies (NHS Trusts, local authorities and from the independent sector) and the SHA. Joint management held the tension between the parties as they designed, developed, delivered and evaluated a common learning (or IPE) programme which all could own and endorse, taking into account local needs, circumstances and priorities, and implementation of national education, health and social care policies.

Albeit working from the same blueprint, development on the ground has necessarily taken many forms, depending upon topography from sparsely populated rural regions, at one extreme, to metropolitan counties and segments of London, at the other. It has taken into account historically and accidentally determined distribution of education programmes for the various health and social care professions between faculties or schools within the same and different Higher Education Institutes (HEIs) in the same and different cities. Sustainability remains problematic. Over-complex formulae for partnership falter in the face of financial and workload implications while relatively high unit costs render IPE liable to be watered down or jettisoned.

Generalisation about these developments is hazardous in the absence of a database of pre-registration IPE programmes,⁸ but four 'common learning pilot sites' funded by the Department of Health have been extensively reported (Barr 2007b; Miller *et al.* 2006). Two of these sites (King's College London with Greenwich and London South Bank universities, and the Newcastle, Northumbria and Teesside universities) concentrated on developing models for interprofessional practice learning. The third (Sheffield Hallam and Sheffield universities) developed the capability framework (see above).

The fourth (Southampton and Portsmouth universities) was alone in attempting to revise curricula both to cultivate collaborative practice and to develop a more flexible workforce. Its 'New Generation Project' (NGP) remodelled the entire curriculum for pre-registration medicine, nursing, allied health professions and social work studies to comprise 'learning in common' in accordance with QAA benchmarking statements. Logistics and sheer scale precluded arranging such studies concurrently in the same classrooms or practice settings across professional groups. Instead, each group followed the same curriculum separately. Provision was, however, made for relatively short periods of intensive interactive study between the groups designed to cultivate collaboration in learning and practice. Resources have been curtailed for the long-term follow up of the NGP students. Data may therefore not be forthcoming to establish the extent to which this highly ambitious

project met both objectives. Nor would it have been easy to deduce whether greater mobility in career progression or closer collaboration with other professions in practice was attributable to following the same common curriculum separately or to the time-limited intensive interprofessional learning together.

An exhaustive review of pre-registration IPE would take into account evaluations from other common learning sites. Suffice it to say that most, if not all, concentrated on preparing students for collaborative practice with few signs that workforce development was built into programme design or required outcomes. Universities have, however, responded positively to opportunities funded by SHAs to launch Foundation Degree programmes catering for a broad band of entrants to health and social care employment, and programmes for new occupational groups such as physician assistants, both of which contribute to workforce reform.

Promoting IPE Internationally

Communication and collaboration between IPE developments in the UK and other countries have progressed apace during the years under review, triggered by a seminal report from the WHO (1988) which drew on examples in developed and developing countries to inform a unifying definition and rationale for IPE.⁹ Students, said the WHO, should learn together during certain periods of their education to acquire the skills necessary for solving the priority health problems of individuals and communities known to be particularly amenable to teamwork. Emphasis should be put on learning how to interact with one another, community orientation to ensure relevance to the health needs of the people and team competence.

IPE, said the WHO, should fulfil the following seven objectives (Box 1.6):

Box 1.6 Seven Objectives of IPE

1. Modify reciprocal attitudes;
2. Establish common values, knowledge and skills;
3. Build teams;

Box 1.6 (Continued)

4. Solve problems;
5. Respond to community needs;
6. Change practice;
7. Change the professions.

The first of these objectives acknowledged that ignorance, prejudice and negative stereotyping can impede effective working relations between professions, but be eased by creating opportunities to learn first hand from and about each other. The second recognised the need to establish a common foundation of values and knowledge, complemented by collaborative skills. The third treated teamwork as the primary vehicle to cultivate collaborative practice and IPE as a means to that end. The fourth accounted for the emphasis on problem-based learning (PBL) in those IPE initiatives instigated in response to the WHO lead. The fifth enlisted IPE in pursuit of a longstanding WHO objective to strengthen community based care. The sixth focused on the reform of services and the improvement of professional practice. The seventh went further, invoking IPE to change the professions from within. No one IPE initiative could realistically meet all these objectives, but many respond to one or more (Barr 2003).

Twenty years later, another WHO study group (Box 1.7) has been convened in partnership with the International Association for Inter-professional Education and Collaborative Care (InterEd):

Box 1.7 Aims of InterEd

- To review the 1988 report of the WHO Study Group on Multiprofessional Education of Health Personnel and evaluate the positive outcomes of this report as well as the areas in which little or no progress has been made;
- To assess the current state of research evidence on IPE and collaborative practice, synthesize it within an international context, and identify the gaps that must still be addressed;
- To conduct an international environmental scan to determine the current uptake of IPE and collaborative practice, discover examples that illuminate successes, barriers and enabling factors, and identify the best practices currently known in this area;

- To develop a conceptual framework that would identify the key issues that must be considered and addressed by WHO and its partners when formulating a global operational plan for IPE and collaborative practice;
- To identify, evaluate and synthesize evidence on the potential facilitators, incentives and levers for action that could be recommended as part of a global strategy for IPE and collaborative practice.

(Yan *et al.* 2007)

It is clear from deliberations, so far, that impact from this second IPE report within WHO will depend upon addressing its two overriding concerns: first, application of lessons learned from IPE in developed countries to developing countries and, second, the relevance of IPE to the WHO's strategy to tackle the global crisis in the number, distribution and deployment of skilled personnel in the healthcare workforce (WHO 2006). Much the same pressure may then be building up internationally as nationally to enlist IPE as an agent of workforce reform.

There is, however, nothing in the international literature of IPE (Barr 2005) to suggest that workforce objectives have been included. Findings from systematic reviews must be treated with extreme caution, based on highly selected examples of IPE initiatives subjected to robust evaluation. The Interprofessional JET scanned over 10,000 reports of IPE evaluations from which it selected 107 to include in its first analysis (Barr *et al.* 2005) and 21 in its second adopting a higher threshold (Hammick *et al.* 2007). It classified outcomes as follows based on a modification of the scale devised by Kirkpatrick (1967) for vocational training (Table 1.1):

Table 1.1 The JET Classification of IPE Outcomes

Level 1 – Reaction	Learners' views on the learning experience and its interprofessional nature.
Level 2a – Modification of attitudes/perceptions	Changes in reciprocal attitudes or perceptions between participant groups. Changes in perception or attitude towards the value and/or use of team approaches to caring for a specific client group.
Level 2b – Acquisition of knowledge/skills	Including knowledge and skills linked to interprofessional collaboration.

Table 1.1 Continued

Level 3 – Behavioural change	Identifies individuals' transfer of interprofessional learning to their practice setting and their changed professional practice.
Level 4a – Change in organisational practice	Wider changes in the organisation and delivery of care.
Level 4b – Benefits to patients/clients	Improvements in health or wellbeing of patients/clients.

Based on its analysis, JET distinguished between three overlapping types of IPE by primary focus:

1. Preparing the individuals for collaborative practice;
2. Developing teamwork;
3. Improving services.

The first of these applied most strongly to pre-registration IPE and the third to work based IPE between experienced practitioners. The second was under-represented at both stages, despite much lip service paid to teambuilding in the interprofessional literature.

JET's working definition for IPE focused on learning for collaborative practice. It made no reference to developing a more flexible workforce. Examples of learning together with that focus might have been missed. Account must also be taken of the time lag between initiatives being conducted and evaluated, and a systematic review reporting. It may well be prudent therefore to allow for the possibility that learning together for health and social care professions has developed more recently. Furthermore, it might characterise such learning in developing countries underrepresented in the IPE literature and absent from systematic reviews.

Conclusion

Despite sustained endeavours to instil coherence, IPE remains a 'broad church'. That may be its strength, provided that systems for planning, delivery and evaluation are robust enough to reconcile different objectives operationally. At issue is whether IPE and common learning are one and the same, or whether the former is qualitatively different to

be embedded within the latter, following the Southampton/Portsmouth model.

For common learning to pave the way for substitution and career progression, it needs either to be taught to the same level across the constituent professions or topped up as necessary. Either way, it needs to be applied to different roles in different work settings.

For interprofessional learning to cultivate collaborative practice, it needs not only common but also comparative curricula, complemented by interactive, exchange-based learning methods. Logistics and costs may dictate that it remains a relatively small proportion of the overall study time compared to the common learning within which it is embedded. This puts a premium on its potency, but its impact may depend also upon the extent to which its values and insights come to characterise both the common and the profession-specific learning.

Much remains to be done to reconcile these two agendas, once their different objectives and implications for content and learning methods are better understood and stakeholders locally, nationally and internationally engage.

Notes

1. The term 'service user' did not gain currency for another 20 years.
2. www.caipe.org.uk.
3. www.informahealthcare.com.
4. All of whom were active members of CAIPE.
5. Health Sciences and Practice, Medicine, Dentistry and Veterinary Medicine, and Social Work and Social Policy.
6. With 'Skills for Care' as agents of central government working with Strategic Health Authorities, human resources management in NHS trusts and local authorities.
7. See www.skillsforhealth.org.uk.
8. Numerous national reviews of IPE up to 1997 (summarised in Barr 2007b), all reported before these programmes were established.
9. The WHO preferred the term MPE at that time, but accorded the same meaning as the term IPE, which it later adopted.

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