Transforming learning: the challenge of interprofessional education

Sanjiv Ahluwalia, Robert Clarke, Maureen Brennan

Interprofessional education (IPE) is the foundation for collaborative practice. It is resource intensive because it requires a shift away from didactic teaching towards a model of facilitated small group learning. This article discusses the ways in which IPE is supported by educational theory and summarizes the increasing evidence for its effectiveness in transforming health-care organizations, leading to increased staff motivation and direct improvements in patient care.

WHAT IS INTERPROFESSIONAL LEARNING?

Interprofessional learning occurs when two or more professions learn from, and about, each other to improve collaboration and the quality of care (Committee for the Advancement of Interprofessional Education (CAIPE), 1997). This implies that an explicit aim should be an increased understanding of each other's roles, which distinguishes it from multiprofessional learning where different professions just happen to coincide in a learning environment. Carpenter and Hewstone (1996) have suggested that simply putting students together in mixed classes is unproductive.

Interprofessional learning necessitates that professionals learn with, from and about each other. In organizational terms, this requires small group learning, rather than large group didactic teaching. The shift is resource intensive, because it is so much easier and cheaper to organize a lecture with a multiprofessional audience. However, interprofessional education (IPE) has much greater potential to produce good learning, which can transform organizations by supporting true collaborative practice.

Interprofessional learning improves communication and teamwork between different professionals and agencies (Pratt, 1999), which benefits both patients and health professionals. It also has the potential to counter the effects of ignorance, prejudice and tribalism arising from professional rivalries (Zagier Roberts, 1994)

Collaborative work requires different professionals with diverse ways of working, attitudes, and bodies of knowledge to work in the best interests of patients. It is not the aim of interprofessional learning that these distinct and diverse cultures and their differences should be eliminated; rather these differences must be explicitly acknowledged. Exploiting the differences in how different members of the team think and approach their clinical practice brings about new ways of resolving problems. The key is that teams should not be attempting to remove differences or blur boundaries, but attempting to clarify and understand the different ways of thinking and combine the different knowledge and skills to benefit patients.

THE THEORETICAL BASIS FOR INTERPROFESSIONAL LEARNING

Interprofessional learning is strongly supported by educational theory and its effectiveness is reflected in a growing base of evidence. Adults learn most effectively when they are active participants of the learning process (Bruner, 1966) and have the opportunity to reflect on their experiences (Schon, 1983). They learn best experientially, deriving abstract concepts for themselves from their experience and then testing these concepts in new situations (Kolb, 1984).

Improvements for patients are likely to occur if the range of professionals responsible for providing a particular service are brought together to share their different knowledge and experiences, agree what improvements they would like to see, test these in practice, and jointly learn from their results. As they build their knowledge about how things work, such groups are likely to discover that their difficulties are more often derived from the process of sharing care than from each other (Headrick et al, 1998).

WHY USE INTERPROFESSIONAL LEARNING?

The policy context

The Bristol Inquiry into the deaths of children at a paediatric cardiac surgery centre (Bristol Royal Infirmary Inquiry, 2001), as well as the Laming Report (2003) into the death of Victoria Climbié, highlighted significant deficiencies in the care of children. This was found to have arisen from poor communication, a lack of effective team working, and patterns of professional working that had developed a hierarchy of professions that had become resistant to questioning and change, and therefore did not serve the interests of the patients involved. The Laming Report made specific recommendations in relation to interprofessional learning, e.g:

> **'…each of the training bodies covering services provided by doctors, nurses, teachers, police officers, officers working in housing departments and social workers should demonstrate that effective joint working between each of these professional groups features in their national training programmes.'**

The DH's response to the Bristol

Dr Sanjiv Ahluwalia is Course Organizer, Barnet Vocational Training Scheme, **Dr Robert Clarke** is Associate Director, London Deanery, London WC1N 1DZ and **Ms Maureen Brennan** is Senior Lecturer, Department of Nursing and Midwifery, University of Hertfordshire

Correspondence to: Dr R Clarke

Enquiry in the publication *Working Together – Learning Together* (DH, 2001), has been:

'...that there should be more opportunities for different health-care professions to share learning and that more emphasis should be placed on the non-clinical aspects of care, such as communication skills in the education, training, and development of those working in the NHS.'

Working and learning interprofessionally are the cornerstones of recent government policy. *The New NHS: Modern and Dependable* (DH, 1997); *A First Class Service: Quality in the New NHS* (DH, 1998) and *Clinical Governance: Quality in the New NHS* (NHS Exexcutive, 1999) all espouse the philosophy of collaboration. These policy documents recommend a move away from uniprofessional working to interprofessional working where practitioners make a commitment to work with each other across boundaries for the benefit of the patient or client (Kenny, 2002).

THE EVIDENCE SUPPORTING INTERPROFESSIONAL LEARNING

A study drew on a national survey of 400 health-care teams involved in primary, secondary, or community health-care (Borrill et al, 2000). This research indicated that primary health-care teams with clear objectives, higher levels of participation, and emphasis on quality and support for innovation, provided the most effective patient care. Better communication leads to higher levels of effectiveness. This in turn leads to new and improved ways of delivering clinical services. Members of such teams had relatively low levels of work stress and retention of staff was greater.

Freeth et al (2002) reported a systematic review of evaluations of interprofessional learning programmes. The authors concentrated on 53 studies, most of which were about post-registration continuing development, based on workshops or short courses. The majority were from the USA. The learning experience was always formal and of medium or long duration. Nursing and medicine were the most frequently represented professions. Among the 53 studies, the authors found 14 studies that reported improved cooperation and communication, 24 studies reported changes in knowledge and skills, 12 studies reported changes in behaviour, 21 studies reported changes in organizational practice, and 9 studies reported benefit to patients. Five studies reported no change and overall there were no negative comments.

Koppel et al (2001) carried out a review to address the question: 'What kind of IPE, under what circumstances, produces what kind of outcomes?' Their first conclusion was that the impact of interprofessional learning appears to be related to its duration, with longer courses more likely to produce individual behaviour and organizational or patient-based change. They also noted the importance of location, in that only work-based learning programmes led to organizational or patient-related outcomes. In addition, the maturity of the learner appears to influence outcomes. Studies focused on pre-qualifying learners rarely had positive outcomes beyond the reaction and learning of the individual. In contrast most of the studies at the continuing professional education level reported change both for organizations and for patients.

The evidence supporting interprofessional learning, however, is not without its critics. In a Cochrane review, Zwarenstein et al (2001) failed to find any educational evaluation meeting their required criteria of having robust experimental design and demonstrating benefit to patient outcomes. Knowledge of its effectiveness is also limited because much of the literature is discursive. Few empirical studies have described the content of the interprofessional programmes and the outcomes are poorly described or identified. The lack of rigorous evidence does not mean that interprofessional education does not work. Nor should it be assumed that it supports the status quo. The education of health professionals in the UK engenders discipline-specific norms and attitudes that interfere with interprofessional collaboration (McPherson et al, 2001).

PROMOTING INTERPROFESSIONAL WORKING AND LEARNING

Hewstone and Brown (1986) suggest that successful interprofessional working and learning depend on a number of factors, of which perhaps the most important are institutional support, equal status of participants and a co-operative ethos. Headrick et al (1998) highlight some barriers to interprofessional collaboration and education, particularly differences in history and culture between participants, interprofessional rivalries, differences in language and jargon and differences in schedules and professional routines. There are also differences in regulations and accreditation of education, as well as differences in pay and status, which can be strong barriers to collaboration.

To encourage IPE in the context of teams, the Interdisciplinary Professional Education Collaborative (IPEC, 1999) suggested that teams should invest time in developing shared aims and use reflection to help stimulate discussion across professional boundaries. Barr (1998) also highlighted the competencies required of individuals to participate successfully in interprofessional learning and working. Barr suggested that an individual needs the ability to describe his/ her roles and responsibilities clearly to other professions, recognizing the constraints of that role and respecting the roles of others. So long as these competencies are present, practical problem-solving in collaboration with other professionals can provide opportunities for increased understanding, e.g. by reviewing care of individual patients, introducing change to service provision and improving standards.

CASE STUDY

For many years, child health has been taught to general practice registrars in 1-day courses, which were largely lecture-based with a uniprofessional audience. The London Deanery wished to promote an interprofessional approach and funded five sites across London to establish interprofessional courses,

TABLE 1.
Examples of comments from participants at an interprofessional course in child health

'The more we work together with other groups the better we communicate and bridge barriers' (Student health visitor).
'I feel the younger general practitioners (GPs) will be more informed and may consult their health visitor, school nurse colleagues now these teaching sessions are in progress' (Student health visitor).
'I learned about the health visitor's role within child protection. Had not had any contact with school nurses until today' (GP registrar).
'Useful forum for learning as aims to unify different disciplines break down the them-and-us mentality' (GP registrar).
'I learned how to deal with child protection issues on a practical level. If a case came up tomorrow I would know how to act' (GP registrar).
'The majority of children on the child protection register are of school age. GPs should contact school nurses and not health visitors when children are aged 5 years or over. The GP's sometimes seem to be unaware of this' (School nurse).
'It seemed to me a very sharing session. Members of our group appeared to feel able to seek answers and to explore the gaps in knowledge' (Student health visitor).

with participation of health professionals, such as health visitor students, school nurses and general practice registrars. The courses were well evaluated and a number of important lessons were learned by the organizers. This is a resource intensive method of working and the course leader team needed to work explicitly on interprofessional collaboration to create an experience that promoted collaboration among participants. The effect of modelling was noted: where course leader teams were working well, students displayed successful examples of the same processes. Furthermore, students from all professional groups valued the opportunity to learn not just about child health, but about each other's roles. They were frequently surprised that their stereotypical view of another professional did not match reality and this was empowering for all concerned. Examples are given in *Table 1*.

Despite the highly successful nature of the individual courses, the programme organizers continued to encounter obstacles with funding bodies which, while paying lip-service to 'joined-up thinking' and 'supporting collaborative practice', presented obstacles to joined-up funding.

CONCLUSIONS

IPE is an exciting development that has strong support in educational theory, as well as an increasing evidence base for its effectiveness. Important benefits include a deeper understanding of the roles of other professionals, which can help transform organizations, as well as leading directly to improved patient care. Successful initiatives are resource intensive as they require small group working and facilitation, together with a commitment to interprofessional leadership-by-example among the course team.

KEY POINTS

- Multiprofessional learning takes place when different professionals just happen to coincide at an educational event.
- Interprofessional education (IPE) requires that an explicit aim of the programme will be to reach a greater understanding of each other's roles, not a blurring of these roles.
- Small group teaching methods, which are resource intensive, are ideally suited to programmes of IPE.
- IPE has the power to transform organizations and help motivate and retain staff. There is increasing evidence that it leads to improved patient care.
- Barriers to implementing IPE include the uniprofessional nature of many funding streams, interprofessional rivalries and differences in accreditation requirements between professions.

The biggest barrier to implementation is likely to be the attitude of funding bodies. It is easy to pay lip-service to collaborative practice, but, in the authors' experience, it is much harder to promote this approach when there are multiple specific service needs competing for funding. It is likely to take some time before the benefits of IPE are appreciated. **HM**

Conflict of interest: none

Barr H (1998) Promoting Partnership. *J Interprof Care* **15:** 117–18

Borrill C, West M, Shapiro D, Rees S (2000) Team working and effectiveness in health care *Br J Healthcare Management* **6:** 364–71

Bristol Royal Infirmary Inquiry (2001) Bristol Royal Infirmary Inquiry, Bristol

Bruner J (1966) *Towards a theory of instruction.* Belknap, Cambridge, Massachusetts

Carpenter J, Hewstone C (1996) Shared learning for doctors and social workers: evaluation of a programme. *Br J Soc Work* **26:** 239–57

Committee for the Advancement of Interprofessional Education (1997) Interprofessional Education: A Definition *CAIPE Bulletin* **13:** 19

Department of Health (1997) *The New NHS: Modern and Dependable.* DH, London

Department of Health (1998) *A First Class Service: Quality in the New NHS.* DH, London

Department of Health (2001) *Working Together – Learning Together.* DH, London

Freeth D, Hammick M, Koppel I, Reeves S, Barr H (2002) A Critical Review of Evaluations of Interprofessional Education. *CAIPE Bulletin*, London

Headrick LA, Wilcock PM, Batalden PB (1998) Interprofessional working and continuing medical education. *Br Med J* **316:** 771–4

Hewstone M, Brown R, eds (1986) *Contact and Conflict in Intergroup Encounters.* Blackwell, Oxford

Interdisciplinary Professional Education Collaboration (1999) *Guidelines to accelerate teaching and learning about the improvement of health care.* IPEC

Kenny G (2002) Interprofessional working: opportunities and challenges. *Nurs Stand* **17:** 33–5

Kolb D (1984) *Experiential Learning: Experiences as a Source of Learning and Development.* Prentice Hall, New Jersey

Koppel I, Barr H, Reeves S, Freeth D, Hammick M (2001) Establishing a systematic approach to evaluating the effectiveness of interprofessional education *Issues in interdisciplinary care* **3:** 41–9

Laming (2003) The Victoria Climbié Inquiry: Report of an Inquiry. Department of Health, London

McPherson K, Headrick L, Moss F (2001)Working and learning together: good quality care depends on it, but how can we achieve it? *Qual Health Care* **10**(Suppl 2): 46–53

NHS Executive (1999) *Clinical Governance: Quality in the New NHS.* NHS Executive, London

Obholzer A, Roberts VZ (1994) *The Unconscious at Work.* Routledge, London

Pratt J, Gordon P, Plamping D (1999) *Working Whole Systems.* King's Fund, London

Schon D (1983) *The Reflective Practitioner.* Basic Books, New York

Zwarenstein M, Reeves S, Barr H, Hammick M, Koppel I, Atkins J (2001) Interprofessional education: effects on professional practice and health care outcomes. *Cochrane Database Syst Rev* 2001(1), CD002213. Update Software, Oxford